From: DSHS HRSA PROVIDERS [mailto:dshshrsaproviders@HCA.WA.GOV]
Sent: Tuesday, October 02, 2012 3:42 PM
To: HRSA-PROVIDERS@LISTSERV.WA.GOV
Subject: Clinicians,Mngedcare: PN 12-80 Physician-Related Services/ Healthcare Professional Services Medicaid Provider Guide revisions and updates

Washington State
Health Care Authority
Medicaid

Provider Notice 12-80

Effective for dates of service on and after October 1, 2012, the Medicaid Program of the Health Care Authority (Agency) will revise the *Physician-Related Services/ Healthcare Professional Services Medicaid Provider Guide* with the following updates:

- Add procedure codes for low-osmolar contract media;
- Clarification of policy for payment of services for teaching physicians;
- Add procedure code for collagen implants;
- Add information regarding genetic counselors;
- Add two diagnoses to the EPA for hysterectomy – ICD-9; 641.2 and 626.9;
- Provide information regarding the EPA number for hysteroscopic sterilizations
- Add procedure code L8604; and
- Update coverage and prior authorization requirements for selected procedure codes.

Coverage Changes

Change coverage for the following procedure code from ***covered to non-covered***:

Procedure Code	Brief Description	Comments
54400	Insert semi-rigid prosthesis	

Change the following procedure code from **covered without PA to covered with PA**:

Procedure Code	Brief Description	Comment
21199	Reconst lwr jaw w/advance	PA

Change the following procedure code from **covered without PA to covered with PA through Qualis Health**:

Procedure Code	Brief Description	Comment
22532	Lat thorax spine fusion	
22533	Lat lumbar spine fusion	
22534	Lat thor/lumb addl seg	

For more information about Qualis prior authorization see section E of the *Physician-Related Services/ Healthcare Professional Services Medicaid Provider Guide* at:
http://hrsa.dshs.wa.gov/billing/documents/physicianguides/physician_section_e.pdf.

Change the following procedure codes from **noncovered to covered with PA**:

Procedure Code	Brief Description	Comment
91110	GI Tract capsule endoscopy	PA
91111	Esophageal capsule endoscopy	PA

Change the following procedure codes from **covered with PA to covered without PA:**

Procedure Code	Brief Description	Comment
A9552	F18 fdg	

Add limitation to the following procedure code:

Procedure Code	Brief Description	Comment
L8604	Dextranomer/hyaluronic acid	Limitation – Only available for diagnosis 599.82

For more details regarding rates, see the Physician-Related Services/Healthcare Professional Services *Fee Schedule* at: http://hrsa.dshs.wa.gov/rbrvs/index.html#P

For more details, see the "What Has Changed" table in the *Physician-Related Services/ Healthcare Professional Services Medicaid Provider Guide* at: http://hrsa.dshs.wa.gov/billing/physician-related_services.html.

Effective for dates of service on and after January 1, 2013, the Agency will discontinue separate payment to independent laboratories for the technical component of pathology services.

Independent Laboratory Billing for Pathology Services

The Agency expects independent laboratories to bill hospitals for the technical component of anatomic pathology services furnished to hospital inpatient and outpatient clients. To prevent duplicate payment, the Agency ***will not pay*** independent laboratories, if they bill Medicaid for these services.

Thank you.

BC - AL
Provider Publications Team
Medicaid Program
Health Care Authority

NOTE: Please do not reply directly to this Listserv message as it is not monitored. If you have feedback or questions, please select one of the options at http://hrsa.dshs.wa.gov/contact/default.aspx. Your message will be delivered to the appropriate staff member.

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About This Guide

This guide published by Health Care Authority (the Agency), supersedes all previous Agency *Physician-Related Services/HealthCare Professional Medicaid Provider Guides* published by the Agency.

Note: The Agency now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

What Has Changed?

Reason for Change	Effective Date	Section/Page No.	Subject	Change
Provider Notice 12-80	October 1, 2012	B.36	Oral Maxiofacial Surgery	Add procedure code 21199 to the Services Perfromed by a Dentist and/or Physician Specializing in Oral Maxillofacial Surgery table.
	October 1, 2012	D.14	Radiology Services	Add HCPCS procedure codes for low-osmolar contrast media (LOCM) Q9965, Q9966, or Q9967.
	October 1, 2012	E.33	Physician fee schedule payment for services of teaching physicians.	Clarification of policy for payment of services for teaching physicians.
	October 1, 2012	F.1	Collagen Implants	Add code L8604.
	October 1, 2012	F.2	Billing for Genetic Counseling	Add information regarding genetic counselors.
	October 1, 2012	H.20	EPA for Hysterectomy	Add two additional diagnoses to the EPA for hysterectomy ICD-9 641.2 and 641.9.
	October 1, 2012	H.22	EPA for Hysteroscopic Sterilizations	Provide information regarding the EPA number for Hysteroscopic Sterilizations.
	October 1, 2012	Medical Supplies and Equipment J.6	Urinary Tract Implants	Add L8604 to the table.

Physician Fee Schedule Payment for Services of Teaching Physicians.

General Rule: If a resident physician participates in providing a service in a teaching setting, physician fee schedule payment is made only if a teaching physician is present during the key portion of any service or procedure for which payment is sought.

- **Surgical, high-risk, or other complex procedures:** the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure.
  - ✓ **Surgery**, the teaching physician's presence is not required during opening and closing of the surgical field.
  - ✓ **Procedures performed through an endoscope**, the teaching physician must be present during the entire viewing.
- **Evaluation and management services**: the teaching physician must be present during the portion of the service that determines the level of service billed. (However, in the case of evaluation and management services furnished in hospital outpatient departments and certain other ambulatory settings, the requirements of 42 C.F.R. §415.174 apply.)

Pain Management Services

- Pain Management services and selected surgical services that are commonly performed by anesthesiologists and CRNAs are not paid with anesthesia base and time units. These services are paid using the Agency's-assigned maximum allowable fee for the procedure code.

- When billing for pain management and other services that are payable using the Agency's-assigned maximum allowable fee, do not use anesthesia modifiers. The Agency denies claims for these services billed with an anesthesia modifier.

- Two postoperative procedures for pain management are allowed during the same inpatient stay. Only one (1) unit may be billed per procedure. Do NOT bill time.

See next page for Pain Management Procedure Codes

under section 501(c)(3) of the Internal Revenue Code (nonprofit educational, charitable, and similar organizations), from Federal taxation.

(2) The organization is an organization of physicians who, under the terms of their employment by an entity that meets the requirements of paragraph (b)(1) of this section, are required to turn over to that entity all income that the physician organization derives from the physician services.

(c) *Status of a fund.* A fund approved for payment under paragraph (a) of this section has all the rights and responsibilities of a provider under Medicare except that it does not enter into an agreement with CMS under part 489 of this chapter.

§415.170 Conditions for payment on a fee schedule basis for physician services in a teaching setting.

Services meeting the conditions for payment in §415.102(a) furnished in teaching settings are payable under the physician fee schedule if—

(a) The services are personally furnished by a physician who is not a resident; or

(b) The services are furnished by a resident in the presence of a teaching physician except as provided in §415.172 (concerning physician fee schedule payment for services of teaching physicians), §415.174 (concerning an exception for services furnished in hospital outpatient and certain other ambulatory settings), §415.176 (concerning renal dialysis services), and §415.184 (concerning psychiatric services), as applicable.

§415.172 Physician fee schedule payment for services of teaching physicians.

(a) *General rule.* If a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made only if a teaching physician is present during the key portion of any service or procedure for which payment is sought.

(1) In the case of surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure.

(i) In the case of surgery, the teaching physician's presence is not required during opening and closing of the surgical field.

(ii) In the case of procedures performed through an endoscope, the teaching physician must be present during the entire viewing.

(2) In the case of evaluation and management services, the teaching physician must be present during the portion of the service that determines the level of service billed. (However, in the case of evaluation and management services furnished in hospital outpatient departments and certain other ambulatory settings, the requirements of §415.174 apply.)

(b) *Documentation.* Except for services furnished as set forth in §§415.174 (concerning an exception for services furnished in hospital outpatient and certain other ambulatory settings), 415.176 (concerning renal dialysis services), and 415.184 (concerning psychiatric services), the medical records must document the teaching physician was present at the time the service is furnished. The presence of the teaching physician during procedures may be demonstrated by the notes in the medical records made by a physician, resident, or nurse. In the case of evaluation and management procedures, the teaching physician must personally document his or her participation in the service in the medical records.

(c) *Payment level.* In the case of services such as evaluation and management for which there are several levels of service codes available for reporting purposes, the appropriate payment level must reflect the extent and complexity of the service when fully furnished by the teaching physician.

§415.174 Exception: Evaluation and management services furnished in certain centers.

(a) In the case of certain evaluation and management codes of lower and mid-level complexity (as specified by CMS in program instructions), carriers may make physician fee schedule payment for a service furnished by a resident without the presence of a teaching physician. For the exception to apply,

low or mid lvl complexity
99201-99203
99211-99213

all of the following conditions must be met:

(1) The services must be furnished in a center that is located in an outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining intermediary payments to a hospital under §§413.75 through 413.83.

(2) Any resident furnishing the service without the presence of a teaching physician must have completed more than 6 months of an approved residency program.

(3) The teaching physician must not direct the care of more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must—

(i) Have no other responsibilities at the time;

(ii) Assume management responsibility for those beneficiaries seen by the residents;

(iii) Ensure that the services furnished are appropriate;

(iv) Review with each resident during or immediately after each visit, the beneficiary's medical history, physical examination, diagnosis, and record of tests and therapies; and

(v) Document the extent of the teaching physician's participation in the review and direction of the services furnished to each beneficiary.

(4) The range of services furnished by residents in the center includes all of the following:

(i) Acute care for undifferentiated problems or chronic care for ongoing conditions.

(ii) Coordination of care furnished by other physicians and providers.

(iii) Comprehensive care not limited by organ system, or diagnosis.

(5) The patients seen must be an identifiable group of individuals who consider the center to be the continuing source of their health care and in which services are furnished by residents under the medical direction of teaching physicians.

(b) Nothing in paragraph (a) of this section may be construed as providing a basis for the coverage of services not determined to be covered under Medicare, such as routine physical checkups.

[60 FR 63178, Dec. 8, 1995, as amended at 61 FR 59554, Nov. 22, 1996; 70 FR 47490, Aug. 12, 2005]

§415.176 Renal dialysis services.

In the case of renal dialysis services, physicians who are not paid under the physician monthly capitation payment method (as described in §414.314 of this chapter) must meet the requirements of §§415.170 and 415.172 (concerning physician fee schedule payment for services of teaching physicians).

§415.178 Anesthesia services.

(a) *General rule.* (1) *For services furnished prior to January 1, 2010,* an unreduced physician fee schedule payment may be made if a physician is involved in a single anesthesia procedure involving an anesthesia resident. In the case of anesthesia services, the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure. The teaching physician cannot receive an unreduced fee if he or she performs services involving other patients during the period the anesthesia resident is furnishing services in a single case. Additional rules for payment of anesthesia services involving residents are specified in §414.46(c)(1)(iii) of this chapter.

(2) *For services furnished on or after January 1, 2010,* payment made under §414.46(e) of this chapter if the teaching anesthesiologist (or different teaching anesthesiologists in the same anesthesia group practice) is present during all critical or key portions of the anesthesia service or procedure involved; and the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure.

(b) *Documentation.* Documentation must indicate the teaching physician's presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist.

[74 FR 62014, Nov. 25, 2009]

Exception for Evaluation and Management Services Furnished in Certain Primary Care Centers

Medicare may grant a primary care exception within an approved GME Program in which you, the teaching physician, are paid for certain E/M services the resident performs when you are not present. The lower- and mid-level E/M services included under the primary care exception are shown in the chart below.

New Patient	Established Patient
CPT Code 99201	CPT Code 99211
CPT Code 99202	CPT Code 99212
CPT Code 99203	CPT Code 99213

The Healthcare Common Procedure Coding System (HCPCS) codes included under the primary care exception are shown in the chart below.

HCPCS Code G0402	Initial preventive physical examination; face-to-face visit services limited to new beneficiary during the first 12 months of Medicare enrollment (effective January 1, 2005)
HCPCS Code G0438	Annual wellness visit, including personal preventive plan service, first visit (effective January 1, 2011)
HCPCS Code G0439	Annual wellness visit, including personal preventive plan service, subsequent visit (effective January 1, 2011)

For the exception to apply, a primary care center must attest in writing that all of the following conditions are met for a particular residency program:

- The services must be furnished in a primary care center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining DGME payments to a teaching hospital. This requirement is not met when the resident is assigned to a physician's office away from the primary care center or he or she makes home visits. The nonhospital entity should verify with the Fiscal Intermediary (FI) or A/B Medicare Administrative Contractor (MAC) that it meets the requirements of a written agreement between the hospital and the entity;
- Residents who furnish billable patient care without the physical presence of a teaching physician must have completed more than six months of an approved residency program;
- The teaching physician who submits claims under the exception must not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability;
- The teaching physician may include residents who have completed less than six months in an approved GME Residency Program in the mix of four residents under his or her supervision; however, the teaching physician must be physically present for the critical or key portions of these services (i.e., the primary care exception does not apply in the case of residents who have completed less than six months in an approved GME Residency Program);