MEDICARE PART A BULLETIN

November 26, 1997 General Medicare Bulletin G-305

TO: All Medicare Providers

FROM: Medical Policy Development

SUBJECT: **MEDICARE PART A LOCAL MEDICAL REVIEW POLICY (LMRP) IMPLEMENTATION IMPACTS AND THE LMRP FORMAT**

ATTENTION MEDICARE BUSINESS OFFICE: Please distribute to all appropriate health care facility personnel.

Health Care Financing Administration (HCFA) instructions regarding development of Local Medical Review Policy (LMRP) are addressed in the Medicare Intermediary Manual (HCFA Publication 13-3, Section 3911), which indicates: "Medical review policy is a composite of statutory provisions, regulations, nationally published Medicare coverage policies, and Local Medical Review Policies (LMRPs)." In the absence of statute, regulations, or national coverage policy, Medicare contractors (intermediaries and carriers) are instructed to develop LMRPs to describe when and under what circumstances an item or service will be covered. LMRPs are also developed to clarify or to provide specific detail on national coverage guidelines and are the basis for medical review decisions made by the Medicare contractor's medical review staff.

Medical review initiatives are designed to ensure the appropriateness of medical care and to ensure that the medical policies and review guidelines developed are consistent with the accepted standards of medical practice.

In January 1997, Medicare Part A, Blue Cross and Blue Shield of Florida, began developing and implementing LMRPs at an accelerated rate. Providers are encouraged to place the LMRPs in a manual and updated it with all new and revised policies. Providers are also encouraged to review and update all activities/procedures that would be affected by the LMRP (i.e., charge masters, billing procedures, beneficiary notification of noncoverage, etc.).

LOCAL MEDICAL REVIEW POLICY (LMRP) IMPLEMENTATION IMPACTS MAY RESULT IN DENIALS AND/OR RTP CLAIMS NOT EXPERIENCED TO DATE!!!

Effective 30 days from the date of this bulletin, the Florida Shared System (FSS) HCPCS code and revenue code tables will be updated to reflect the information that was published in all finalized LMRPs. This means that providers may receive return-to-provider (RTP) claims if they do not implement the revenue and HCPCS code requirements that were published in the LMRP. Also, the Artificial Intelligence (AI) system will be updated to ensure that all applicable AI applications review all type of bill (TOB) codes that were published in the final LMRP. Therefore, providers need to ensure that they have identified any processes that are affected by a final LMRP and ensure that patients are appropriately notified when services are considered noncovered.

WHAT DOES THIS MEAN?

This means that you may begin to experience denials and/or RTP edits as a result of the FSS system being updated to reflect the revenue and HCPCS coding requirements published via final LMRPs. Also, the Artificial Intelligence (AI) system will be updated to ensure that all applicable AI applications review all type of bill codes (e.g., Hospitals, Skilled Nursing Facilities, Rural Health Clinics, End Stage Renal Disease Facilities, etc.). Providers should review the LMRP sections which identify all applicable types of bill codes, acceptable revenue code(s), and acceptable HCPCS code(s) to ensure compliance.

HOW DO I KNOW WHAT LMRPs HAVE/ARE BEING IMPLEMENTED?

There is no set schedule of LMRP implementation. As new policies are finalized, they are published to the provider community via the bulletin mechanism, generally with a minimum 30-day effective date.

Providers should be aware of the LMRPs that exist for services that they are rendering. If providers need a copy of published LMRP bulletins, they may utilize the Medicare Bulletin Board System (BBS-BLINE), the Medicare A Xpress (MAX) line (904/355-8263), or contact the Medicare Part A Customer Service Department (904/355-8899) to obtain/request LMRP bulletins.

HOW WILL I KNOW WHICH SERVICES ARE COVERED/NONCOVERED ?

Providers should pay particular attention to the final LMRPs that identify those diagnoses for which certain services are considered to be medically necessary. If a claim is submitted with a diagnosis that is not reflected within the specific LMRP, the claim may be denied.

WHY ARE THESE DENIALS AND RTPs NECESSARY?

It is the responsibility of the fiscal intermediary to ensure that only those services reasonable and medically necessary are reimbursed. Denials resulting from failure to meet the diagnosis criteria safeguard unnecessary Medicare program expenditures for medically inappropriate services.

Additionally, RTPs for inconsistencies between revenue and HCPCS codes assist us in maintaining the integrity of our claims data and accuracy of your claim submissions.

MEDICARE PART A MEDICAL POLICY PROCEDURES

Medical Policy may be applied to Medicare claims on either a prepayment or post-payment basis. Medicare participating providers are accountable for compliance with published policy application. This includes Medicare coverage and policy information published via national HCFA Manual Transmittals, or intermediary publication of LMRP.

LMRP FORMAT

Each LMRP is written in a standard format designed to convey pertinent information about an item/service in an organized and concise manner. The format is divided into distinct sections, many of which contain information the provider must know to ensure compliance. The following table has been developed to assist the provider in understanding the sections of the PART A LMRP.

LMRP SECTION	DESCRIPTION
SUBJECT	The subject is located in the upper left hand corner of the policy and identifies the name of the policy.
POLICY IDENTIFIER	Each policy is assigned an individual number, located in the upper right hand corner of the policy. All Medicare Part A policies begin with the letter "A". If the policy has a direct correlation to a specific HCPCS/CPT code, the policy number will be the HCPCS code preceded by the alpha character "A", such as: Policy No: A77300 Basic Radiation Dosimetry Calculation. Some policy numbers relate to the subject/title of a specific service/item/procedure and consist of all alpha characters, such as: Policy No: ADYSPHT Dysphagia/ Swallowing Diagnosis and Therapy. **Additional services closely related to the topic or subject matter may be included in one policy.**
DESCRIPTION	Defines the item/service and explains how it operates or is performed.
TYPE OF BILL	Identifies those types of providers and billing classifications addressed by the policy (e.g., Comprehensive Outpatient Rehabilitation Facility [CORF]-75X or Community Mental Health Center [CMHC]-76X). This section will only identify those provider types under Blue Cross and Blue Shield of Florida's medical review jurisdiction.
REVENUE CODES	Lists the codes which most accurately represent the item/service (e.g., 420- Physical Therapy, general classification or 324- Chest X-ray, Radiology-diagnostic).
INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY	Lists the specific indications for which an item/service is covered and/or considered medically necessary by Medicare. It may also contain limitations on coverage.

LMRP SECTION	DESCRIPTION
HCPCS CODES	Lists the applicable HCPCS code or code ranges related to the item/service the policy addresses. A policy may be associated with one or more HCPCS codes or code ranges. (Some policies will not be associated with HCPCS codes.)
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY	Lists the ICD-9 code or code ranges for which the item/service is generally covered. A policy may be associated with one or more ICD-9 codes or code ranges. **The list of ICD-9 code(s) that support medical necessity applies to each of the HCPCS codes identified in the policy.** (Some policies will not be associated with diagnosis codes.)
HCPCS SECTION AND BENEFIT CATEGORY	Defines the section of the HCPCS to which the policy applies (i.e., chemotherapy drugs and medical services).
HCFA NATIONAL COVERAGE POLICY	References any existing HCFA National Coverage Policy.
REASONS FOR DENIAL	Indicates the specific situations under which an item/service will ALWAYS be denied. It also lists other reasons for denial (i.e., investigational, cosmetic, routine screening, program exclusion, or never medically necessary) that apply to the item/service.
NONCOVERED ICD-9 CODES	Some item(s)/service(s) billed will always deny for a certain ICD-9 code. This section lists the ICD-9 code(s) or code range(s) that are NEVER covered for those item(s)/service(s). **The list of noncovered ICD-9 code(s) applies to each of the HCPCS codes identified in the policy.**
SOURCES OF INFORMATION	Lists the information sources and pertinent references (other than National Coverage Policy) used in the development of the policy.
CODING GUIDELINES	Describes the relationship between codes and defines how the item(s)/service(s) are billable (e.g., units of service, HCPCS, modifiers, etc.).

LMRP SECTION	DESCRIPTION
DOCUMENTATION REQUIREMENTS	Describes the specific information from the medical records or other pertinent resources that would be required to justify the item/service (e.g., pathology reports, progress notes, or photographs).
OTHER COMMENTS	Further defines terms or provides relevant information not included in other sections of the policy.
RATIONALE FOR CREATING POLICY	Identifies the reason the policy was created (i.e., to revise an existing policy, to provide clarification of coverage for an item/service, etc.).
CAC NOTES	Validates that the policy was presented to the Carrier Advisory Committee (CAC) at the quarterly meeting and that other sources of input were considered in the development of the policy.
START DATE OF COMMENT PERIOD	Indicates the date the LMRP was released for comment. The provider community is given 45 days from this date to disseminate the draft policy among their peers and provide any constructive feedback and comments to the medical policy area of Medicare Part A, Blue Cross and Blue Shield of Florida for consideration.
START DATE OF NOTICE PERIOD	Indicates the date the provider community was notified of the finalized LMRP. This date represents the start of the required 30-day advance notification period, prior to the implementation of the policy. This notification will take place via the Medicare Bulletin to the Part A provider community.
ORIGINAL EFFECTIVE DATE	Indicates the actual effective date that the original LMRP rules, requirements, and limitations could be applied and are expected to be adhered to by the provider community.
REVISED EFFECTIVE DATE	Indicates the effective date of the revised LMRP. When a policy is revised, all policy rules, requirements and limitations become effective as of this date. The expiration date of the original LMRP is the day before the effective date of the revised policy.
REVISION HISTORY	Documents the history of the policy for tracking purposes (e.g., the reason for the revision of the policy, previous revisions, etc.).

Questions regarding this bulletin may be addressed to the Medicare Part A Customer Service Department by calling (904) 355-8899.