

Medicare B Update!

A Newsletter for Florida Medicare Part B Providers

Changes to the 2000 Medicare Physician Fee Schedule Database

Procedure codes that are subject to specific reimbursement rules on the Medicare Physician Fee Schedule Database (MPFSDB) were provided in the *Medicare B Update! Special Issue "2000 HCFA Common Procedure Coding System and Medicare Physician Fee Schedule Database Update"* (December 1999). Since that publication was released, the Health Care Financing Administration (HCFA) has made changes to the policy indicators for a number of procedure codes. These changes, effective for services rendered on or after January 1, 2000, do not affect the allowances that were published in the *2000 Medicare Part B Physician and Non-Physician Practitioner Fee Schedule* book that was sent to providers in mid-November, with the exception of procedure codes 94760 and 94761 (pulse oximetry services).

Corrections to Local Medical Review Policies

These changes to the 2000 MPFSDB affect the payment status of procedure codes 94760 (Noninvasive ear or pulse oximetry for oxygen saturation; single determination) and 94761 (Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations [e.g., during exercise]). As a result of these changes, revisions have been made to the Coding Guidelines section of the local medical review policies (LMRPs) for Enhanced External Counterpulsation, Independent Diagnostic Testing Facility (IDTF), and Noninvasive Ear or Pulse Oximetry for Oxygen Saturation. The statement now reads:

Effective January 1, 2000, procedure codes 94760 and 94761 are considered bundled services and are, therefore, not separately reimbursable when billed with other physician fee schedule services by the same provider on the same day.

The LMRP for Pulse Oximetry will be republished in its entirety in the March/April 2000 issue of the *Medicare B Update!* Refer to the January/February 2000 *Update!* (pages 30-31) for the LMRP on Enhanced External

Counterpulsation. The IDTF LMRP is in the July/August 1999 *Update!* (pages 13-17); a revision is on page 29 of the January/February 2000 *Update!*

This change also identifies procedure code 20979 (Low intensity ultrasound stimulation to aid bone healing, noninvasive [nonoperative]) as noncovered; therefore, this procedure code was moved from the local noncoverage section to the national noncoverage section of the "The List of Medicare Noncovered Services." This service is noncovered because it is considered investigational or experimental.

Payment for Pulse Oximetry Services

In addition to the LMRP changes listed above, reimbursement guidelines for pulse oximetry services changed as a result of the payment status change. For services rendered prior to January 1, 2000, separate payment for these services was available. However, effective with the 2000 Medicare Physician Fee Schedule (released November, 1999), the payment status changed to "Bundled: Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient)."

The status of these codes is being revised again; pulse oximetry services are not always bundled. The new status is: "Injections. There are RVUs and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made."

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CHANGES TO THE 2000 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

Changes...(continued from previous page)

Pulse oximetry services are obviously not injections; however, this change means that pulse oximetry *may* be separately payable, but *only in situations where no other services payable under the physician fee schedule are billed on the same date by the same provider*. HCFA intends to revise the definition of the status for injections at a later date, to reflect the inclusion of other services, such as pulse oximetry.

For those situations where pulse oximetry is payable, the 2000 allowances are:

CODE/MOD	PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
94760	7.22	8.07	8.82	6.86	7.67	8.38	7.89	8.82	9.64
94761	17.01	19.04	20.86	16.16	18.09	19.82	18.58	20.80	22.79

Changes to Medicare Physician Fee Schedule Policies

These changes affect the December 1999 *Special Issue Update!* MPFSDB Appendices (pages 22-78). The changes are as follows:

Procedure Revision

G0171	Remove from Appendix V - Procedures Subject to Multiple Surgery Rules
13102	Remove from Appendix V - Procedures Subject to Multiple Surgery Rules
13122	Remove from Appendix V - Procedures Subject to Multiple Surgery Rules
13133	Remove from Appendix V - Procedures Subject to Multiple Surgery Rules
13153	Remove from Appendix V - Procedures Subject to Multiple Surgery Rules
15001	Remove from Appendix V - Procedures Subject to Multiple Surgery Rules
20690	Add to Appendix V - Procedures Subject to Multiple Surgery Rules
20692	Add to Appendix V - Procedures Subject to Multiple Surgery Rules
20979	Add to Appendix XXIII - Non-Covered Services. Remove from Appendix I - Procedures with 90 Follow-Up Days (Major Surgery) Remove from Appendix XXII - Procedures Subject to Facility Pricing
30930	Add to Appendix XIII - Procedures Allowed at 150 Percent When Performed Bilaterally
33968	Remove from Appendix V - Procedures Subject to Multiple Surgery Rules Remove from Appendix I - Procedures with 90 Follow-Up Days (Major Surgery) Add to Appendix III - Procedures with 0 Follow-Up Days (Minor Surgery)
36823	Add to Appendix I - Procedures with 90 Follow-Up Days (Major Surgery)

47560	Remove from Appendix I - Procedures with 90 Follow-Up Days (Major Surgery) Add to Appendix III - Procedures with 0 Follow-Up Days (Minor Surgery)
62263	Remove from Appendix III - Procedures with 0 Follow-Up Days (Minor Surgery). Add to Appendix II - Procedures with 10 Follow-Up Days (Minor Surgery).
94760	Remove from Appendix XXIV - Bundled Services
94761	Remove from Appendix XXIV - Bundled Services
96570	Remove from Appendix III - Procedures with 0 Follow-Up Days (Minor Surgery). Remove from Appendix XV - Base Endoscopies and Related Procedures (remove from endo base code 31622)
96571	Remove from Appendix III - Procedures with 0 Follow-Up Days (Minor Surgery). Remove from Appendix XV - Base Endoscopies and Related Procedures (remove from endo base code 31622)

For the following procedures, the concepts of multiple surgery, bilateral surgery, assistant surgery, co-surgery, and team surgery do not apply:

G0102	76005-26	93741
G0166	76873	93741-TC
G0167	76873-TC	93741-26
G0169	76873-26	93742
72275	77427	93742-TC
72275-TC	77520	93742-26
72275-26	77523	93743
73542	78456	93743-TC
73542-TC	78456-TC	93743-26
73542-26	78456-26	93744
76005	92961	93744-TC
76005-TC	93727	93744-26

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