

INTRODUCTION

Key for Medicare Status Indicators

Procedure Code Status

Medicare assigns a "Status Indicator" to each code in the Medicare Fee Schedule. This is what they mean:

- A Active Code. Paid separately, if covered.
- B Bundled Code. Payment is always bundled into payment for another service.
- C Carrier priced Code. Usually done on an individual case basis, based on documentation.
- D Deleted Code. These codes are deleted effective with the beginning of the calendar year.
- E Excluded from Fee Schedule by regulation. No RVUs.
- F Deleted Discontinued Code: Code not subject to a 90 day grace period
- G Not valid for Medicare purposes. Medicare uses another code for these services.
- H Deleted Modifier. Code formerly had a TC or 26 modifier.
- I Not valid for Medicare purposes. Medicare uses another code for these services.
- N Non-covered Services. These services are not covered by Medicare.
- P Bundled/Excluded Codes. No RVUs; no payment should be made for these services.
- R Restricted Coverage. Special coverage instructions apply. Normally not covered.
- T Injections. Paid for only if no other services are billed same day by same provider.
- X Statutory Exclusion. Not included in the statutory definition of "physician services."

Relative Values

The Medicare physician fee schedule amounts are adjusted to reflect the variation in practice costs from area to area. A geographic practice cost index (GPCI) has been established for every Medicare payment locality for each of the three components of a procedure's relative value unit (i.e., the RVUs for work, practice expense, and malpractice). The GPCIs are applied in the calculation of a fee schedule payment

amount by multiplying the RVU for each component times the GPCI for that component.

Section 121 of the Social Security Act Amendments of 1994 required CMS to replace the existing charge-based practice expense relative value units for all Medicare Physician Fee Schedule services with new resource-based ones. The Balanced Budget Act of 1997 requires a four year transition from the existing charge-based system to the new resource-based system beginning on January 1, 1999. In 1999, the practice expense relative value units are based on 75 percent of the charge-based system and 25 percent of the resource-based system. In 2001, they are based on 50 percent of the charge-based system and 50 percent of the resource-based system. In 2001, they are based on 25 percent of the charge-based system and 75 percent of the resource based system. In 2002 and beyond, the practice expense relative value units are based entirely on the resource-based system. Under the charge-based system, CMS had a policy that reduces the practice expense relative value units for certain services by 50 percent when they are performed in a facility setting. Under the resource-based system, this policy is no longer applicable because, where appropriate, CMS developed practice expense relative value units specific to the facility and non-facility settings. Generally, under the resource-based system, the facility practice expense RVUs will be used for services performed in inpatient or outpatient hospital settings, emergency rooms, skilled nursing facilities, or ambulatory surgical centers (ASCs). The nonfacility practice expense relative value units will be used for services furnished in all other settings.

The payment formula for 2005 is as follows:

2005 Non-Facility Pricing Amount =
[(Work RVU * Work GPCI) + (RB Non-Facility PE RVU * PE GPCI) +
(MP RVU * MP GPCI)] * Conversion Factor

2005 Facility Pricing Amount =
[(Work RVU * Work GPCI) +(RB Facility PE RVU * PE GPCI) +
(MP RVU * MP GPCI)] * Conversion Factor

The next three columns show the Global Service Allocation of RVUs

- | | |
|------------------------|--|
| <i>Pre-operative</i> | The percentage of the global service package allocated to pre-operative care. |
| <i>Intra-operative</i> | The percentage allocated to intraoperative care, including post-operative work in the hospital |
| <i>Post-operative</i> | The percentage allocated to postoperative care, following discharge, provided in the office. |

Global Surgery	The post-surgical timeframe for the global surgery package.
000	Endoscopic or minor procedure. Pre and postoperative values included in the fee schedule amount.
010	Minor procedure; 10 day post operative period; E&M services on day of surgery and during 10 day period are generally not payable.
090	Major surgery; 1 day pre-operative and 90 day postoperative period included in the fee schedule amount.
MMM	Maternity codes; usual global surgery period does not apply.
XXX	The global surgery period does not apply.
YYY	Carrier determines if global concept applies, and determines postoperative period at time of pricing.
ZZZ	Code related to another service that is always included in the global period of another service.

PC/TC Indicators

Professional and Technical component indicators

- 0 Physician Service Codes. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes.
- 1 Diagnostic Tests for Radiology Services. Modifiers 26 and TC may be used.
- 2 Professional component only codes. Use no modifiers with these codes.
- 3 Technical component only codes. Use no modifiers with these codes.
- 4 Global Test Only. Modified versions of these codes may also be used.
- 5 Incident To: Codes. Covered services provided by auxiliary personnel employed by the physician and working under his/her direct supervision. Not covered when provided in hospital (inpatient or outpatient). Do not use modifiers 26 or TC with these codes.
- 6 Lab Physician Interpretation Codes. Actual performance of tests paid separately. Do not use a modifier with these codes.
- 7 Physical therapy service for which payment may not be made. Payment may not be made if provided in a hospital (inpatient or outpatient) by an independently practicing therapist.
- 8 Physician Interpretation Codes. Codes for which the physician may be paid for interpretation if the physician interprets an abnormal smear for a hospital inpatient. No payment is made for codes 88141, 85060 or P3001-26 if provided to outpatients or non-hospital patients.
- 9 Concept does not apply.

Multiple Procedures

When more than one procedure is performed at the same surgical session, the multiple procedure modifier may be required, which means that reimbursement will be modified. Use your normal fee for each procedure, whether or not modifier 51 is used.

The following are the status indicators for multiple procedures:

- 0 No payment adjustment rules for multiple procedures apply. Report in addition to any other procedures performed on the same day.
- 1 Standard payment adjustment rule in effect before 1/1/95 applies:
If reported in addition to other procedures with an indicator of 1, 2 or 3, rank in relative value order/fee schedule amount and pay 100%, 50%, 25%, 25%, and 25%.
- 2 Standard payment adjustment rule applies:
If reported in addition to other procedures with an indicator of 1, 2 or 3, rank in relative value order/fee schedule amount and pay 100%, 50%, 50%, 50%, 50% and by report.
- 3 Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy. The effect of this rule is that you are paid for the base endoscopy PLUS the difference between the base endoscopy and the endoscopy you performed.⁹ Concept does not apply.

Bilateral Procedures

- 1 Bilateral concept applies. Procedures billed with the 50 modifier, or if the same procedure is billed twice on the same day by any other means, payment amount will be 150% of the normal fee schedule amount or the actual charge, whichever is lower.

The bilateral adjustment is applied **BEFORE** applying any multiple procedure rules.

- 2 Bilateral payment adjustment does not apply, because the RVUs for the procedure are already based on the procedure being performed bilaterally.

If only one side is done, use modifier 52 and reduce your fee by one half.

- 3 Bilateral payment adjustment does not apply. If both sides are done, they should be charged separately, at their normal fee. Services in this category are typically radiology procedures.
- 9 Concept does not apply.

Assistant at Surgery

- 0 Payment restriction applies unless supporting documentation is supplied to establish medical necessity.
- 1 Statutory restriction. Assistant at surgery may not be paid
- 2 Payment restriction does not apply. Assistant at surgery may be paid.
- 9 Concept does not apply.

Co-Surgeons

This indicator identifies services for which two surgeons, of different specialties, may be paid.

- 0 Co-surgeons not permitted for this procedure.
- 1 Co-surgeons could be paid, but documentation is required to support the medical necessity of two surgeons for the procedure.
- 2 Co-surgeons permitted. No documentation is required if the two specialty requirement is met.
- 9 Concept does not apply.

Team Surgery

Indicates services for which team surgeons may be paid.

- 0 Team surgeons not permitted for this procedure.
- 1 Team surgeons could be paid, but documentation supporting the medical necessity of a team is required.
- 2 Team surgeons permitted; paid by report.
- 9 Concept does not apply.

Physician Supervision

This indicator is for informational use only. Used for Diagnostic post payment review.

- 1 Must be performed under the general supervision of a physician.
- 2 Must be performed under the direct supervision of a physician.
- 3 Must be performed under the personal supervision of a physician.
- 4 Does not apply if personally furnished by a qualified independent psychologist or clinical psychologist; otherwise, must be performed under the general supervision of a physician.
- 5 Does not apply if personally furnished by a qualified audiologist; otherwise, must be performed under the general supervision of a physician.

- 6 Must be personally performed by a physician or a physical therapist who is certified by the American Board of Physical Therapy Specialties as a qualified electrophysiologic clinical specialist, AND is permitted to provide the service under state law.
- 7 Must be personally performed by a physical therapist who is certified by the American Board of Physical Therapy Specialties as a qualified electrophysiologic clinical specialist AND is permitted to provide the service under state law OR is performed under the direct supervision of a physician State law.
- 21 Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician.
- 22 May be performed by a technician with on-line real-time contact with physician.
- 66 May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure.
- 6A Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill.
- 77 Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician.
- 7A Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill.
- 9 Concept does not apply

Billable Medical Supplies

Under resource based practice expense, all billable medical supplies have been incorporated into the practice expense relative values of individual services.

Endoscopic Base Code

Code which identifies an endoscopic base code for each code with a multiple surgery indicator of "3." No spine procedures have this indicator.