



DEPARTMENT OF HEALTH & HUMAN SERVICES

Region IX
Health Care Financing Administration

Memorandum

Date JUN 3 1992
From Chief
Technical and Special Issues Section
Subject Various PPR Issues
To Bernard Patashnik, Director
Division of Medical Services Payment, BPD
Refer to MCR-C-FJC

Please clarify HCFA's policy on the following issues:

(1) Status Code "T"

The definition for this Status Code includes the instruction that carriers must deny these codes if "other services are billed on the same date by the same provider". Please define "other services". Carriers have taken the position that any other service warrants denial, including clinical laboratory, drugs, technical components of diagnostic testing, etc. It is our opinion that "other services" means a visit or surgical procedure. Edey Fisher has been contacted on this issue.

Question (2)
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(2) What Is Included In Medicare's Payment For The Professional Component?

We recently received an inquiry from a physician regarding the professional component of radiology services. This hospital-based physician has been approached by the hospital's administration and asked to pay for the transcription costs associated with transcribing his recorded interpretation to the medical records. The hospital is alleging that the Medicare payment for the professional component, under the fee schedule, includes the cost of the transcribing the interpretation.

In our opinion, the Medicare payment covers the cost of billing the service and malpractice expenses. Other nonphysician services are not included. Was William Hsiao given any guidelines when he was asked to develop the RVUs for the professional component of diagnostic testing? Does HCFA have any guidelines on what is included in the payment for the professional component?