Program Memorandum Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1438

SUBJECT: 2001 Physician Fee Schedule for Payment Policies

This Program Memorandum (PM) contains the issues addressed in the Medicare Physician Fee Schedule Regulation for 2001. This issue also clarifies the definition of assistant at surgery.

Geographic Practice Cost Indices (GPCI)

The statute requires that payments based on the nationally uniform relative values under the Medicare physician fee schedule be adjusted for each locality by a geographic adjustment factor. The GPCIs account for the geographic differences associated with providing services in the 89 different localities used for payment under the Medicare physician fee schedule. The statute requires that GPCIs be reviewed and, if necessary, adjusted at least every 3 years. Only the malpractice and rental components of the GPCIs are updated for 2001.

Under the revised GPCIs, the changes are minimal. Further, GPCI revisions for 2001, would be only one-half of these amounts, as the revised GPCIs will be phased in over a 2-year period, as required by Medicare statute.

Resource-Based Practice Expense Relative Value Units (RVUs)

The transition to resource-based practice expense RVUs began in 1999 with payments based on a combination of the old charge-based RVUs and the new resource-based RVUs. In 2001, payments will be based on a blend of 75 percent of the resource-based RVUs and 25 percent of the charge-based RVUs.

In 2002, all components of the fee schedule will be resource-based. Other changes in PERVUs are based on our acceptance of most of the recommendations from the Practice Expense Advisory Committee for refinements to individual Common Procedural Terminology (CPT) codes.

Resource-Based Malpractice Expense Relative Value Units

The malpractice RVUs for 2001 are based upon newer malpractice premium data (1996-1998). Prior to this, we used 1993-1995 malpractice premium data, as it was the best available data at the time. The use of the newer malpractice premium data did not result in significant impacts for any one specialty.

Antigen Supply/Dose (CPT Code 95165)

The regulation was revised to allow beneficiaries to receive up to a 12-month supply of antigen. Previously, beneficiaries could receive only up to a 12-week supply of antigen. A 12-month supply ensures patient care and is more in line with current industry standards.

Additionally, for purposes of resource-based practice expense inputs, we now define a “dose” as a one cc aliquot from a multi-dose vial. This clarification will allow physicians to bill Medicare for each dose prepared from each multi-dose vial.

Care Plan Oversight (CPO)

For 2001 we have created two new Health Care Financing Administration Common Procedural Coding System (HCPCS) codes for care plan oversight. We created these two HCPCS codes (G0179 and G0182) due to revisions CPT made to existing CPT codes 99375 and 99378. The definitional revisions to CPT codes 99375 and 99378 are inconsistent with current Medicare policy as the new CPT definitions now defines the code to include, as physician work, communication with non-professionals, which current Medicare policy does not recognize for purposes of CPO. Communication with non-professionals is part of the pre/post service work of other evaluation and management services and is not attributable to CPO. For 2001, all RVUs and indicators have been crosswalked from former CPT codes 99375 and 99378 to new HCPCS codes G0181 and G0182. CPT codes 99375 and 99378 are non-covered services on the database.

We are also clarifying that, under the provisions of the Balanced Budget Act of 1997, nurse practitioners, physician assistants, and clinical nurse specialists, practicing within the scope of State law, may bill for care plan oversight. These non-physician practitioners must be providing ongoing care for the beneficiary through evaluation and management services (but not if they are involved only in the delivery of the Medicare covered home health or hospice service).

Physician Certification and Recertification of Home Health Plans of Care

For 2001 we have created two new HCPCS codes for the certification (HCPCS code G0180) and recertification (HCPCS code G0179) and development of plans of care for Medicare-covered home health services. The use of these two new HCPCS codes are available only to physicians who are permitted to certify that home health services are required by a patient in accordance with to §1814 (a) (2) (C) and §1835 (a) (2) (A) of the Act. The home health agency certification code (HCPCS code G0180) can be billed only when the patient has not received Medicare-covered home health services for at least 60 days. The home health agency recertification code (HCPCS code G0179) is used after a patient has received services for at least 60 days (or one certification period) when the physician signs the certification after the initial certification period. HCPCS code G0179 will be reported only once every 60 days, except in the rare situation when the patient starts a new episode before 60 days elapses and requires a new plan of care to start a new episode.

Observation Care Codes (CPT Codes 99234 Through 99236)

This clarifies the use of CPT codes 99234 through 99236:

- For a physician to appropriately report CPT codes 99234 through 99236, the patient must be an inpatient or an observation care patient for a minimum of 8 hours on the same calendar date.

- When the patient is admitted to observation status for less than 8 hours on the same date, the physician must use CPT codes 99218 through 99220 and no discharge code must be reported.

- When patients are admitted for observation care and then discharged on a different calendar date, the physician must use CPT codes 99218 through 99220 and CPT observation discharge code 99217.

- When patients are admitted to inpatient hospital care and then discharged on a different calendar date, the physician must use CPT codes 99221 through 99233 and CPT hospital discharge day management codes 99238 or 99239.

- For an inpatient admission with discharge less than 8 hours later on the same calendar date, CPT codes 99221 through 99223 must be used for the admission service, and the hospital discharge day management service must not be billed.

The physician must satisfy the documentation requirements for both admission to and discharge from inpatient or observation care to bill CPT codes 99234, 99235, or 99236. The length of time for observation care or treatment status must also be documented.

Clarification of Existing Policy on Assistant at Surgery Services

We are also clarifying the services which may be billed for assistant at surgery services.

First, as the words denote, an assistant at surgery must actively assist when a physician performs a Medicare-covered surgical procedure. This necessarily entails that the assistant be involved in the actual performance of the procedure, not simply in other, ancillary services. Since an assistant would, thus, be occupied during the surgical procedure, the assistant would not be available to perform (and thus, could not bill for) another surgical procedure during the same time period.

The *effective date* for this PM is *January 1, 2001.*

The *implementation date* for this PM is *January 1, 2001.*

These instructions should be implemented within your current operating budget.

This PM may be discarded after January 31, 2002.

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