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DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care  
Financing Administration

Refer to: FQA-541

Memorandum

Date

DEC 29 1992

From

Director  
Division of Medical Services Payment, BPD

Subject

Various PPR Issues (Your Memorandum, 6-3-92)--INFORMATION

To

Associate Regional Administrator  
Division of Medicare  
San Francisco  
ATTN: Chief  
Technical and Special Issues Section

I am responding to your memorandum on various fee schedule issues. I regret the delay in my reply.

(1) Status Code "T"

The 1993 physician fee schedule notice clarifies in Addendum B that code T services are payable only if there are no other services payable under the physician fee schedule are billed on the same day by the same "provider."

Answer →

(2) Transcription Costs of Radiology Interpretation

Under the scenario presented, a radiologist who has an arrangement with a hospital to interpret radiology procedures performed for the hospital's patients is being asked by the hospital to pay for the costs associated with transcribing his recorded interpretation into the medical records. The hospital maintains that such transcription costs are included in payments for the professional component (PC) of the procedure. You have suggested that the PC payment reflects billing costs and malpractice expenses and have inquired about any guidelines given to the Harvard team for the inclusion of other nonphysician services in the PCs of diagnostic tests.

I would generally agree with your analysis of the composition of the PC. With specific regard to radiology, the PC values were developed by the American College of Radiology (ACR) and were rescaled for inclusion with the Harvard values. I think it is safe to say that no one involved with the processes of developing either the radiologist or physician fee schedule made a decision that would have specifically placed transcription costs in the PC.

We view transcription costs in the hospital setting to be a component of a hospital's record-keeping activities, the cost of which would have been rebundled into operating costs of inpatient hospital services for services furnished in both prospective payment and excluded hospitals. Of course, the rebundling requirements are a protection for the beneficiary rather than the physician, and we would not be able to exercise any leverage on behalf of the physician to say that a hospital may not charge a physician for any activities payable through the diagnosis related group payment. It has been Medicare policy that hospitals and physicians are free to enter into mutually acceptable arrangements without interference from the Federal government. However, with the enactment of the anti-kickback provision, under the purview of the Office of the Inspector General (OIG), agreements calling for the change of anything of value must be based on the fair market value of the goods and services exchanged. We suggest you check with the regional OIG to determine if they have a problem with the specific arrangement.