Medicare B Update!
A Newsletter for Connecticut and Florida Medicare Part B Providers

Special Issue

Final Update to the 2003 Medicare Physician Fee Schedule Database

The Centers for Medicare & Medicaid Services (CMS) has identified various inconsistencies in the 2003 Medicare Physician Fee Schedule Database (MPFSDB), and has provided changes in a final quarterly update to the 2003 MPFSDB. **Unless otherwise stated, the changes that follow are effective for claims with dates of service March 1, 2003 or later, processed October 1, 2003 or later.** All changes are applicable in Connecticut and Florida, except for differences in allowances (as noted).

Changes included in this final update to the 2003 MFSDB are as follows:

Changes to Policy Indicators

Diagnostic Supervision Indicator = 01

Procedure must be performed under the general supervision of a physician.

G0248
G0249

Bilateral Procedure Indicator = 2

150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure.

0025T ***(Effective for services performed on or after January 1, 2002.)***
92136-26

Multiple Procedure Indicator = 0

No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.

78306
78306-26
78306-TC
78320
78320-26
78320-TC

Continued on page 2...

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www.connecticutmedicare.com *and* www.floridamedicare.com

This *Medicare B Update! Special Issue* is published by the Medicare Communication & Education department of First Coast Service Options, Inc. (FCSO) to provide timely and useful information to Medicare Part B providers in Connecticut and Florida. Questions concerning this publication or its contents may be directed in writing to:

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The *Medicare B Update!* should be shared with all healthcare practitioners and managerial members of the provider/supplier staff. Publications issued beginning in 1997 are available at no cost from our provider Web sites: *www.connecticutmedicare.com* and *www.floridamedicare.com*.

Routing Suggestions:

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

Multiple Endoscopy Base Code

Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). If an endoscopic procedure is reported with only its base procedure, carriers do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy.

The base procedure for 52347 is changed to 52010.

Changes to Procedure Description

Long descriptor:

G0275 Renal angiography, non-selective, one or both kidneys, performed at the same time as cardiac catheterization and/or coronary angiography, includes positioning or placement of any catheter in the abdominal aorta at or near the origins (ostia) of the renal arteries, injection of dye, flush aortogram, production of permanent images, and radiologic supervision and interpretation (List separately in addition to primary procedure).

(Effective for services performed on or after January 1, 2003.)

G0278 Iliac and/or femoral artery angiography, non-selective, bilateral or ipsilateral to catheter insertion, performed at the same time as cardiac catheterization and/or coronary angiography, includes positioning or placement of the catheter in the distal aorta or ipsilateral femoral or iliac artery, injection of dye, production of permanent images, and radiologic supervision and interpretation (List separately in addition to primary procedure).

(Effective for services performed on or after January 1, 2003.)

Changes to Procedure Status

Code G0027 was inadvertently deleted from the MFSDB and is now being reinstated with procedure status = X, retroactive to March 1, 2003.

New Codes Added

The final update to the 2003 MPFSDB adds several new procedure codes. Allowances for some of these codes will be posted to our provider education Web sites in the near future.

G0296, G0296-26, G0296-TC

(Effective for services performed on or after October 1, 2003.)

Q3000

(Effective for services performed on or after January 1, 2003.)

Q0453

(Effective for services performed on or after July 1, 2003.)

Q4076, Q4077, Q4078

(Effective for services performed on or after October 1, 2003.)

Changes to Relative Value Units (RVUs) and Updated Allowances

The RVUs have been changed for procedure code 93012 for the facility fee. Therefore, the allowances have been updated so the facility and nonfacility fees match (see below).

Updated Allowances—Connecticut

Code/Mod	Par	Non Par	LC
G0296 26	105.76	100.47	115.54
	(Effective for services performed on or after October 1, 2003.)		
93012	260.05	247.05	284.10
	(Effective for services performed on or after May 1, 2003.)		

Updated Allowances—Florida

	Par			Non Par			Limiting Charge		
Code/Mod	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04
G0296 26	95.73	100.68	104.58	90.94	95.65	99.35	104.59	109.99	114.25
	(Effective for services performed on or after October 1, 2003.)								
93012	215.43	234.67	245.75	204.66	222.94	233.46	235.36	256.38	268.48
	(Effective for services performed on or after May 1, 2003.)								

Source: CMS Transmittal AB-03-119, CR 2853