

CALIFORNIA OFFICIAL MEDICAL FEE SCHEDULE FOR PHYSICIAN'S SERVICES BEGINNING 1/1/2014

Suzanne Honor-Vangerov, Esq.
CPC, CPC-I

Suzanne Honor-Vangerov

- ▣ Managing Attorney, Lien Unit – Floyd Skeren & Kelly LLP
- ▣ Owner of Honor System Consulting
- ▣ Prior Manager of the Division of Workers' Compensation Medical Unit, in charge of the QME program, MPN, Independent Medical Review, Utilization Review, Spinal Surgery Second Opinion, and the Official Medical Fee Schedule.
- ▣ She is a Certified Professional Coder, Coder Instructor and Certified Medicare Secondary Payer Professional.

Overview

- ▣ What services are covered?
- ▣ Conversion Factors
- ▣ Tables
- ▣ Status Codes
- ▣ Code Sets
- ▣ Calculation of the fee
- ▣ “By Report” Codes
- ▣ Health Professional Shortage Area (HPSA) Bonus
- ▣ National Correct Coding Initiative (NCCI) Edits

- ▣ Supplies
- ▣ Drugs
- ▣ Non-Physician Practitioner (NPP)
- ▣ “Incident To”
- ▣ Evaluation and Management
- ▣ Consultations
- ▣ Reports
- ▣ Anesthesia
- ▣ Surgery
- ▣ Radiology
- ▣ Medicine: Ophthalmology, Diagnostic Cardiovascular Procedures, Physical Medicine, Acupuncture, Manipulation

What Services Are Covered?

- ▣ All services provided by physicians, nurse practitioners, physician assistants, other non-physician practitioners defined as Physician's Services by the regulations.
- ▣ Any provider, regardless of specialty, may use any section of the OMFS as long as it contains procedures performed within his/her scope of practice or license as defined by California law.
 - E/M codes are to be used by physicians as well as physician assistants and nurse practitioners who are acting within the scope of their practice and under the direction of a supervising physician..
 - Osteopathic Manipulation Codes 98925 - 98929 are to be used only by licensed MDs and DOs.

Conversion Factors

Physician's Fee Schedule Conversion Factors



| Type of Service | OMFS Budget-Neutral CF | 120% 2012 Medicare | 2014 (75 Percent OMFS/ 25 Percent 120 % Medicare) | 2015 (50 Percent OMFS/ 50 Percent 120 % Medicare) | 2016 (25 Percent OMFS/ 75Percent 120 % Medicare) | 2017 (120% Medicare) |
|--------------------|------------------------|--------------------|---|---|--|----------------------|
| Anesthesia | 34.5903 | 25.6896 | \$32.9605 | 30.1400 | 27.9148 | 25.6896 |
| Surgery | 55.6849 | 40.8451 | \$52.9311 | 48.2650 | 44.5551 | 40.8451 |
| Radiology | 52.9434 | 40.8451 | \$50.8371 | 46.8943 | 43.8697 | 40.8451 |
| All other services | 34.4566 | 40.8451 | \$36.7169 | 37.6509 | 39.2480 | 40.8451 |

Tables

- ❑ CMS' Medicare National Physician Fee Schedule Relative Value File
- ❑ Federal Office of Workers' Compensation Program (OWCP) fee schedule RVUs (*maybe*)
- ❑ Medi-Cal Rates - DHCS - "J" codes
- ❑ Anesthesia Base Units by CPT Code
- ❑ 2013 Primary Care HPSA
- ❑ 2013 Mental Health HPSA
- ❑ Physician Time
- ❑ Cast and Splint Supplies 2014

Status Codes

- ❑ Status codes indicate whether or not particular procedure codes are payable, if the payment is under the Physician's Schedule or a different schedule
- ❑ Code C, N, or R are paid using the OWCP relative values or, if no RV's listed, "by report" (*rules currently being revised*)
- ❑ Code I (*rules currently being revised*)
 - Should utilize a different CPT code used by Medicare, if applicable
 - If it's a "J" HCPCS code it should be paid using the Medi-Cal "J" code schedule
 - Use the RVUs in either the Medicare or OWCP schedule

Code Sets

- ❑ Current Procedural Terminology (CPT®), Fourth Edition
- ❑ California-Specific Codes
- ❑ Health Care Financing Administration Common Procedure Coding System (HCPCS)
- ❑ National Drug Codes – (NDC)
- ❑ International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9)
- ❑ International Classification of Disease, Tenth Revision, Clinical Modification (ICD-10)

Calculating the Fee Non-facility Site of Service

- ▣ “Non-Facility Total RVUs” shall be used where the place of service is listed as non facility (“NF”) the Place of Service (POS) Table

$$[(\text{Work RVU} * \text{Statewide Work GAF}) + (\text{Non-Facility PE RVU} * \text{Statewide PE GAF}) + (\text{MP RVU} * \text{Statewide MP GAF})] * \text{Conversion Factor (CF)} = \text{Base Maximum Fee}$$

Key: RVU = Relative Value Unit

GAF = Average Statewide Geographic Adjustment Factor

Work = Physician Work

PE = Practice Expense

MP = Malpractice Expense

Calculating the Fee

Facility Site of Service

- ▣ “Facility RVUs” shall be used where the place of service is listed as facility (“F”) the Place of Service (POS) Table.

$$[(\text{Work RVU} * \text{Statewide Work GAF}) + (\text{Facility PE RVU} * \text{Statewide PE GAF}) + (\text{MP RVU} * \text{Statewide MP GAF})] * \text{Conversion Factor (CF)} = \text{Base Maximum Fee}$$

Key: RVU = Relative Value Unit
GAF = Average Statewide Geographic Adjustment Factor
Work = Physician Work
PE = Practice Expense
MP = Malpractice Expense

“By Report Codes”

- ❑ An unlisted procedure shall be billed using the appropriate unlisted procedure code from the CPT. The procedure shall be billed by report (report not separately reimbursable), justifying that the service was reasonable and necessary to cure or relieve from the effects of the industrial injury or illness.
- ❑ Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service
- ❑ In determining the value of a By Report procedure, consideration may be given to the value assigned to a comparable procedure or analogous code. The comparable procedure or analogous code should reflect similar amount of resources, such as practice expense, time, complexity, expertise, etc. as required for the procedure performed.

Health Professional Shortage Area (HPSA) Bonus

- ❑ Physicians who provide professional services in a Health Professional Shortage Area (HPSA) are eligible for a 10 % bonus payment
 - Primary Care
 - Mental Health
- ❑ Determined by zip code of POS
- ❑ Areas determined by 12/31 of the previous year
 - If not on the automated file, but still in the designated areas should use Modifier AQ

- ❑ If the zip code falls into both Primary Care and Mental Health areas only one bonus will be paid for a given service
- ❑ If the POS falls into a zip code that is only partially covered, should use Modifier AQ
- ❑ A letter from Health Resources and Services Administration (HRSA) will serve as indication of eligibility for the 10% bonus. Use Modifier AQ
- ❑ When there is both a professional and technical component, the 10% is only on the professional component

NCCI Edits

- ❑ National Correct Coding Initiative Policy Manual for Medicare Services (NCCI) – determines what services are bundled into other services
- ❑ Medically Unlikely Edits – determine the maximum number of units that may be billed on a given date of service
- ❑ NCCI edits adopted by the CMS shall apply to payments for medical services under the Physician Fee Schedule unless where DWC ground rules differ

Supplies

- ❑ Separate payment for routinely bundled supplies is not allowed
- ❑ Physician-administered drugs/biological/vaccines/blood products are separately reimbursable
- ❑ “Administer” means the direct application of a drug or device to the body of a patient by injection, inhalation, ingestion, or other means
- ❑ Splints and casting supplies are payable separately in addition to payment for the procedure for applying the splint or cast, performed in a physician’s office, see Cast and Splint Supplies 2014

Drugs

- ❑ Vaccines shall be reported using the NDC and CPT-codes for the vaccine
- ❑ Other physician-administered drugs, biological and blood products shall be reported using the NDC and J-codes assigned to the product
- ❑ The maximum reimbursement shall be determined using the “Basic Rate” for the HCPCS code contained on the Medi-Cal Rates file for the date of service
- ❑ All claims for a physician-administered drug, biological, vaccine, or blood product must include the specific name of the drug and dosage

Injections

- ❑ The “Basic Rate” price listed on the Medi-Cal rates page of the Medi-Cal website for each physician-administered drug includes an injection administration fee of \$4.46 which must be subtracted from the payment
- ❑ The RBRVS fee schedule shall be used to determine the maximum reimbursement for the drug administration fee
 - Injection services (codes 96365 through 96379) are not paid for separately, if the physician is paid for any other physician fee schedule service furnished at the same time
 - Pay separately for cancer chemotherapy injections (CPT codes 96401-96549) in addition to the visit furnished on the same day

Radiopharmaceuticals

- ❑ When furnished to patients in settings in which a technical component is payable, separate payments may be made for low osmolar contrast material used during intrathecal radiologic procedures (HCPCS Q-codes Q9965-9967)
- ❑ Pharmacologic stressing agents used in connection with nuclear medicine and cardiovascular stress testing procedures HCPCS A-codes A4641, A4642, A9500-A9507, A9600)
- ❑ Radionuclide used in connection nuclear medicine procedures furnished to beneficiaries in settings in which TCs are payable

Non-Physician Practitioners

- ▣ Practitioners who are not physicians include nurse practitioners, physician assistants, clinical nurse specialists and clinical social workers, who are acting within the scope of their license.
- ▣ Reimbursement:
 - Incident to – 100% of physician's fee
 - Except for clinical social workers – 85% of physician's fee
 - Clinical social workers – 75% of physician's fee
 - Assistant-at-surgery – 13.6% of physician's fee, must use AS modifier

Incident To

- ▣ Non-Institutional setting
 - Anywhere other than a hospital or skilled-nursing facility
 - ▣ Without direct physician supervision, separately payable at NPP rate
 - ▣ If under direct physician supervision, no separate payment for NPP, payment treated as physician's reimbursement. Services must be:
 - An integral, although incidental, part of the physician's professional service
 - Commonly rendered without charge or included in the physician's bill
 - Of a type commonly furnished in physician's offices or clinics
 - Furnished by the physician or by auxiliary personnel under the physician's direct supervision

- ▣ Institutional setting
 - Must meet incident to requirements
 - Payment made to hospital
- ▣ Direct physician supervision
 - Physician must be present in office suite and immediately available to assist or direct
 - Outside the office setting – physician must accompany NPP
 - Institutional setting – telephone availability or physician being somewhere else in the facility is not adequate
 - Physician directed clinic – more than one physician can be responsible for supervision

Misc. Information

- ▣ The maximum fee for physician and non-physician practitioner services shall be the lesser of the actual charge or the calculated rate established by this fee schedule.

Coding Evaluation & Management Services

- New patient is one who is new to the physician or medical group or an established patient with a new industrial injury or illness.
 - Only one new patient visit is reimbursable to a single physician or medical group per specialty for evaluation of the same patient relating to the same incident, injury or illness
- Established patient is a patient who has been seen previously for the same industrial injury or illness by the physician or medical group.
- Documentation Standards
 - 1995 Documentation Guidelines for Evaluation & Management Services
 - 1997 Documentation Guidelines for Evaluation & Management Services

Consultations

- ❑ Do not use the Consultation CPT codes (99241 – 99245, or 99251 – 99255)
- ❑ Use the E/M code for new or established patient based on the place where the service occurred.
 - In an inpatient hospital or nursing facility setting the practitioner may use CPT codes 99221 – 99223, 99231 – 99233, 99304 – 99306 or 99307 – 99310
 - In an office or outpatient setting the practitioner may use 99201 – 99205 or 99211 – 99215
- ❑ For reports requested by the WCAB or AD use Modifier -32
- ❑ For reports requested by the QME or AME use Modifier -30 (*only for Acupuncture QME/AME's*)

Prolonged Services

- ❑ A treating or consulting physician may be paid for service which extends beyond the usual service time indicated for an E/M code.
- ❑ Where the physician is required to spend at least 30 minutes or more of direct contact time in addition to the time set forth in the appropriate CPT code (i.e.: 40 minutes listed under E/M code 99215)
 - 99354 (30 – 74 minutes)
 - 99355 (each additional 30 minutes)

- ▣ When a physician is required to spend 30 or more minutes before and/or after direct patient contact in reviewing records, tests or other communications. (*these services are currently not payable*)
- ▣ The service must relate to a service or patient where face-to-face care has occurred or will occur and relate to ongoing patient management.
 - 99358 (30 – 90 minutes)
 - 99359 (each additional 30 minutes)
 - ▣ Must go at least 15 minutes beyond the first hour to be payable
- ▣ No reports are payable with these codes

Reports

- ▣ Separately reimbursable
 - PR-2 – WC002: flat fee no matter how many pages
 - PR-3 – WC003: payable per page, 6 page maximum
 - PR-4 – WC004: payable per page, 7 page maximum
 - Psychiatric Report requested by WCAB or AD – WC005: payable per page, 6 page maximum
 - Consultations requested by the WCAB, AD, QME or AME– WC007: payable per page, 6 page maximum

- ❑ Not Separately reimbursable
 - Doctor's First Report – WC001
 - Secondary Treating Physician Reports
 - Other Consultation reports
 - Reports related to Prolonged Service codes
- ❑ Chart Notes – WC008
 - Upon written request of the Claims Administrator
- ❑ Duplicate Reports – WC009
 - Upon written request of the Claims Administrator

Anesthesia Services

▣ Payment

$[Base\ Unit + Time\ Unit] * CF * Statewide\ Anesthesia\ GAF = Base\ Maximum\ Fee$

▣ One time unit for each 15 minutes

- ▣ If physician performed entire anesthesia service alone
- ▣ If a teaching physician is supervising a resident in one anesthesia case and was present during all critical portions of procedure
- ▣ If a teaching physician and is training residents in either a single anesthesia case, two concurrent anesthesia cases involving residents or one anesthesia case with medical direction and is present during all critical portions of the procedures

- The physician is continuously involved in a single case involving a student nurse anesthetist
- The physician is continuously involved in one case involving a Certified Registered Nurse Anesthetist (CRNA) or Assistant Anesthetist (AA)
- The physician and CRNA or AA are involved in one case and the services of both are found medically necessary

▣ Medically Directed Rate

- Paid at 50% of the service if it had been performed by the physician alone directing 2, 3 or 4 concurrent cases
 - ▣ Performs a pre-anesthetic exam and evaluation
 - ▣ Prescribes an anesthesia plan
 - ▣ Personally participates in the most demanding portions including induction and emergence
 - ▣ Ensures that anything not performed personally are performed by a qualified anesthetist
 - ▣ Monitors the course of anesthesia
 - ▣ Remains physically present and available for diagnosis and treatment of emergencies

■ Medically Supervised Rate

- Only 3 base units per procedure when furnishing more than 4 concurrent procedures or is performing other services while directing the concurrent procedures.
 - May be entitled to an extra unit if documentation of presence during induction

▫ Multiple Anesthesia Procedures

- Report procedure with highest base unit value. Use Modifier -51
- Combine total of all time under anesthesia for all procedures
- Use the base value for the highest procedure and all of the time values

❑ Anesthesia time calculation

- Starts from time patient is prepared for anesthesia services
- Ends when anesthesia practitioner is no longer furnishing anesthesia services
- Divide total time by 15 minutes to get total number of units. Round to one decimal place
- No time units for code 01996

❑ Base Unit reduction for Concurrent Medically Directed Procedures

- For 2 concurrent procedures base units reduced by 10%
- For 3 concurrent procedures base units reduced by 25%
- For 4 concurrent procedures base units reduced by 40%
- For cataract or iridectomy reduce base units for each cataract or iridectomy by 10%

- ▣ Monitored Anesthesia Care (MAC)
 - Use Modifier QS
 - Involves intra-operative monitoring by a physician or qualified individual under medical direction of a physician.
 - Includes pre-anesthetic examination and evaluation, prescription of anesthesia care required, administration of any necessary oral or parenteral medications and provision of indicated post-op anesthesia care

- ❑ The following modifiers are used when billing for anesthesia services:
 - AA - Anesthesia services performed personally by the anesthesiologist
 - AD - Medical Supervision by a physician; more than 4 concurrent anesthesia procedures
 - G8 - Monitored anesthesia care (MAC) for deep complex complicated, or markedly invasive surgical procedures
 - G9 - Monitored anesthesia care for patient who has a history of severe cardio- pulmonary condition
 - QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
 - QS - Monitored anesthesiology care services (can be billed by a qualified non-physician anesthetist or a physician)
 - QX - Qualified non-physician anesthetist with medical direction by a physician
 - QY - Medical direction of one qualified non-physician anesthetist by an anesthesiologist
 - QZ - CRNA without medical direction by a physician
 - GC - these services have been performed by a resident under the direction of a teaching physician

- ▣ Anesthesia and Medical/Surgical Service provided by the same physician
 - Conscious (moderate) sedation 99143 – 99145 are payable as long as the underlying procedure is not in Appendix G of the CPT book
 - If a second physician provides moderate sedation in a facility setting and the code is in Appendix G the second physician may use 99148 – 99150
 - For anesthesia for diagnostic or therapeutic nerve blocks and a different provider performs the block, the provider may use code 01991
 - ▣ Must meet requirements for moderate sedation
 - If physician performing the procedure also provides anesthesia lower than moderate sedation, no payment is allowed

Surgery Services

- ▣ Global Surgical Package
 - Bundle of services included in a surgery service
 - Includes pre-operative, intra-operative and post-operative services
 - ▣ Post-op days: 00, 10, 90, or ZZZ (included in another service, no post-op work)
 - ▣ Post-op complications that don't require a return to the operating room
 - ▣ Post-op pain management
 - ▣ Supplies
 - ▣ Misc.

- Not included in the Global Surgical Package
 - Initial evaluation of problem by surgeon
 - Services of other physicians with transfer of care
 - Visits unrelated to the diagnosis that resulted in the surgery
 - Treatment for the underlying condition unrelated to surgical recovery
 - Diagnostic tests and procedures
 - Clearly distinct surgical services
 - Complications resulting in a return to the operating room
 - A more extensive procedure after a less extensive procedure fails
 - Splints and casts
 - Immunosuppressive therapy for organ transplants
 - Critical care services
 - PTP Progress Reports and specified E/M visits

- ▣ More than one physician providing parts of the package (not in the same practice)
 - Modifier -54 for intra-operative services
 - Modifier -55 for post-operative services
 - Modifier -56 for pre-operative services
 - Percentages for each segment of the package are found in the Fee Schedule table
- ▣ Global Surgery Period
 - Major Surgery: One day immediately prior to the surgery date, the date of the surgery and the 90 days following the surgery
 - Minor Surgery: The date of the surgery and either 0 or 10 days following the date of surgery
- ▣ Decision for Surgery
 - E/M service the date immediately before or the day of the surgery that results in the decision for surgery is separately payable. Use Modifier -57

- ❑ Return trip to the OR during post-op period
 - For complications use Modifier -78
 - For staged procedures use Modifier -58
- ❑ Unrelated procedures during post-op period
 - For surgical service use Modifier -79
 - For E/M service use Modifier -24
- ❑ Significant E/M on the day of the surgery
 - For use for a E/M service that is unrelated to the surgery use Modifier -25
- ❑ Critical Care
 - For seriously injured or burned patients
 - Patient critically ill and requires constant attendance of physician
 - Unrelated or above and beyond the care from the surgery
 - Use 99291 – 99292 and Modifier -25 for pre-op or -24 for post-op

▣ Dates of Service

- The surgeon must enter the date of the surgery on the bill
 - If post-operative care is shared with another physician, the date care is transferred must be indicated on the CMS 1500 form on line 19 or the electronic equivalent
- ▣ If post-op care is shared, the payer will apportion the share of the post-op based on the number of days each physician was responsible for care

- ▣ Payment for return trip to OR for complications
 - Based on the intra-op percentage of the total fee
 - If return procedure is unlisted, payment will be 50% of the original procedure's intra-op amount.
- ▣ Circumstances allow E/M charges during the post-op period
 - Look at the Physician Time File
 - Total all days for E/M services, round up
 - If the physician provides more dates of service than the total from the table, additional E/M services may be billed
 - Payments for Progress Reports are payable during the post-op period

▣ Multiple Surgeries

- The major service has no modifier and is paid at 100%
- Additional services use Modifier -51. Look at Physician's Fee Schedule table for indicator "2" in the Multiple Procedure column. Up to 4 additional procedures are paid at 50%
- Additional procedures beyond the first 4 are paid "by report", but no less than 50%
- Different surgeons performing distinctly different services are not subject to the multiple procedure reduction unless the individual surgeon performs multiple procedures
- For interventional radiology both the radiology code and primary surgery code are paid at 100%

❑ Multiple endoscopies

- Indicator of “3” in the Multiple Procedure column
- Look for “base” endoscopic procedure in the Endo Base column
- If only the base code and a related procedure are billed, there is no payment for the base code
- If more than two codes are billed, pay 100% of the highest and the difference between the base endoscopy rate and the next highest
- If two endoscopies are unrelated, the regular multiple procedure rules apply

▣ Bilateral procedures

- Look in the Physician's Fee Schedule Table under the Bilateral Procedure Column
- If indicator is "0", "2" or "3" bilateral rules don't apply. Some "0" procedures may be performed more than once in a day, if so they are subject to the multiple procedure rule
- If indicator is "1" bilateral rules apply
- Pay at 150% of a single sided procedure. Use Modifier -50
- For purposes of the multiple procedure rule, use the 150% for ranking and payment purposes
- Global surgery rules apply to bilateral procedures

- Team surgeons are more than two surgeons in different specialties performing a specific procedure. Use Modifier -66
 - Look in Team Surgery Column of Physician's Fee Schedule table
 - If indicator is "1" provide documentary support for use of team
 - If indicator is "2" then no documentation is necessary
 - Payment is "by report"
- If surgeons of different specialties are performing different procedures the co-surgery rules do not apply
- Global surgery rules do apply

- ▣ Assistants-at-surgery
 - Paid at 16% of the surgical payment
 - Use Modifiers -80, -81, -82 or AS
 - Check the Assistant Surgery column of the Physician's Fee Schedule Table
 - ▣ If indicator is "0" provide documentary support for use of assistant
 - ▣ If indicator is "1" no assistant is payable
 - ▣ If indicator is "2" assistant is payable
 - No assistant is payable for co-surgeons or team surgeons

Radiology Services

▣ PC/TC

- PC is the professional component performed by a radiologist or other physician interpreting the results
- TC is the technical component performed by the entity performing the actual radiological procedure
- Global Service is the combination of both the PC and TC portions

▣ Multiple Procedures

- Check Physician Fee Schedule table under Multiple Procedure column.
 - ▣ If indicator is “4” subject to multiple procedure rule
- Pay highest paid procedure at 100% of both PC and TC component
- Pay subsequent PC services at 75%
- Pay subsequent TC services at 50%

▣ Radiology Consultations

- Only one interpretation of an x-ray procedure shall be reimbursed
- There must be a written report
- Use Modifier -26
- Reimbursement of a second interpretation shall only be allowed under unusual circumstances which must be documented
- Use Modifier -77
- Do not use code 76140

Medicine Section

- ▣ Ophthalmology Multiple Procedures
 - When multiple services are furnished to the same patient on the same day
 - Check Physician's Fee Schedule table under Multiple Procedure column
 - If indicator is "7" subject to multiple procedure rule
 - Applies only to the TC portion of the service
 - Pay highest value TC service at 100%
 - Subsequent TC services are paid at 80%
 - For services subject to both the multiple procedure payment reduction and the OPSS cap on imaging, the MPPR shall be applied first, then the reduced amount will be compared with the OPSS cap, and the lower amount shall be used.

- ▣ Diagnostic Cardiovascular Multiple Procedures
 - Check Physician's Fee Schedule table under Multiple Procedure column
 - If indicator is "6" subject to multiple procedure rule
 - Applies only to the TC portion of the service
 - Pay highest value TC service at 100%
 - Subsequent TC services are paid at 75%
 - For services subject to both the multiple procedure payment reduction and the OPPI cap on imaging, the MPPR shall be applied first, then the reduced amount will be compared with the OPPI cap, and the lower amount shall be used.

Physical Medicine

- ❑ Timed procedures are 15 minutes, can be billed in multiple units
- ❑ Maximum of 60 minutes per visit
- ❑ Maximum of four codes, no more than two modalities
- ❑ Modality is a service listed under the sub-heading of “Modality” in the CPT book
- ❑ Procedure is a service listed under the sub-headings of “Therapeutic Procedures”, “Other Procedures”, “Acupuncture”, and “Chiropractic Manipulative Treatment”

❑ Multiple procedures

- Check Physician's Fee Schedule table under Multiple Procedure column
 - If indicator is "5" subject to multiple procedure rule
 - In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943
- Applies when more than one of the affected codes are billed on the same date
 - Timed codes may be billed with multiple units. Each unit counts as a procedure
- Applies to the PE portion of the payment
- Procedure with the highest PE portion is paid at 100%
- Subsequent procedures have the PE portion paid at 50%
- Applies in a group practice or "incident to" regardless of how whether there are multiple disciplines involved

Questions?

Contact Information:

e-mail: suehonor@hotmail.com
website: <http://www.honorsystemconsulting.com>
phone: 650-787-3782

Resources:

DWC website: <http://www.dir.ca.gov/dwc/>
Medicare's website: <http://www.cms.gov/Medicare/Medicare.html>
Medi-Cal Rates: http://files.medi-cal.ca.gov/pubsdoco/Rates/rates_download.asp
AMA Bookstore: <https://commerce.ama-assn.org/store/>