

# Medicare Coverage Sourcebook

Essential Information for Medicare Covered and Non-Covered Services



2011

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## Pub. 100-02 – Medicare Benefit Policy Manual

The *Medicare Benefit Policy Manual* is a manual that replaces the current Medicare general coverage instructions that are not National Coverage Determinations (NCDs). These instructions were previously found in Chapter II of the Carriers Manual, Intermediary Manual, and other provider manuals, and in Program Memoranda.

## Pub. 100-03 – Medicare National Coverage Determination (NCDs) Manual

The NCDs are limited on services, procedures, and items that are considered reasonable and necessary for the diagnosis or treatment of an illness or injury and within the scope of a Medicare benefit category. The NCDs are based on an evidence-based process, with opportunities for public participation. In some cases, CMS' own research is supplemented by an outside technology assessment and/or consultation with the Medicare Coverage Advisory Committee (MCAC). In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare contractors based on a local coverage determination (LCD).

The *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* amended several portions of the NCD development process with an effective date of January 1, 2004. On and after January 1, 2004, the following changes to the NCD process will be effective:

- For NCD requests not requiring an external technology assessment (TA) or Medicare Coverage Advisory Committee (MCAC) review, the decision on the request shall be made not later than six months after the date the completed request is received (§731(a)(2)(A)).
- For those NCD requests requiring either an external TA and/or MCAC review, and in which a clinical trial is not requested, the decision on the request shall be made not later than nine months after the date the completed request is received (§731(a)(2)(B)).
- Not later than the end of the six or nine month period described above, the proposed decision shall be made available on the CMS website (or other appropriate means) for public comment. This comment period shall last 30 days, and comments will be reviewed and a final decision issued not later than 60 days after the conclusion of the comment period. A summary of the public comments received and responses to the comments will continue to be included in the final NCD (§731(a)(3)(A)).
- An Annual Report shall be issued listing the national coverage determinations made in the previous year and explaining how to get more information on those determinations (§953(b)).

## Pub. 100-04 – Medicare Claims Processing (MCP) Manual

In this publication, general and specific claims requirements are referenced for claims processing. It includes facility and physician/non-physician practitioner information, as well as billing instructions. Select chapters included in the *Medicare Coverage Sourcebook* are the chapters that are typically used. For more claims processing information, see: <http://www.cms.hhs.gov/>

[Manuals/iom/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS018912&intNumPerPage=10](http://www.cms.hhs.gov/Manuals/iom/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS018912&intNumPerPage=10)

## Pub. 100-05 – Medicare Secondary Payer (MSP) Manual

This publication assists the user in determining under which circumstances Medicare is the primary or secondary payer. In 1980, Congress enacted a series of provisions that made Medicare secondary payer to certain primary plans. These are called the Medicare Secondary Payer (MSP) provisions and prohibit Medicare from making payment if payment has been made or can be reasonably expected to be made by:

- Group Health Plans
- Workers' Compensation Plans
- Liability Insurance
- No-Fault Insurance

If payment has not been made or cannot be expected to be made promptly by any of the insurers listed above, Medicare may make a conditional payment, under some circumstances, subject to Medicare payment rules. Conditional payments are made subject to repayment when the primary plan makes payment.

When Medicare is the secondary payer, the provider, physician, other supplier, or beneficiary must first submit the claim to the primary payer. The primary payer is required to process and make primary payment on the claim in accordance with the coverage provisions of its contract. The primary payer may not decline to make primary payment on the grounds that its contract calls for Medicare to pay first. If, after the primary payer processes the claim, it does not pay in full for the services, Medicare secondary benefits may be paid for the services. See <http://www.cms.hhs.gov/Manuals/iom/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019017&intNumPerPage=10> for more information on Medicare as a secondary payer.

## Pub. 100-08 – Medicare Program Integrity Manual (PIM)

This manual reflects the principles, values, and priorities for the Medicare Integrity Program (MIP). The primary principle of the Program is to protect the Medicare Trust Fund from fraud, waste, and abuse. In order to meet this goal, contractors must ensure that they pay the right amount for covered and correctly coded services rendered to eligible Medicare beneficiaries by legitimate providers. CMS follows four parallel strategies in meeting this goal:

- Preventing fraud through effective enrollment and through education of providers and beneficiaries.
- Early detection through, for example, medical review and data analysis.
- Close coordination with partners, including contractors and law enforcement agencies.
- Fair and firm enforcement policies.

The chapter chosen for this book is the *Local Carrier Determinations* chapter. All other Medicare Program Integrity Manual information can be viewed at:

<http://www.cms.hhs.gov/Manuals/iom/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019033&intNumPerPage=10>

### **110.5 – Incurred Expense Dates for Durable Medical Equipment**

(Rev. 1, 10-01-03)

The date of service on the claim must be the date that the beneficiary or authorized representative received the DMEPOS item. If the date of delivery is not specified on the bill, the contractor should assume, in the absence of evidence to the contrary, that the date of purchase was the date of delivery.

For mail order DMEPOS items, the date of service on the claim must be the shipping date.

The date of service on the claim must be the date that the DMEPOS item(s) was received by the nursing facility if the supplier delivered it or the shipping date if the supplier utilized a delivery/shipping service.

An exception to the preceding statements concerning the date of service on the claim occurs when items are provided in anticipation of discharge from a hospital or nursing facility. If a DMEPOS item is delivered to a patient in a hospital up to two days prior to discharge to home and it is for the benefit of the patient for purposes of fitting or training of the patient on its use, the supplier should bill the date of service on the claim as the date of discharge to home and should use POS=12.

See the *Medicare Program Integrity Manual*, Chapter 5, “Items and Services Having Special DMERC Review Considerations,” for additional information pertaining to the date of service on the claim. Also see the *Medicare Claims Processing Manual*, Chapter 20, “Durable Medical Equipment, Surgical dressings and Casts, Orthotics and Artificial Limbs, and Prosthetic Devices,” for additional DME billing and claims processing information.

### **110.6 – Determining Months for Which Periodic Payments May Be Made for Equipment Used in an Institution**

(Rev. 1, 10-01-03)

If a patient uses equipment subject to the monthly payment rule in an institution, which does not qualify as his or her home, the used months during which the beneficiary was institutionalized are not covered.

### **110.7 – No Payment for Purchased Equipment Delivered Outside the United States or Before Beneficiary’s Coverage Began**

(Rev. 1, 10-01-03)

In the case of equipment subject to the lump sum payment rules, the beneficiary must have been in the United States and must have had Medicare coverage at the time the item was delivered. Therefore, where an item of durable medical equipment paid for as a lump sum was delivered to an individual outside the United States or before his or her coverage period began, the entire expense of the item would be excluded from coverage. Payment cannot be made in such cases even though the individual later uses the item inside the United States or after his or her coverage begins.

If the individual is outside the U.S. for more than 30 days and then returns to the U.S., the DMERC determines medical necessity as in an initial case before resuming payments.

## **120 – Prosthetic Devices**

(Rev. 1, 10-01-03)

### **A. General**

Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ are covered when furnished on a physician’s order. This does not require a determination that there is no possibility that the patient’s condition may improve sometime in the future. If the medical record, including the judgment of the attending physician, indicates the condition is of long and indefinite duration, the test of permanence is considered met. (Such a device may also be covered under §60.1 as a supply when furnished incident to a physician’s service.)

Examples of prosthetic devices include artificial limbs, parenteral and enteral (PEN) nutrition, cardiac pacemakers, prosthetic lenses (see Subsection B), breast prostheses (including a surgical brassiere) for postmastectomy patients, maxillofacial devices, and devices which replace all or part of the ear or nose. A urinary collection and retention system with or without a tube is a prosthetic device replacing bladder function in case of permanent urinary incontinence. The foley catheter is also considered a prosthetic device when ordered for a patient with permanent urinary incontinence. However, chucks, diapers, rubber sheets, etc., are supplies that are not covered under this provision. Although hemodialysis equipment is a prosthetic device, payment for the rental or purchase of such equipment in the home is made only for use under the provisions for payment applicable to durable medical equipment.

An exception is that if payment cannot be made on an inpatient’s behalf under Part A, hemodialysis equipment, supplies, and services required by such patient could be covered under Part B as a prosthetic device, which replaces the function of a kidney. See the *Medicare Benefit Policy Manual*, Chapter 11, “End Stage Renal Disease,” for payment for hemodialysis equipment used in the home. See the *Medicare Benefit Policy Manual*, Chapter 1, “Inpatient Hospital Services,” §10, for additional instructions on hospitalization for renal dialysis.

**NOTE:** Medicare does not cover a prosthetic device dispensed to a patient prior to the time at which the patient undergoes the procedure that makes necessary the use of the device. For example, the carrier does not make a separate Part B payment for an intraocular lens (IOL) or pacemaker that a physician, during an office visit prior to the actual surgery, dispenses to the patient for his or her use. Dispensing a prosthetic device in this manner raises health and safety issues. Moreover, the need for the device cannot be clearly established until the procedure that makes its use possible is successfully performed. Therefore, dispensing a prosthetic device in this manner is not considered reasonable and necessary for the treatment of the patient’s condition.

- What will be the average time to device failure when the device is made available to larger numbers of patients?
- Do results adequately give a reasonable indication of the full range of outcomes (both positive and negative) that might be expected from more widespread use?

The clinical study must meet all of the following criteria:

- The study must be reviewed and approved by the FDA.
- The principal purpose of the research study is to test whether a particular intervention potentially improves the participants' health outcomes.
- The research study is well supported by available scientific and medical information, or it is intended to clarify or establish the health outcomes of interventions already in common clinical use.
- The research study does not unjustifiably duplicate existing studies.
- The research study design is appropriate to answer the research question being asked in the study.
- The research study is sponsored by an organization or individual capable of executing the proposed study successfully.
- The research study is in compliance with all applicable Federal regulations concerning the protection of human subjects found at 45 CFR Part 46. If a study is FDA-regulated it also must be in compliance with 21 CFR Parts 50 and 56.
- All aspects of the research study are conducted according to appropriate standards of scientific integrity (see <http://www.icmje.org>).
- The research study has a written protocol that clearly addresses, or incorporates by reference, the standards listed here as Medicare requirements for coverage with study participation (CSP) or CED coverage.
- The clinical research study is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life threatening as defined in 21 CFR § 312.81(a) and the patient has no other viable treatment options.
- The clinical research study is registered on the ClinicalTrials.gov website by the principal sponsor/investigator as demonstrated by having a National Clinical Trial control number.
- The research study protocol specifies the method and timing of public release of all pre-specified outcomes to be measured including release of outcomes if outcomes are negative or study is terminated early. The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer-reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors (<http://www.icmje.org>). However a full report of the outcomes must be made public no later than three (3) years after the end of data collection.

- The research study protocol must explicitly discuss subpopulations affected by the treatment under investigation, particularly traditionally underrepresented groups in clinical studies, how the inclusion and exclusion criteria effect enrollment of these populations, and a plan for the retention and reporting of said populations in the trial. If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, the protocol must discuss why these criteria are necessary.

The research study protocol explicitly discusses how the results are or are not expected to be generalizable to the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability, or Medicaid eligibility.

Consistent with section 1142 of the Social Security Act (the Act), the Agency for Healthcare Research and Quality (AHRQ) supports clinical research studies that CMS determines meet the above-listed standards and address the above-listed research questions.

The principal investigator of an artificial heart clinical study seeking Medicare payment should submit the following documentation to the Centers for Medicare & Medicaid Services (CMS) and should expect to be notified when the CMS review is complete:

- Complete study protocol (must be dated or identified with a version number);
- Protocol summary;
- Statement that the submitted protocol version has been agreed upon by the FDA;
- Statement that the above study standards are met;
- Statement that the study addresses at least one of the above questions related to artificial hearts;
- Complete contact information (phone number, email address, and mailing address); and,
- Clinicaltrials.gov registration number.

The above information should be mailed to:

Director, Coverage and Analysis Group Centers for Medicare and Medicaid Services Re: Artificial Heart Mailstop C1-09-06 7500 Security Blvd. Baltimore, MD 21244-1850

Clinical studies that are determined by CMS to meet the above requirements will be listed on the CMS Web site at: [http://www.cms.hhs.gov/MedicareApprovedFacilities/06\\_artificialhearts.asp](http://www.cms.hhs.gov/MedicareApprovedFacilities/06_artificialhearts.asp).

### ❖ 20.10 – Cardiac Rehabilitation Programs

*(Rev. 116; Issued: 03-05-10; Effective Date: 02-22-10; Implementation Date: 04-05-10)*

*This section of the NCD Manual was repealed February 22, 2010, as a result of section 144 of the Medicare Improvements for Patients and Providers Act. Instead, refer to Pub. 100-04, Chapter 32, Section 140.*

## 20.11 – Intraoperative Ventricular Mapping

(Rev. 1, 10-03-03)

Intraoperative ventricular mapping is the technique of recording cardiac electrical activity directly from the heart. The recording sites are usually identified from an anatomical grid and may consist of epicardial, intramural, and endocardial sites. A probe with electrodes is used to explore these surfaces and generate a map that displays the sequence of electrical activation. This information is used by the surgeon to locate precisely the site of an operative intervention.

The intraoperative ventricular mapping procedure is covered under Medicare only for the uses and medical conditions described below:

- Localize accessory pathways associated with the Wolff-Parkinson-White (WPW) and other preexcitation syndromes.
- Map the sequence of atrial and ventricular activation for drug-resistant supraventricular tachycardias.
- Delineate the anatomical course of His bundle and/or bundle branches during corrective cardiac surgery for congenital heart diseases.
- Direct the surgical treatment of patients with refractory ventricular tachyarrhythmias.

## 20.12 – Diagnostic Endocardial Electrical Stimulation (Pacing)

(Rev. 1, 10-03-03)

Diagnostic endocardial electrical stimulation (EES), also called programmed electrical stimulation of the heart, is covered under Medicare when used for patients with severe cardiac arrhythmias.

Diagnostic endocardial electrical stimulation involves the detection and stimulation of cardiac electrical activity for the purpose of studying arrhythmias and abnormalities of the heart's conduction system. Intracardiac electrode catheters, intracardiac and extracardiac recordings and a stimulator device are required. From two to six multipolar electrode catheters are inserted percutaneously, usually through the femoral veins, and advanced to the heart under fluoroscopic control. Other venous or arterial routes may be employed as well. An intracardiac His bundle cardiogram is usually obtained during EES as are conventional electrocardiograms. No separate charge will be recognized for the His Bundle cardiogram. (See §20.16.)

The EES is used to investigate the mechanisms, site of origin and pathways of cardiac arrhythmias as well as to select therapeutic approaches for their resolution. EES is also employed to identify patients at risk of sudden arrhythmic death. The principal use for EES is in the diagnosis and treatment of sustained ventricular tachycardia. However, it has also proven to be of value in the diagnosis and management of other complex arrhythmias, conduction defects, and after cardiac arrest.

## 20.13 – His Bundle Study

(Rev. 1, 10-03-03)

The His Bundle Study is a specialized type of electrocardiography requiring catheterization of the

right side of the heart and is a recognized diagnostic procedure. Medicare coverage of the procedure would be limited to selected patients: those with complex ongoing acute arrhythmias, those with intermittent or permanent heart block in whom pacemaker implantation is being considered, and those patients who have recently developed heart block secondary to a myocardial infarction. When heart catheterization and the His Bundle Study are performed at the same time, the program will cover only one catheterization and a small additional charge for the study.

When a His bundle cardiogram is obtained as part of a diagnostic endocardial electrical stimulation, no separate charge will be recognized for the His bundle study. (See §20.12, "Diagnostic Endocardial Electrical Stimulation.")

## 20.14 – Plethysmography

(Rev. 1, 10-03-03)

Plethysmography involves the measurement and recording (by one of several methods) of changes in the size of a body part as modified by the circulation of blood in that part.

Plethysmography is of value as a noninvasive technique for diagnostic, preoperative and postoperative evaluation of peripheral artery disease in the internal medicine or vascular surgery practice. It is also a useful tool for the preoperative podiatric evaluation of the diabetic patient or one who has intermittent claudication or other signs or symptoms indicative of peripheral vascular disease which have a bearing on the patient's candidacy for foot surgery.

The oldest form of plethysmography is the venous occlusive pneumoplethysmography. This method is cumbersome, time consuming, and requires considerable training to give useful, reproducible results. Nonetheless, in the setting of the hospital vascular laboratory, this technique is considered a reasonable and necessary procedure for the diagnostic evaluation of suspected peripheral arterial disease. It is unsuitable for routine use in the physician's office.

Recently, however, a number of other plethysmographic methods have been developed which make use of phenomena such as changes in electric impedance or changes in segmental blood pressure at constant volume to assess regional perfusion. Several of these methods have reached a level of development which makes them clinically valuable.

Medicare coverage is extended to those procedures listed in Category I below when used for the accepted medical indications mentioned above. The procedures in Category II are still considered experimental and are not covered at this time. Denial of claims because a noncovered procedure was used or because there was no medical indication for plethysmographic evaluation of any type should be based on §1862(a)(1) of the Act.

### Category I—Covered

- Segmental Plethysmography—Included under this procedure are services performed with a regional plethysmograph, differential plethysmograph, recording oscillometer, and a pulse volume recorder.
- Electrical Impedance Plethysmography

CPT codes are used to report E/M services in facilities assigned places of service (POS) codes 13 (Assisted Living Facility), 14 (Group Home), 33 (Custodial Care Facility) and 55 (Residential Substance Abuse Facility). Assisted living facilities may also be known as adult living facilities.

Physicians and qualified nonphysician practitioners (NPPs) furnishing E/M services to residents in a living arrangement described by one of the POS listed above must use the level of service code in the CPT code range 99324–99337 to report the service they provide. The CPT codes 99321–99333 for Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services are deleted beginning January, 2006.

Beginning in 2006, reasonable and medically necessary, face-to-face, prolonged services, represented by CPT codes 99354–99355, may be reported with the appropriate companion E/M codes when a physician or qualified NPP provides a prolonged service involving direct (face-to-face) patient contact that is beyond the usual E/M visit service for a Domiciliary, Rest Home (e.g., Boarding Home) or Custodial Care Service. All the requirements for prolonged services at §30.6.15.1 must be met.

The CPT codes 99341 through 99350, Home Services codes, are used to report E/M services furnished to a patient residing in his or her own private residence (e.g., private home, apartment, town home) and not residing in any type of congregate/shared facility living arrangement including assisted living facilities and group homes. The Home Services codes apply only to the specific 2-digit POS 12 (Home). Home Services codes may not be used for billing E/M services provided in settings other than in the private residence of an individual as described above.

Beginning in 2006, E/M services provided to patients residing in a Skilled Nursing Facility (SNF) or a Nursing Facility (NF) must be reported using the appropriate CPT level of service code within the range identified for Initial Nursing Facility Care (new CPT codes 99304–99306) and Subsequent Nursing Facility Care (new CPT codes 99307–99310). Use the CPT code, Other Nursing Facility Services (new CPT code 99318), for an annual nursing facility assessment. Use CPT codes 99315–99316 for SNF/NF discharge services. The CPT codes 99301–99303 and 99311–99313 are deleted beginning January, 2006. The Home Services codes should not be used for these places of service.

The CPT SNF/NF code definition includes intermediate care facilities (ICFs) and long term care facilities (LTCFs). These codes are limited to the specific 2-digit POS 31 (SNF), 32 (Nursing Facility), 54 (Intermediate Care Facility/Mentally Retarded) and 56 (Psychiatric Residential Treatment Center).

The CPT nursing facility codes should be used with POS 31 (SNF) if the patient is in a Part A SNF stay and POS 32 (nursing facility) if the patient does not have Part A SNF benefits. There is no longer a different payment amount for a Part A or Part B benefit period in these POS settings.

### **30.6.14.1 – Home Services (Codes 99341–99350)**

*(Rev. 1, 10-01-03)*

#### **A. Requirement for Physician Presence**

Home services codes 99341-99350 are paid when they are billed to report evaluation and management services provided in a private residence. A home visit cannot be billed by a physician unless the physician was actually present in the beneficiary's home.

#### **B. Homebound Status**

Under the home health benefit the beneficiary must be confined to the home for services to be covered. For home services provided by a physician using these codes, the beneficiary does not need to be confined to the home. The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.

#### **C. Fee Schedule Payment for Services to Homebound Patients under General Supervision**

Payment may be made in some medically underserved areas where there is a lack of medical personnel and home health services for injections, EKGs, and venipunctures that are performed for homebound patients under general physician supervision by nurses and paramedical employees of physicians or physician-directed clinics. Section 10 provides additional information on the provision of services to homebound Medicare patients.

### **30.6.15 – Prolonged Services and Standby Services (Codes 99354–99360)**

#### **❖30.6.15.1 – Prolonged Services With Direct Face-to-Face Patient Contact Service**

*(Codes 99354-99357) (ZZZ codes)*

*(Rev. 1875, Issued: 02-14-09, Effective: 01-01-10, Implementation: 01-04-10)*

#### **A. Definition**

Prolonged physician services (CPT code 99354) in the office or other outpatient setting with direct face-to-face patient contact which require one hour beyond the usual service are payable when billed on the same day by the same physician or qualified nonphysician practitioner (NPP) as the companion evaluation and management codes. The time for usual service refers to the typical/average time units associated with the companion evaluation and management service as noted in the CPT code. Each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services may be reported by CPT code 99355.

Prolonged physician services (code 99356) in the inpatient setting, with direct face-to-face patient contact which require one hour beyond the usual service are payable when they are billed on the same day by the same physician or qualified NPP as the companion evaluation and management codes. Each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services may be reported by CPT code 99357.

Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the evaluation and management codes.

Code 99355 or 99357 may be used to report each additional 30 minutes beyond the first hour of prolonged services, based on the place of service. These codes may be used to report the final 15 – 30 minutes of prolonged service on a given date, if not otherwise billed. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

### B. Required Companion Codes

- The companion evaluation and management codes for 99354 are the Office or Other Outpatient visit codes (99201 - 99205, 99212 – 99215), the Office or Other Outpatient Consultation codes (99241 – 99245), the Domiciliary, Rest Home, or Custodial Care Services codes (99324 – 99328, 99334 – 99337), the Home Services codes (99341 - 99345, 99347 – 99350).
- The companion codes for 99355 are 99354 and one of the evaluation and management codes required for 99354 to be used.
- The companion evaluation and management codes for 99356 are the Initial Hospital Care codes and Subsequent Hospital Care codes (99221 - 99223, 99231 – 99233), the Inpatient Consultation codes (99251 – 99255); Nursing Facility Services codes (99304 -99318).
- The companion codes for 99357 are 99356 and one of the evaluation and management codes required for 99356 to be used.
- Prolonged services codes 99354 – 99357 are not paid unless they are accompanied by the companion codes as indicated.

### C. Requirement for Physician Presence

Physicians may count only the duration of direct face-to-face contact between the physician and the patient (whether the service was continuous or not) beyond the typical/average time of the visit code billed to determine whether prolonged services can be billed and to determine the prolonged services codes that are allowable. In the case of prolonged office services, time spent by office staff with the patient, or time the patient remains unaccompanied in the office cannot be billed. In the case of prolonged hospital services, time spent reviewing charts or discussion of a patient with house medical staff and not with direct face-to-face contact with the patient, or waiting for test results, for changes in the patient's condition, for end of a therapy, or for use of facilities cannot be billed as prolonged services.

### D. Documentation

Documentation is not required to accompany the bill for prolonged services unless the physician has been selected for medical review. Documentation is required in the medical record about the duration and content of the medically necessary evaluation and management service and prolonged services billed. The medical record must be appropriately and sufficiently documented by the physician or qualified NPP to show that the physician or qualified NPP personally furnished the direct face-to-face time with the patient specified in the CPT code definitions. The start and end times of the visit shall be documented in the medical record along with the date of service.

### E. Use of the Codes

Prolonged services codes can be billed only if the total duration of all physician or qualified NPP direct face-to-face service (including the visit) equals or exceeds the threshold time for the evaluation and management service the physician or qualified NPP provided (typical/average time associated with the CPT E/M code plus 30 minutes). If the total duration of direct face-to-face time does not equal or exceed the threshold time for the level of evaluation and management service the physician or qualified NPP provided, the physician or qualified NPP may not bill for prolonged services.

### F. Threshold Times for Codes 99354 and 99355 (Office or Other Outpatient Setting)

If the total direct face-to-face time equals or exceeds the threshold time for code 99354, but is less than the threshold time for code 99355, the physician should bill the evaluation and management visit code and code 99354. No more than one unit of 99354 is acceptable. If the total direct face-to-face time equals or exceeds the threshold time for code 99355 by no more than 29 minutes, the physician should bill the visit code 99354 and one unit of code 99355. One additional unit of code 99355 is billed for each additional increment of 30 minutes extended duration. Contractors use the following threshold times to determine if the prolonged services codes 99354 and/or 99355 can be billed with the office or other outpatient settings including domiciliary, rest home, or custodial care services and home services codes.

### Threshold Time for Prolonged Visit Codes 99354 and/or 99355 Billed with Office/Outpatient and Consultation Codes

Code	Typical Time for Code	Threshold Time to Bill Code 99354	Threshold Time to Bill Codes 99354 and 99355
99201	10	40	85
99202	20	50	95
99203	30	60	105
99204	45	75	120
99205	60	90	135
99212	10	40	85
99213	15	45	90
99214	25	55	100
99215	40	70	115
99241	15	45	90
99242	30	60	105
99243	40	70	115
99244	60	90	135
99245	80	110	155
99324	20	50	90
99325	30	60	105
99326	45	75	120
99327	60	90	135
99328	70	45	150

$(\$90 \text{ divided by } \$110) \times \$88 = \$72$

The provider enters \$72 in value code/amounts (FLs 39-41).

**EXAMPLE 2:**

Total charges were \$5,000. Medicare covered charges were \$4,000. The primary payer's payment was \$3,000. Since the non-PPS provider cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$(\$4,000 \text{ divided by } \$5,000) \times \$3,000 = \$2,400$

The non-PPS provider enters \$2,400 in the value code amount.

**EXAMPLE 3:**

Total charges were \$550. Medicare covered charges were \$500. The primary payer's payment was \$330. Since the HHA cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$(\$500 \text{ divided by } \$550) \times \$330 = \$300$

The HHA enters \$300 in the value code amount.

### **40.3 – Annotation of Claims Denied by GHP's, Liability or No-Fault Insurers**

*(Rev. 37, Issued: 10-14-05, Effective: N/A,  
Implementation: N/A)*

Primary Medicare benefits are paid (if the beneficiary is not appealing the GHP denial) when a single or a multiple employer plan for which CMS has approved the plan's multi-employer exemption request denies a claim for primary benefits because:

- The beneficiary is age 65 or over and is enrolled in a single employer plan of an employer who does not employ 20 or more employees.
- The beneficiary is age 65 or over and is enrolled in a multi-employer plan by virtue of employment with an employer that does not employ 20 or more employees and the plan has elected the small employer exception;
- The beneficiary is not entitled to primary benefits under the plan.
- The beneficiary is under age 65 and disabled and the employer does not employ 100 or more employees and the employer is not a member of a multiple employer GHP which has at least one employer that employs 100 or more employees.
- The beneficiary is not entitled to benefits under the plan on the basis of rules that apply equally to all participants without regard to age or Medicare entitlement.
- Benefits under the GHP are exhausted for the services involved.
- The services are not covered by the GHP under any circumstances for any covered individual.
- The beneficiary has Medicare based on ESRD (under age 65 and eligible based on ESRD) and not in a Medicare coordination period.

Medicare does not pay primary Medicare benefits if it is believed that the GHP covers the particular service and the plan asserts that the services are not covered for "primary payment" when provided to Medicare beneficiaries.

Where a GHP denies payment for any of these reasons, the provider shows occurrence code 24 or 25 (insurance denied) and the date of denial in FLs 32-35 (occurrence codes). In addition, it provides the reason for the denial in Remarks (FL 84).

Medicare primary benefits cannot be paid when a GHP offers only secondary coverage of services covered by Medicare and it does not allege that the employer has fewer than 20 employees (or 100 employees in the case of disabled beneficiaries). The provider enters occurrence code 24 (insurance denied) and the date of denial in FLs 32-35 (occurrence codes). In addition, it enters the annotation "Plan offers secondary coverage of services covered by Medicare."

#### **40.3.1 – Annotation of Claims to Request Conditional Payments**

*(Rev. 37, Issued: 10-14-05, Effective: N/A,  
Implementation: N/A)*

When a liability or no-fault insurer does not make payment e.g., the services are not covered under no-fault insurance or the individual's insurance coverage expired, the provider bills Medicare as usual. In addition, the proper occurrence code is shown in FLs 32-35. Occurrence code 24 is completed to show the date the other payer denied the claim, and the reason for denial is shown in Remarks (FL 84).

A conditional primary payment may be requested if conditional payment criteria are met.

The provider enters value code 14 with a zero value amount in FLs 39-41 to indicate the type of other insurer and that conditional payment is requested. The identity of the other payer is shown on line A of FL 50, and the identifying information about the insured is shown on line A of FLs 58-60. The provider enters the proper occurrence code in FLs 32-35 and the address of the insurer in FL 38 or Remarks (FL 84). In addition, an explanation of why the conditional payment is justified is shown in Remarks (FL 84). (See Chapter 7, §50.2.2 for an explanation of policy and procedures for conditional payment situations for contested, delayed, or no-fault claims.)

When a GHP does not make payment for the reasons described below, a conditional Medicare payment can be requested. Conditional payments may be requested where:

- The provider has filed a proper claim under the plan and the plan denies the claim in whole or in part.
- The provider fails to file a proper claim because of the physical or mental incapacity of the beneficiary.

The provider requests conditional primary payment by entering the appropriate value code to indicate the type of other insurer. Applicable GHP value codes are 12, 13 or 43. The value amount is completed with zero value in FLs 39-41. In addition, it includes occurrence code 24 (insurance denied) and the date of denial by the GHP. The identity of the GHP is entered on line A of FL 50, the identifying information about the insured is entered on line A of FLs 58-62, and the address of the GHP is entered on FL 38 or Remarks (FL 84). In addition, the provider enters the annotation "Beneficiary has appealed or is protesting GHP denial" in Remarks, FL 84.

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