Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 2321

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
15360 – 15501 (Cont.)	15-73 - 15-74.2 (4 pp.)	15-73 - 15-74.1(3 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 1, 2001*
IMPLEMENTATION DATE: October 25, 2002

Section 15501 Evaluation and Management Service Codes – General. Subsection B is revised to address payment for E/M services provided by physicians and non-physician practitioners (NPP) and also shared evaluation and management services between a physician and an NPP in the same group practice. (Also restores language erroneously deleted from the first paragraph of subsection A.)

Carriers need not search their files to either retract payment for claims already paid or to retrospectively pay claims.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

C. Therapy Assistants as Clinical Instructors.--Physical therapist assistants and occupational therapy assistants are not precluded from serving as clinical instructors (CIs) for therapy students, while providing services within their scope of work and performed under the direction and supervision of a licensed physical or occupational therapist to a Medicare beneficiary.

D. Services Provided Under Part A and Part B.--The payment methodologies for Part A and B therapy services rendered by a student are different. Under the physician fee schedule (Medicare Part B), Medicare pays for services provided by physicians and practitioners that are specifically authorized by statute. Students do not meet the definition of practitioners under Medicare Part B. Under SNF PPS, payments are based upon the case mix or RUG category that describes the patient. In the rehabilitation groups, the number of therapy minutes delivered to the patient determine the RUG category. Payment levels for each category are based upon the costs of caring for patients in each group rather than providing specific payment for each therapy service as is done in Medicare Part B.

15350. DIALYSIS SERVICES (CODES 90935-90999)

A. ESRD Monthly Capitation Payments.--Effective January 1, 1995, monthly capitation payments are made under the physician fee schedule. For their adult patients, physicians may bill either the monthly code (CPT code 90921) or the daily code (CPT code 90925) with units that represent the number of days in a single month, but may not bill both.

To bill for a month of services for pediatric patients, providers should bill the appropriate monthly code (CPT codes 90918, 90919, or 90920). To bill for less than a month of service, providers bill the appropriate daily code (CPT codes 90922-90925) and units that represent the number of days. Providers may bill either the monthly code or the daily code, but not both. Since billing is done at the conclusion of the month, the patient's age at the end of month is the age of the patient for billing purposes.

B. Inpatient Dialysis On Same Date As Evaluation and Management.--Payment for certain evaluation and management services (CPT codes 99231 through 99233, subsequent hospital visits, and CPT codes 99261 through 99263, follow-up inpatient consultations) is considered bundled into the payment for inpatient dialysis (CPT codes 90935 through 90947) when both are performed on the same day by the same physician for the same beneficiary. Do not pay a physician for both dialysis and a subsequent hospital visit or a follow-up inpatient consultation on the same date of service. If both are billed, pay the dialysis service and deny the evaluation and management service.

Separate payment may be made for an initial hospital visit (CPT codes 99221 through 99223), an initial inpatient consultation (CPT codes 99251 through 99255), and a hospital discharge service (CPT codes 99238 and 99239) when billed for the same date as an inpatient dialysis service. These services may be billed with a modifier -25 to indicate that they are significant and identifiable services.

Payment is not allowed for more than one inpatient dialysis service per day.

15360. ECHOCARDIOGRAPHY SERVICES (CODES 93303 - 93350)

A. Separate Payment for Contrast Media.--Effective October 1, 2000, physicians may separately bill for contrast agents used in echocardiography. Physicians should use HCPCS Code A9700 (Supply of injectable contrast material for use in echocardiography, per study). The type of service code is 9. This code will be carrier-priced.

15400. CHEMOTHERAPY ADMINISTRATION (CODES 96400-96549)

A. General Use of Codes.--Chemotherapy administration codes, 96400 through 96450, 96542, 96545, and 96549, are only to be used when reporting chemotherapy administration when the drug being used is an antineoplastic and the diagnosis is cancer. The administration of other drugs, such as growth factors, saline, and diuretics, to patients with cancer, or the administration of antineoplastics to patients with a diagnosis other than cancer, are reported with codes 90780 through 90784 as appropriate.

B. Chemotherapy Administration By Push and Infusion On Same Day.--Separate payment is allowed for chemotherapy administration by push and by infusion technique on the same day. Allow only one push administration on a single day.

C. Chemotherapy Infusion and Hydration Therapy Infusion On Same Day.--Separate payment is not allowed for the infusion of saline, an antiemetic, or any other nonchemotherapy drug under CPT codes 90780 and 90781 when administered at the same time as chemotherapy infusion (CPT codes 96410, 96412, or 96414). Separate payment is allowed for these two services on the same day when they are provided sequentially, rather than at the same time. Physicians use the modifier -GB to indicate when CPT codes 90780 and 90781 are provided sequentially with CPT codes 96410, 96412, and 96414.

D. Chemotherapy Administration and "Incident To" Services on Same Day.--On days when a patient receives chemotherapy administration but the physician has no face-to-face contact with the patient, the physician may report and be paid for "incident to" services furnished by one of the physician's employees, in addition to the chemotherapy administration, if they are furnished under direct personal supervision in the office by one of the physician's employees and the medical records reflect the physician's active participation in and management of the course of treatment. The correct code for this service is 99211.

E. Flushing Of Vascular Access Port.--Flushing of a vascular access port prior to administration of chemotherapy is integral to the chemotherapy administration and is not separately billable. If a special visit is made to a physician's office just for the port flushing, code 99211, brief office visit, should be used. Code 96530, refilling and maintenance of implantable pump or reservoir, while a payable service, should not be used to report port flushing.

F. Chemotherapy Administration and Hydration Therapy.--Do not pay separately for the infusion of saline, an antiemetic, or any other nonchemotherapy drug under codes 90780 and 90781 when these drugs are administered at the same time as chemotherapy infusion, codes 96410, 96412, or 96414. However, pay for the infusion of saline, antiemetics, or other nonchemotherapy drugs under codes 90780 and 90781 when these drugs are administered on the same day but sequentially to rather than at the same time as chemotherapy infusion, codes 96410, 96412, and 96414. Physicians should use modifier GB to indicate when codes 90780 and 90781 are provided sequentially rather than contemporaneously with codes 96410, 96412, and 96414. Both the chemotherapy and the nonchemotherapy drugs are payable regardless of whether they are administered sequentially or contemporaneously.

15501. EVALUATION AND MANAGEMENT SERVICE CODES - GENERAL (CODES 99201-99499)

A. Use Of CPT Codes.--Advise physicians to use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management services. Medicare will pay for E/M services for specific non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS) and certified nurse midwife (CNM)) whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service, however, the physician collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners. The service provided must be medically necessary and the service must be

within the scope of practice for a non-physician practitioner in the State in which he/she practices. Do not pay for CPT evaluation and management codes billed by physical therapists in independent practice or by occupational therapists in independent practice.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

B. Selection of Level Of Evaluation and Management Service.--Instruct physicians to select the code for the service based upon the content of the service. The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care as described in subsection C.

Any physician or non-physician practitioner (NPP) authorized to bill Medicare services will be paid by the carrier at the appropriate physician fee schedule amount based on the rendering UPIN/PIN.

"Incident to" Medicare Part B payment policy is applicable for office visits when the requirements for "incident to" are met (see §§2050.1, 2050.2 and 15501 Subsection G).

Office/Clinic Setting.-- In the office/clinic setting when the physician performs the E/M service the service must be reported using the physician's UPIN/PIN. When an E/M service is a shared/split encounter between a physician and a non-physician practitioner (NP, PA, CNS or CNM), the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient. If "incident to" requirements are not met for the shared/split E/M service, the service must be billed under the NPP's UPIN/PIN, and payment will be made at the appropriate physician fee schedule payment.

Hospital Inpatient/Outpatient/Emergency Department Setting.--When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the NPP's UPIN/PIN. Payment will be made at the appropriate physician fee schedule rate based on the UPIN/PIN entered on the claim.

Examples of Shared Visits:

1. If the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, the physician or the NPP may report the service.

2. In an office setting the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the "incident to" requirements are met, the physician reports the service. If the "incident to" requirements are not met, the service must be reported using the NPP's UPIN/PIN.

In the rare circumstance when a physician (or NPP) provides a service that does not reflect a CPT code description, the service must be reported as an unlisted service with CPT code 99499. A description of the service provided must accompany the claim. The carrier has the discretion to

value the service when the service does not meet the full terms of a CPT code description (e.g., only a history is performed). The carrier also determines the payment based on the applicable percentage of the physician fee schedule depending on whether the claim is paid at the physician rate or the non-physician practitioner rate. CPT modifier -52 (reduced services) must not be used with an evaluation and management service. Medicare does not recognize modifier -52 for this purpose.

C. Selection Of Level Of Evaluation and Management Service Based On Duration Of Coordination Of Care and/or Counseling.--Advise physicians that when counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim.

EXAMPLE: A cancer patient has had all preliminary studies completed and a medical decision to implement chemotherapy. At an office visit the physician discusses the treatment options and subsequent lifestyle effects of treatment the patient may encounter or is experiencing. The physician need not complete a history and physical examination in order to select the level of service. The time spent in counseling/coordination of care and medical decision-making will determine the level of service billed.

The code selection is based on the total time of the face-to-face encounter or floor time, not just the counseling time. The medical record must be documented in sufficient detail to justify the selection of the specific code if time is the basis for selection of the code.

In the office and other outpatient setting, counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported. Face-to-face time refers to the time with the physician only. Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service. The code used depends upon the physician service provided.