Internal Medicine Coding Alert

HCFA Fee Schedule has a Wealth of Information for Coders

Every year, HCFA updates its **Fee Schedule for Physicians** . The 2001 national **Physician Fee Schedule** Relative Value File contains relative value units (RVUs) and other essential information to help internal medicine coders obtain maximum reimbursement on claims. "The HCFA fee schedule is used by coders to determine RVUs for specific procedures. On closer examination, however, the document contains additional useful information," notes **Kathy Pride, CPC, CCS-P,** coding supervisor at Martin Memorial Health Systems in Stuart, Fla.

Note: The accompanying insert provides directions for downloading the RVU file and provides an example of the format, using codes referenced throughout this article.

Using the Fee Schedule

The fee schedule comprises 30 fields (labeled as columns A through Z, and AA, AB, AC and AD). While each field is important, internal medicine coders may find that the most pertinent information is contained in specific fields. This article addresses the fields most relevant to internal medicine practices.

Preliminary coding information is found in columns A through E. Column A lists the code, while column C contains an abbreviated description of the code. Column B identifies if the code has a professional component (designated by modifier -26) or a technical component (designated by modifier -TC). An empty B column denotes that the service is global, including both professional and technical components. Codes may be reported in any of these three ways. For example, 71020 (radiologic examination, chest, two views, frontal and lateral) appears three times in the file -- once with no indication in the Modifier column, once with modifier -TC, and once with modifier -26. A physician who owns x-ray equipment and interprets the film would assign 71020 globally, while the physician who interprets the x-rays taken at a hospital-owned facility would assign 71020-26.

For services other than those with a professional and technical component, a blank will appear in column B with one exception: modifier -53 (discontinued procedure) attached to colonoscopy code 45378. The modifier indicates that separate RVUs and a fee schedule amount have been established for this procedure should it be terminated before completion.

Column D contains the status of the code:

1. "A" indicates an active code
2. "R" signifies restrictions where special coverage instructions apply (e.g., carrier-priced)
3. "D" shows that the code has been deleted
4. "I" represents codes that are not valid for Medicare, but may be reported with HCPCS Level II codes.

For example, 36415 (routine venipuncture or finger/heel/ear stick for collection of specimen[s]) is designated with an "I." For Medicare beneficiaries, this service should be reported with HCPCS code G0001 (routine venipuncture for collection of specimen[s]).

Other less common designations include:

5. "C," noting that local carriers determine the fee allowance (e.g., 17999, unlisted procedure, skin, mucous membrane and subcutaneous tissue)
6. "B," signifying that the code is bundled
7. "N," indicating codes not covered by Medicare. (i.e., preventive care codes 99381-99397).

Determining Relative Value Units

The information found in columns "F" through "P" is the foundation for calculating what Medicare will pay physicians for their services. Three components -- physician work, practice expense and malpractice expenses -- are added to produce the RVU total. Physician work (column F) and malpractice expenses (column L) RVUs occupy one field each, but practice expense RVUs vary based on where the service was performed -- either in a facility (i.e., hospital) or nonfacility (i.e., office).

Both facility and nonfacility practice expense RVUs are listed two ways: transitioned and fully implemented. The difference relates to HCFA adjustments of fees paid for procedures over a four-year cycle that began in 1998. For procedures or services performed in 2001, only the transitioned column applies. In 2002, when HCFA's fee schedule changes are in place, the fully implemented column will be updated.

The file also provides the total number of practice expense RVUs for each procedure, sparing coders from adding the data found in columns M through P. The coder can select the appropriate RVU from one of the columns, depending on the procedure setting (facility or nonfacility) and whether the procedure fee is transitioned or fully implemented.

For instance, the number of RVUs (1.39) for a diagnostic sigmoidoscopy (45330) performed in a facility is found in column P, which lists the transitioned total RVUs for services performed in a facility.

There are also geographic practice cost indices (GPCIs) used to adjust RVUs on a regional basis. Because there are separate GPCIs for work, practice expense and malpractice expenses, GPCI corrections cannot be applied to the total RVU column. Rather, they must be made to each of the three specific RVUs, which are then added to determine the adjusted GPCI total. This number is then multiplied by the current national conversion factor ($38.2581 in 2001) to arrive at the Medicare fee schedule expected payment (see calculation example on this page).

RVUs are not meant as a guide to establishing how much the physician should charge for his or her services. RVUs are simply the tools Medicare uses to calculate its reimbursement to physicians. Because some payers exceed Medicare's fee schedule, coding experts agree that physicians should determine what their usual fees are (based on in-house methods) and not use Medicare reimbursement as a benchmark.

Global Procedures

Columns R through U provide information about global periods. Column R indicates the number of global days HCFA assigns to a procedure or service. Coders in internal medicine are most familiar with 0- or 10-day global periods, such as the 10-day global period associated with 11600 (excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.5 cm or less).

The fee schedule also includes procedures with the following global periods descriptors:

8. XXX, the global concept does not apply. XXX typically applies to minor procedure codes, such as 11200 (removal of skin tags)

9. YYY, the carrier determines if the global concept applies and establishes a postoperative period, if applicable, at the time of pricing. For use with unlisted procedure codes

10. ZZZ, the code is related to another service and is always included in the global period of the other service. Typically used for add-on codes, such as 17003 (destruction, benign or premalignant lesions& second through 14 lesions, each).

Multiple Procedures

Column V indicates how a procedure should be paid if it is not the primary procedure performed during the session. Diagnostic tests, such as x-rays, usually include an indicator of "0," meaning that no payment adjustment is made and the service is paid at 100 percent, even if it was performed at the same time as another service. Surgical procedures,

such as those performed on the integumentary system, may have an indicator of "2," designating that the standard multiple-procedure rule applies (100 percent for the highest-paying procedure, 50 percent for the others).

Bilateral Procedures

Column W tells physicians and coders how a procedure will be paid if it is performed on both sides. A "0" indicator in column W demonstrates that two sides do not exist (e.g., 45330 to describe the procedure performed on the sigmoid colon); therefore, the procedure cannot be billed as bilateral. Conversely, if the procedure can be performed on two sides and there are distinct codes for the procedure when performed bilaterally and unilaterally, the unilateral procedure will show a "0" in column W as well (e.g., 73500, radiologic examination, hip, unilateral; one view).

If the procedure shows a "1" in column W and is reported with modifiers -50 (bilateral procedure), -RT (right side) or -LT (left side), or with a "2" in the units field of the HCFA 1500 claims form, there is a 150 percent payment adjustment on the first procedure, notes **Barbara Cobuzzi, MBA, CPC, CPC-H,** a coding and reimbursement specialist and president of Cash Flow Solutions in Lakewood, N.J.

Note: According to HCFA, if the bilateral procedure is performed at the same time as any other procedure, the bilateral adjustment should be applied before any multiple-procedure adjustment is made.

If column W contains a "2," no fee adjustment should be made because the RVUs for the code assume a bilateral procedure. According to HCFA, this is the case when (a) the code descriptor states that the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or (c) the procedure is usually performed as a bilateral procedure. In the rare event that a procedure performed bilaterally includes a "3" in column W, both sides should be billed at 100 percent. A "9" in column W indicates that the concept of bilateral surgery does not apply.

Physician Supervision

Column AA does not relate to payment, but shows physicians the level of supervision they need to provide if ancillary providers, such as physicians assistants or nurses, perform services. A "1" in column AA indicates that general supervision (physician available by telephone) is required; "2" indicates direct supervision (physician must be in the suite or office, but not necessarily in the same room with the ancillary provider and the patient); and a "3" indicates personal supervision, meaning the physician must be in the same room with the provider and the patient. If column AA contains a "P," HCFA has not decided on the kind of supervision required for the procedure.

Column AB indicates which HCPCS code (if any) may be billed for supplies.