Medicare Desk Reference for Physicians
Contents

Update Summary Sheet ................................................................. Introduction–1
Introduction .................................................................................. Introduction–1
Index .......................................................................................... Index–1

A–C
Advance Beneficiary Notice ................................................................. 1–1
Allergen Immunotherapy ................................................................. 1–9
Ambulance Services ................................................................. 1–11
Ambulatory Surgery Center ............................................................... 1–28
Anesthesia ........................................................................ 1–54
Anesthesiology Assistants and Anesthesiology Physician Assistants .......... 1–59
Appealing the Denied Claim .............................................................. 1–61
Balance Billing ........................................................................ 1–67
Billing Services ................................................................. 1–68
Blood and Blood Administration .......................................................... 1–71
Blood Clotting Factors ................................................................. 1–73
Blood Glucose Monitors and Testing Strips for Diabetics ......................... 1–74
Bone-Mass Measurements ................................................................. 1–76
Care Plan Oversight ........................................................................ 1–78
Casting, Splinting, and Strapping ............................................................ 1–82
Certified Registered Nurse Anesthetists .................................................. 1–84
Chemotherapy ........................................................................ 1–86
Chiropractic Services ........................................................................ 1–93
Clinical Laboratory Improvement Amendments ........................................... 1–98
Clinical Laboratory Services ............................................................. 1–115
Clinical Psychologists ................................................................. 1–118
Clinical Social Workers ................................................................. 1–120
CMS-1500 Claim Form ................................................................. 1–122
Coding Systems ........................................................................ 1–139
Collagen Implants for Incontinence .......................................................... 1–147
Colorectal Cancer Screening Examinations ............................................... 1–148
Comprehensive Outpatient Rehabilitation Facilities .................................... 1–151
Correct Coding Initiative ................................................................ 1–158
Cosmetic Surgery ........................................................................ 1–171
Covered vs. Noncovered Services .......................................................... 1–173

D–G
Deductibles and Copayments .............................................................. 2–1
Diabetes Outpatient Self-Management Training Services ................................ 2–3
Drugs and Injectables ....................................................................... 2–8
Durable Medical Equipment ............................................................... 2–12
Elective Surgery Notification .............................................................. 2–36
Medicare Desk Reference for Physicians

Electrocardiographic Services ................................................................. 2–37
Electronic Data Interchange ................................................................. 2–42
Emergency Services ........................................................................... 2–45
Endoscopies ......................................................................................... 2–52
End-Stage Renal Disease ................................................................. 2–57
Epoetin Alfa ....................................................................................... 2–76
Evaluation and Management Services ........................................... 2–79
Experimental and Investigational ...................................................... 2–120
Explanation of Benefits ................................................................ 2–122
Glaucoma Screening ...................................................................... 2–126

H–M
Health Insurance Claim Numbers .................................................. 3–1
Health Insurance Portability and Accountability Act of 1996 .......... 3–2
Health Professional Shortage Areas and Physician Scarcity Areas .......... 3–23
Hepatitis B Vaccine ........................................................................ 3–25
Home Health Services .................................................................. 3–26
Home Prothrombin Time International Normalized Ratio Monitoring .......... 3–30
Hospice Care ................................................................................ 3–31
Identification Numbers .................................................................. 3–34
Immunosuppressive Drugs ................................................................. 3–36
Incident-to Services and Supplies .................................................. 3–37
Incomplete or Invalid Claims ......................................................... 3–38
Independent Diagnostic Testing Facility ...................................... 3–39
Indirect Payment Procedure .......................................................... 3–40
Influenza Virus Vaccine ................................................................. 3–42
Inherent Reasonableness ................................................................. 3–43
Insulin Infusion Pumps .................................................................. 3–44
Intravenous Immune Globulin .................................................... 3–45
Limitation of Liability Provision ................................................... 3–46
Limiting Charge ............................................................................. 3–48
Locum Tenens Arrangements .......................................................... 3–93
Magnetic Resonance Angiography .................................................. 3–95
Magnetic Resonance Imaging ........................................................... 3–97
Mammography ............................................................................... 3–100
Medical Necessity ......................................................................... 3–104
Medical Nutritional Therapy ......................................................... 3–105
Medical Review ............................................................................ 3–107
Medicare Secondary Payer ............................................................ 3–112
Medigap ....................................................................................... 3–119
Mental Health Services ................................................................. 3–120
Modifiers ..................................................................................... 3–128
Monitored Anesthesia Care ............................................................. 3–142
<table>
<thead>
<tr>
<th>N–S</th>
</tr>
</thead>
<tbody>
<tr>
<td>National and Local Policies ......................................................... 4–1</td>
</tr>
<tr>
<td>Neuromuscular Electrical Stimulation ............................................... 4–5</td>
</tr>
<tr>
<td>Nurse-Midwives ............................................................................ 4–6</td>
</tr>
<tr>
<td>Nurse Practitioners and Clinical Nurse Specialists ................................ 4–8</td>
</tr>
<tr>
<td>Obstetrics and Gynecology ................................................................ 4–13</td>
</tr>
<tr>
<td>Occupational Therapy Services ....................................................... 4–14</td>
</tr>
<tr>
<td>Office of Inspector General Work Plan .............................................. 4–21</td>
</tr>
<tr>
<td>Ostomy Supplies ........................................................................... 4–23</td>
</tr>
<tr>
<td>Oxygen Therapy Equipment ............................................................. 4–24</td>
</tr>
<tr>
<td>Pain Management ........................................................................... 4–28</td>
</tr>
<tr>
<td>Pap Smears ................................................................................... 4–30</td>
</tr>
<tr>
<td>Parenteral and Enteral Nutrition Therapy .......................................... 4–33</td>
</tr>
<tr>
<td>Participation Program ..................................................................... 4–35</td>
</tr>
<tr>
<td>Pathology Services ......................................................................... 4–42</td>
</tr>
<tr>
<td>Percutaneous Image-Guided Breast Biopsy .......................................... 4–46</td>
</tr>
<tr>
<td>Peripheral Neuropathy with Loss of Protective Sensation ..................... 4–47</td>
</tr>
<tr>
<td>PET Scan ..................................................................................... 4–48</td>
</tr>
<tr>
<td>Physical Therapy Services ................................................................ 4–57</td>
</tr>
<tr>
<td>Physician Assistants ..................................................................... 4–69</td>
</tr>
<tr>
<td>Place-of-Service Codes .................................................................. 4–72</td>
</tr>
<tr>
<td>Pneumococcal Pneumonia Vaccination .............................................. 4–77</td>
</tr>
<tr>
<td>Prostate Cancer Screening ................................................................ 4–79</td>
</tr>
<tr>
<td>Purchased Diagnostic Tests .............................................................. 4–80</td>
</tr>
<tr>
<td>Radiation Therapy Billing ................................................................. 4–83</td>
</tr>
<tr>
<td>Radiology Services ......................................................................... 4–85</td>
</tr>
<tr>
<td>Reassignment ............................................................................... 4–96</td>
</tr>
<tr>
<td>Reciprocal Billing Arrangements ..................................................... 4–107</td>
</tr>
<tr>
<td>Referrals ...................................................................................... 4–109</td>
</tr>
<tr>
<td>Refund of Overpayments ................................................................ 4–119</td>
</tr>
<tr>
<td>Relatives or Household Members .................................................... 4–123</td>
</tr>
<tr>
<td>Resource-Based Relative Value Scale ................................................ 4–124</td>
</tr>
<tr>
<td>Rural Health Clinic Services ........................................................... 4–127</td>
</tr>
<tr>
<td>Screening and Preventive Services ................................................... 4–128</td>
</tr>
<tr>
<td>Seat Lift Mechanisms .................................................................... 4–130</td>
</tr>
<tr>
<td>Sleep Disorder Clinics ................................................................... 4–131</td>
</tr>
<tr>
<td>Specimen Collection Fee ................................................................. 4–133</td>
</tr>
<tr>
<td>Speech Generating Device ................................................................. 4–134</td>
</tr>
<tr>
<td>Speech Pathology Services .............................................................. 4–135</td>
</tr>
<tr>
<td>Stark Self-Referral Regulations ......................................................... 4–140</td>
</tr>
<tr>
<td>Superbills .................................................................................... 4–145</td>
</tr>
<tr>
<td>Supplies ....................................................................................... 4–147</td>
</tr>
<tr>
<td>Surgery ......................................................................................... 4–148</td>
</tr>
</tbody>
</table>
T–Z
Teaching Physician Services ................................................................. 5–1
Telehealth Services ............................................................................ 5–10
Telephone Services ............................................................................ 5–13
Transcutaneous Electrical Nerve Stimulation Devices ...................... 5–14
Transportation of Diagnostic Equipment ........................................... 5–15
Travel .................................................................................................. 5–17
Unlisted Procedures ........................................................................... 5–18
Vaccinations ....................................................................................... 5–19
Vitamin B-12 Injections for Strengthening Tendons and Ligaments ....... 5–20

Appendix
Appendix A: Installing and Using the CD-ROM .................................. Appendix A–1
Blood Clotting Factors

Hemophilia is a blood disorder characterized by a deficiency of a factor in the blood that allows the blood to coagulate, resulting in a tendency to bleed. It is a hereditary disease seen in male patients. There are two major types of hemophilia, which are clinically identical. In hemophilia A or classic hemophilia, factor VIII is deficient or absent. In hemophilia B, factor IX is absent or deficient. A less common form of hemophilia, von Willebrand’s disease, affects males and females with factor VIII deficiency and a platelet adhesion defect. Bleeding is managed by replacement of the deficient factor.

Coverage Criteria
To be eligible for coverage of blood clotting factors, the patient must have one of the following conditions:

- Factor VIII deficiency (classic hemophilia)
- Factor IX deficiency (also called Christmas factor or plasma thromboplastin component [PTC] deficiency)
- von Willebrand’s disease

Billing and Coding Rules

HCPCS Level II Codes
The following HCPCS Level II codes are applicable for coding for blood clotting factors:

- J7190 Factor VIII (antihemophilic factor, human), per IU
- J7191 Factor VIII (antihemophilic factor, porcine), per IU
- J7192 Factor VIII (antihemophilic factor, recombinant), per IU
- J7193 Factor IX complex (antihemophilic factor, purified, nonrecombinant) per IU
- J7194 Factor IX complex, per IU
- J7195 Factor IX (antihemophilic factor, recombinant) per IU
- J7198 Anti-inhibitor, per IU
- J7199 Hemophilia clotting factor, not otherwise classified

Q0187 Factor Vlla (coagulation factor, recombinant) per 1.2 mg
Q2022 von Willebrand factor complex, human, per IU

Reimbursement Issues
The carrier’s determination of the amount of clotting factors that may be covered is based on patterns of historical usage by the patient and the need to keep an emergency supply on hand at home.

All suppliers are required to submit claims to the local carrier, including the Red Cross, independent pharmacies, suppliers of durable medical equipment, independent blood banks, and independent hemophilia centers.

With the exception of drugs and biologicals classified under HCPCS Level II as paid under a cost or prospective payment system OPPS, blood-clotting factors are priced under the drug pricing fee schedule. Effective January 1, 2005, the average sales price (ASP) plus 6 percent is used. Local carriers are responsible for the processing of noninstitutional blood-clotting-factor claims, and fiscal intermediaries (FI) are responsible for processing Part A and Part B institutional blood-clotting-factor claims.

The basis of payment is the least expensive medically necessary blood clotting factors. Although blood-clotting factors are available in a virally inactivated form and a recombinant form, the Food and Drug Administration found that both varieties safe and effective. For that reason, unless the prescription specifically calls for the recombinant form (HCPCS code J7190 for factor VIII), payment is made on the basis of the less expensive, nonrecombinant forms (HCPCS codes J7191 and J7195).

Records may be reviewed when carriers see an unusual billing pattern demonstrating that the provider or supplier is billing more frequently for the recombinant form than others.
Deductibles and Copayments

The Medicare deductible is the amount that a Medicare patient must pay before any items or services will be paid by Medicare.

Since 1991, this amount has been $100 annually for Part B services covered under Medicare. However, as the result of passage of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, effective January 1, 2005, this amount increased to $110 for all beneficiaries. Effective for services provided during 2006, and all years after that, the deductible will be the previous year's deductible plus the annual percentage increase in the monthly actuarial rate for Medicare enrollees rounded to the nearest dollar.

The patient does not have to meet a separate deductible for each different type of covered service. Incurred, rather than paid, expenses count toward the deductible. Noncovered expenses do not count toward the deductible.

The copayment or coinsurance is the portion of the balance of covered medical expenses for which the patient is responsible after paying the deductible. For Medicare, this amount is 20 percent of the reasonable charge for the item or service. For instance, if the Medicare reasonable charge for a covered Part B service is $100, the Medicare patient who has met his or her deductible for the year would pay $20 and Medicare would pay $80.

Routine Waiver of Medicare Copayments and Deductibles

The routine waiver of deductibles and copayments is unlawful for the following reasons:

- It results in false claims.
- It violates the antikickback statute.
- It results in excessive utilization of Medicare items and services.

The provider or supplier who routinely waives Medicare deductibles and copayments is misrepresenting the actual charge of that service or supply. For instance, if the provider claims that the charge for a specific service is $100, but routinely waives the copayment, the actual charge is really $80. Medicare should be paying 80 percent of $80, which is $64, rather than 80 percent of $100, which is $80. Each time this service is billed, and the copayment waived, Medicare is paying $16 more for the service than it should be.

Some indications of the practice of improper waiver of deductibles and copayments include the following:

- Advertising promises discounts to Medicare beneficiaries, or that makes statements such as “Medicare accepted as payment in full” or “No out-of-pocket expenses.”
- Deductibles and copayments are collected only when the patient has Medicare supplemental insurance (Medigap) coverage, which means the items or services are free for the patient.
- Financial hardship forms that state that the patient is unable to pay the deductible or coinsurance are routinely used without a good faith attempt to determine the patient’s actual financial status.
- Higher fees are charged to Medicare beneficiaries than to patients receiving similar items and services—with the intent of offsetting the waiver of the coinsurance.
- The provider fails to collect deductibles and copayments from a specific group of Medicare beneficiaries for reasons unrelated to indigence. For instance, the deductible or coinsurance is waived for all patients from a specific hospital in order to obtain referrals.
- A sham insurance program covers deductibles or copayments only for items or services provided by the entity offering the insurance. Premiums may be as low as $1 a month and are used to disguise the routine waiver of deductibles and copayments.

Indigent Patients

For an indigent patient, it may be allowable to accept less than the usual charge. In this case, the provider should not routinely waive any part of the charge for that service.
Evaluation and Management Services

Current Guidelines

As of this printing neither the evaluation and management (E/M) code descriptions in the CPT code book or the 1995 and 1997 federal documentation guidelines have undergone any update or change.

Since E/M services comprise more than a third of all Medicare benefits provided for physician services, and an Office of Inspector General (OIG) audit of Medicare revealed that insufficient or no documentation accounted for $10.8 billion in improper payments, it is a certainty that Medicare will continue to scrutinize physician documentation of the E/M services they provide. Note the continued inclusion of these services on the “Office of Inspector General Work Plan for 2005.”

The AMA workgroup announced that no final guidelines were forthcoming until the E/M codes, found in the proprietary AMA CPT code book, were changed. Indications are that these new code descriptions will resemble the CMS draft of revised guidelines in June and December of 2000. The key change is likely the elimination of the straightforward level of decision-making and the collapse of five-code ranges into three-code ranges. This would make inpatient and outpatient coding more homogeneous.

Until the final guidelines are completed, providers may use either the 1995 or the 1997 documentation guidelines. Medicare carriers have been instructed by CMS to review claims in accordance with both sets of guidelines also and not to penalize physicians for inadvertent errors. For that reason, information regarding both the current and revised guidelines has been included in the following sections.

Billing and Coding Rules

The following charts provide specific qualifying factors for each level of E/M code within a given category to aid in correct code selection. This information is based on the current documentation guidelines. The general guidelines are applicable to the current as well as the revised guidelines.

Although the individual requirements of a specific CPT code must be met to bill for a level of service, the primary payment criterion is medical necessity. It is not medically necessary to bill a higher level of service if a lower level is warranted. Supporting documentation that justifies the level of service should be recorded during, or as soon as possible after, it has been provided to sustain the accuracy of the medical record.

Split and Shared E/M Services

Office and Clinic Setting

E/M services provided in the office or clinic setting by the physician must be billed using the physician’s UPIN/PIN. When the E/M service is shared or split between the physician and a nonphysician practitioner (NPP) such as a nurse practitioner (NP), physician assistant (PA), clinical nurse specialist (CNS) or a certified nurse midwife (CNM) it may be reported in one of two ways.

If the service is provided to an established patient, and the incident-to requirements are met, the service is billed using the physician’s unique physician identification number or provider identification number (UPIN/PIN). If the incident-to provisions are not met, the service must be billed using the UPIN/PIN of the nonphysician practitioner.

Example: In an office setting the nonphysician practitioner 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 nonphysician practitioner’s UPIN/PIN.

Hospital Inpatient/Outpatient/Emergency Department Setting

Whenever an E/M service is shared by a physician and an NPP from the same group, and the physician provides any of the face-to-face portion of the service, the service may be reported using either the physician’s or the nonphysician practitioner’s UPIN/PIN.