

Medicare B Update!

A Newsletter for Florida Medicare Part B Providers

Final Update to the 2001 Medicare Physician Fee Schedule Database

The changes listed in this final update for 2001 are effective for dates of service on or after January 1, 2001, processed on or after October 1, 2001, **except where otherwise noted.**

The procedure status indicator is changed for HCPCS codes A4570, A4580, and A4590. The new procedure status is "I" (Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. [Code NOT subject to a 90 day grace period]. **NOTE: This change is effective for dates of service on or after October 1, 2001.** The new "Q" codes for casting and splinting (see the June 2001 *Medicare B Update! Special Issue*) should be reported for these services.

The procedure status indicator is changed for HCPCS codes G0219, G0219 TC, and G0219 26. The new procedure status is "N" (Non-covered service). **NOTE: This change is effective for dates of service on or after July 1, 2001.** The June 2001 *Medicare B Update! Special Issue* and 4th Quarter 2001 *Medicare B Update!* listed fee allowances for these services; however the descriptor for procedure code G0219 is "PET Imaging whole body; melanoma *for non-covered indications.*" Florida Medicare is revising the PET Scan local medical review policy (LMRP) to reflect this change. The LMRP revision will be provided in a future issue of the *Update!*

The global period for CPT codes 11976 and 33960 is changed to "000" (Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable).

Additionally, the global period for the following CPT codes is changed to 000; however, **these codes are currently noncovered by Florida Medicare:**

15824	15826	15829	15877	15879	36468	41820	41850
15825	15828	15876	15878	17380	36469	41821	41870

The bilateral surgery indicator for CPT codes 63043 and 63044 is changed to "0" (**150 percent payment adjustment for bilateral procedures does not apply.** If procedure is reported with modifier -50 or with modifiers RT and LT, payment is based on the lower of: (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single code).

The bilateral surgery indicator for CPT codes 73718, 73718 26, 73718 TC, 73719, 73719 26, and 73719 TC is changed to "2" (**150 percent payment adjustment for bilateral procedure does not apply.** RVUs [relative value units] are already based on the procedure being performed as a bilateral procedure). If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers with a 2 in the units field), payment for both sides is based on the lower of (a) the total actual charges by the physician for both sides or (b) 100 percent of the fee schedule amount for a *single* code.



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The *Medicare B Update!* should be shared with all health care practitioners and managerial members of the provider/supplier staff. Publications issued after January 1997 are available at no cost from our provider Website, www.floridamedicare.com.

Routing Suggestions:

- Physician/Provider
- Office Manager
- Billing/Vendor
- Nursing Staff
- Other _____



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The co-surgery indicator is changed to "2" (Co-surgeons permitted; no documentation required if two specialty requirements are met) for the following CPT codes:

34800	34808	34820	34830	36870	48554
34802	34812	34825	34831	43231	48556
34804	34813	34826	34832	43232	

The multiple procedural indicator for CPT code 17004 is changed to "2" (Standard payment adjustment rules for multiple procedures apply). The multiple procedural indicator for CPT code 34826 is changed to "0" (No payment adjustment rules for multiple procedures apply).

The team surgery indicator for CPT codes 48554 and 48556 is changed to "2" (Team surgeons permitted; pay by report).

The non-facility practice expense RVUs for CPT codes 76977 and 76977 TC are changed. This results in the following updated fee allowances for these services when provided in a location other than those defined as a facility:

Code/Mod	PARTICIPATING			NONPARTICIPATING			LIMITING CHARGE		
	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04
76977	34.78	38.25	40.80	33.04	36.34	38.76	38.00	41.79	44.57
76977 TC	31.69	34.86	37.11	30.11	33.12	35.25	34.62	38.08	40.54

Finally, since CPT codes 90471, 90472, and 93668 are noncovered services, the malpractice relative values for these codes are changed to 0.00.

Source: CMS Transmittal AB-01-108, CR 1790

Correction of Payment for Diabetes Outpatient Self-Management Training Services

Program Memorandum (PM) B-01-40, released June 15, 2001, mentions the two "G" codes for diabetes education (G0108 and G0109) and the definition change from 60 minutes to 30 minutes. The definition change was made with the January 1, 2001, HCPCS update. However, the payment rate on the Medicare Physician Fee Schedule Date Base (MPFSDB) was not reduced at that time because the final regulation on diabetes education did not become effective until February 27, 2001. The payment rate will be changed in the January 2002 MPFSDB update. Until that time, **providers should use the following instruction to bill for diabetes outpatient self-management training services provided throughout the remainder of 2001.**

- Providers who perform a 1-hour session of diabetes education should bill code G0108 or G0109 (as appropriate) with a "1" in the days or units field (24G) on Form HCFA-1500, or electronic equivalent. Even though the definition of the codes reads 30 minutes, the reimbursement the provider will receive is for 60 minutes.
- Providers who perform a 30-minute service should not bill until a full hour has been completed (i.e., do not submit a claim until the second 30-minute service has been provided). In the event that two 30-minute sessions are provided on different days, use the day the *second* session is conducted as the date of service.
- Providers who bill for a 2-hour session must use a "2" in the units column and not a "4."

This problem will be corrected in January 2002. Services provided on or after January 1, 2002, will be correctly reimbursed based on the 30 minutes in the procedure description.

Source: CMS Transmittal AB-01-109, CR 1789

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