MEDICARE PART A BULLETIN

January 25, 1999 General Medicare Bulletin G-361

TO: All Medicare Providers

FROM: Medicare Education and Outreach

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

This bulletin includes several articles on specific implementation, changes and or revisions affecting the Medicare Part A coverage guidelines, and articles addressing issues of general information on topics of interest or awareness .for all providers furnishing services to beneficiaries of the Medicare Program. Refer to the Table of Contents for easy identification of the issues addressed in this publication.

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

TABLE OF CONTENTS

COVERAGE/REQUIREMENTS

Intermediary Updating of the ICD-9-CM
Coding System---2
Billing for Pneumococcal, Hepatitis B,
and Influenza Virus Vaccines-----------------------2
Prospective Payment System for
Outpatient Rehabilitation Services and
Application of the Financial Limitation-------------2
Requirements for Billing Claims for Services
Subject to Line Item DOS Reporting----------------6
GENERAL INFORMATION
Medicare Deductible and Coinsurance for 1999---------------------6
The Year 2000 Is HCFA's #1 Priority2-------------------------------7
How Providers May Be Affected by the Year 2000 Challenge----9
Sample Provider Y2K Readiness Checklist-------------------------11
Y2K World Wide Web Site References-----------------------------12
Medicare + Choice Scams--14
Medicare Part A 1999 Bulletins Available by Subscription-------15
Medicare Part A 1999 Bulletin Subscription Form----------------16

Intermediary Updating of the ICD-9-CM Coding System

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) coding system for diagnosis and procedures for hospital discharges and outpatient services occurring on or after October 1, 1998, has been changed. A copy of the fiscal year 1999 addendum to ICD-9-CM for volumes I, II, and III is **only** available on the Medicare Online bulletin board system (BBS). Refer to G-361A within the Part A Bulletin section.

These changes are particularly important for Prospective Payment System (PPS) hospitals because of the relationship between coding and payment. Other providers affected by the changes in the ICD-9-CM changes are non-PPS hospitals, skilled nursing facilities (SNFs), home health agencies (HHAs), etc. In addition, the new diagnosis codes are used in hospital outpatient billing.

Billing for Pneumococcal, Hepatitis B, and Influenza Virus Vaccines

The 1999 Health Care Financing Administration Common Procedure Coding System (HCPCS) update has deleted the procedure code 90724 for influenza and replace it with procedures codes 90657, 90658, and 90659. The deleted procedure code 90724 will receive the standard grace period of 90 days from January 1, 1999, through March 31, 1999. Procedure codes 90669 and 90748 have been added to the section for pneumococcal and hepatitis B vaccines. In addition, the definitions for hepatitis B vaccine procedure codes have been updated.

IMPORTANT NOTE: Because of requiring Y2K testing, HCFA is unable to make the necessary changes to processed claims reflecting the new influenza virus vaccine and the pneumococcal HCPCS codes 90657, 90658, 90659, and 90669, until April 1, 1999. **Effective January 1, 1999, claims submitted with the new procedure codes cannot be processed for payment. Providers must continue to bill the old influenza virus vaccine procedure code 90724 through March 31, 1999. Claims received with the new codes during the standard 90 days grace period may be delayed from payment until April 1, 1999. Although procedure code 90724 will be deleted effective April 1, 1999, it is important to continue to use this code until April 1, 1999 to avoid any payment delay**.

Prospective Payment System for Outpatient Rehabilitation Services and Application of the Financial Limitation

The Balanced Budget Act (BBA) of 1997 was signed into law by President Clinton on August 5, 1997. Several provisions of the Balance Budget Act have direct impact to the Medicare program. One of these provisions requires payment under a prospective payment system for outpatient rehabilitation services. Outpatient rehabilitation services include the following services:

- Physical therapy, (which includes outpatient speech-language pathology); and
- Occupational therapy.

This payment system also applies to certain audiology and Comprehensive Outpatient Rehabilitation

Facility (CORF) services. Audiology and CORF services are identified by the procedure codes listed below. The Medicare Physician Fee Schedule (MPFS) will be used as the prospective payment system for these services.

Effective for claims with dates of service on or after January 1, 1999, the MPFS is the method of payment when outpatient physical therapy (which includes outpatient speech-language pathology) **and** occupational therapy services are furnished by:

- Rehabilitation agencies, (outpatient physical therapy providers and CORFs),
- Hospitals (to outpatients and inpatients who are not in a covered Part A stay),
- SNFs (to residents not in a covered Part A stay and to non-residents who receive outpatient rehabilitation services from the SNF), and
- HHAs (to individuals who are not homebound or otherwise are not receiving services under a home health plan of treatment).

The MPFS will be used as a method of payment for outpatient rehabilitation services furnished under arrangement with any of these providers. In addition, the MPFS will also be used as the payment system for audiology and CORF services identified by the HCPCS codes listed below unless otherwise noted. **These services must be billed to the Medicare intermediary. Assignment is mandatory.** The Medicare allowed charge for the services is the lower of the actual charge or the fee schedule amount. The Medicare payment for the services is 80 percent of the allowed charge after the Medicare Part B deductible is met. This is a final payment. The Medicare Physician Fee Schedule payment does not apply to outpatient rehabilitation services furnished by critical access hospitals (CAHs). Services furnished by a critical access hospital is paid on a reasonable cost basis.

Implementation of MPFS

Outpatient occupational therapy (OT) services defined in §1861(g) should not be confused with the "OT" included in the definition of partial hospitalization services by §1861(ff)(2)(B). Partial hospitalization services, including any occupational therapy furnished in that setting, are not payable under the MPFS. Therefore, if a hospital outpatient claim for occupational therapy services contains a condition code 41 designating partial hospitalization services, Medicare payment is made on a reasonable cost basis.

Outpatient Mental Health Treatment Limitation

In accordance with §1833 of the Social Security Act (the Act) payment is made at 62 1/2 percent of the approved amount for outpatient mental health treatment services. This provision will continue to be implemented in accordance with the Act when these services are furnished to beneficiaries by CORFs. Therefore, payment is made at 62 1/2 percent of 80 percent of the approved amount (or in effect 50 percent) for outpatient mental health treatment services.

Financial Limitation

The BBA also requires application of a financial limitation to all rehabilitation services. An annual per beneficiary limit of $1500 will apply to **all** outpatient physical therapy services (including speech-language pathology services). A **separate** $1500 limit will also apply to all occupational therapy

services. The annual limitations do not apply to services furnished directly or under arrangements by a hospital to an outpatient or to an inpatient who is **not** in a covered Medicare Part A stay. This limitation applies to expenses incurred on or after January 1, 1999. Beginning 2002, these limits will be increased by the percentage increase in the Medicare Economic Index. By 2001, a report must be submitted to Congress recommending a revised coverage policy for outpatient rehabilitation services in place of the $1500 limitation.

Application of Financial Limitation
Effective for claims with dates of service on or after January 1, 1999, non-hospital providers will be held accountable for tracking incurred expenses for each beneficiary to assure they do not bill Medicare for patients who have met the annual $1500 limitation at their facility for each separate limitation. **For SNFs, this means that the SNF itself is responsible for the billing of all outpatient rehabilitation services and the tracking of incurred expenses for those services when furnished to a SNF resident not in a covered Part A stay and SNF non-resident receiving outpatient rehabilitation services at the SNF regardless of whether the services are furnished by the SNF itself or by an outside therapist**. However, even though the non-hospital provider realizes services are not covered by Medicare, a bill may be submitted for purposes of receiving a denial notice from Medicare in order to bill Medicaid or other insurers. In this situation, the non-hospital provider must report condition code 21 in Form Locator 24-30 of the HCFA-1450.

Outpatient Rehabilitation HCPCS Codes
The applicable procedure codes for reporting outpatient rehabilitation services are as follows:

11040 11041 11042 11043 11044 29065 29075 29085 29105 29125 29126 29130
29131 29200 29220 29240 29260 29280 29345 29365 29405 29445 29505 29515
29520 29530 29540 29550 29580 29590 64550 90901 90911 92506 92507 92508
92510 92525 92526 92597 92598 95831 95832 95833 95834 95851 95852 96105
96110**** 96111 96115 97001 97002 97003 97004 97010*** 97012 97014
97016 97018 97020 97022 97024 97026 97028 97032 97033 97034 97035 97036
97039 97110 97112 97113 97116 97124 97139 97140 97150 97250 97504** 97520
97530 97535 97537 97542 97545**** 97546**** 97703 97750 97770* 97799****
V5362**** V5363**** V5364****

*Procedure code 97770 is not considered to be an outpatient rehabilitation service when delivered by a clinical psychologist, psychiatrist, or clinical social worker for treatment of a psychiatric condition.

**Procedure code 97504 should not be reported with procedure code 97116.

***Procedure code 97010 is a bundled procedure. Therefore, payment cannot be made for procedure code 97010 when billed alone.

****The fee schedule amount for these procedure codes is determined by the Medicare carriers. The Florida Medicare B carrier has established that procedure codes 96110 and 97799 are reimbursed under individual consideration. Procedure codes 97545, 97546, V5362, V5363, and V5364 are non covered services.

Audiological HCPCS Codes
The applicable procedure codes for reporting audiological services are as follows:

92552 92553 92555 92556 92557 92561 92562 92563 92564 92565 92567 92568
92569 92571 92572 92573 92575 92576 92577 92579 92582 92583 92584 92587
92588 92589 92596 V5299

CORF HCPCS Codes
In addition to the outpatient rehabilitation HCPCS codes listed above, the other HCPCS codes for reporting CORF services are as follows:

90657* 90658* 90659* 90660* 90669* 90732* 90744* 90745* 90746* 90747* 90748*
94664 94665 94667 94668 G0008* G0009* G0010* G0128

*These codes are not subject to payment under the MPFS. Therefore, payment is made as a reasonable cost basis.

Revenue Codes
The applicable revenue codes for reporting outpatient rehabilitation services for ORFs are 42X, 43X, and 44X. The applicable revenue code for reporting audiology services is 47X. For the purpose of this provision, revenue codes for reporting outpatient rehabilitation is not affected. Reporting of CORF services continues to be limited to the revenue codes specified for comprehensive outpatient rehabilitation facilities.

Bill Types
The appropriate bill types are:

12X, 13X, 22X, 23X, 34X, 74X, 75X and 83X.

Outpatient Rehabilitation Service Modifiers
Providers are required to report one of the following modifiers to distinguish the type of therapist who performed the outpatient rehabilitation service (not the payment designation) or, if the service was not delivered by a therapist, then the discipline of the plan of treatment/care under which the service is delivered should be reported:

GN Service delivered personally by a speech-language pathologist or under an outpatient speech-language pathology plan of care;

GO Service delivered personally by an occupational therapist or under an outpatient occupational therapy plan of care; or,

GP Service delivered personally by a physical therapist or under an outpatient physical therapy plan of care.

Requirements for Billing Claims for Services Subject to Line Item Date of Services Reporting

Effective January 1, 1999, when billing for services where the line item date of service reporting is required, the reporting must be limited to 56 lines per claim (55 lines of claim detail plus a total line). A claim that exceeds 55 lines of claim detail plus the 56 total line must be spit and submitted to the intermediary as more than one claim.

If a claim submitted for a given billing period exceeds the 56 lines, it will be returned with instructions to split the claim and resubmit for processing.

Services which currently require line item dates of service reporting include:

- Clinical diagnostic laboratory services subject to the clinical laboratory fee schedule;
- Ambulance Services;
- Home Health visits;
- Hospice services;
- Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility services;
- Ancillaries furnished to skilled nursing residents in a Part B stay (Type of Bill 22x and 23x only);
- Bone mass measurements; and
- Oral anti-nausea drugs used as full therapeutic replacements for intravenous dosage forms as part of a cancer chemotherapeutic regimen.

Medicare Deductible and Coinsurance for 1999

The Health Care Financing Administration (HCFA) has established the new deductible and coinsurance amount for the 1999 calendar year (CY). Effective January 1, 1999, the deductible and coinsurance amounts are:

Part A Hospital (Inpatient)	**Calculation per Benefit Period**	**CY 1999 Benefit Period**
Deductible - 1 through 60 days	Current year inpatient deductible	$768.00 per benefit period
Coinsurance -61 through 90 days	Rate is 1/4 of current year inpatient deductible amount	$192.00 per day
Lifetime Reserve -91 through 150 days (non-renewable days)	Rate is 1/2 of current year inpatient deductible amount	$382.00 per day

Skilled Nursing Facility (SNF)	Calculation Per Benefit Period	CY 1999Benefit Period
SNF - 1 through 20 days	No deductible or coinsurance (full days)	$0 per benefit period
SNF - 21 through 100 days	Rate is 1/8 of current year inpatient deductible amount	$96 per day
Blood Deductible	**Annual Requirement**	**CY1999**
Part A/Part B	Satisfied via Part A and or Part B services	3 pints annually
Part B - Outpatient	**Annual Requirement**	**CY1999**
Annual Deductable	Satisfied via Part B outpatient and or Physician/Supplier Services (Part B)	$100.00

The Year 2000 Is HCFA's #1 Priority

What Is The Year 2000 (Also Known As The Y2K) Challenge And Why Is It Important?
Many computers use just two digits to record the year. If no action is taken, these computers will recognize "00" as the year 1900 rather than the year 2000, resulting in many potential problems for HCFA systems and the providers that treat those individuals that rely upon HCFA programs.

HCFA's computer systems and those of its business partners are critical to the processing of claims for 70 million Medicare and Medicaid beneficiaries. Dates are important to most of HCFA's mission critical systems. Critical dates may include, for example, the date a beneficiary became eligible for Medicare, the date a patient was admitted or discharged from a hospital, the date a wheelchair rental began, or the date an enrollee entered a Medicare managed care plan.

Date-related transactions such as these occur millions of times a day. If the Y2K challenge is not addressed, providers could experience delayed payments or disruptions in receiving HCFA data upon which they rely every day.

What Is HCFA's Action Plan To Be Y2K Ready?
Complying with the Year 2000 challenge is HCFA's number one priority. The agency's goal is to ensure that, come January 1, 2000, providers continue to receive prompt and efficient payment for their services.

The Y2K problem presents one of the greatest information system challenges since the inception of the Medicare program. It requires identifying and renovating all computer and information systems that might have Year 2000 problems. It also requires testing the renovated systems multiple times to make sure the new corrections will work. About 49 million lines of code are being renovated and tested.

Year 2000 activities must take precedence over other projects that require changes to computer and information systems. Postponing other projects is necessary to focus resources and "freeze" systems

so essential Y2K related systems work can be done.

HCFA's Commitment Of Resources To Year 2000 Compliance:
HCFA Administrator Nancy-Ann DeParle has committed significant staff and other resources to this goal. Following are some actions HCFA has taken:

- setting up special teams of employees whose sole responsibility is making Year 2000 fixes;
- hiring retired federal programmers to help with Year 2000 efforts;
- hiring special contractors to make sure Year 2000 fixes are done right and to independently test systems to make sure they work properly;
- amending agreements with the more than 60 Medicare fiscal intermediaries and carriers to ensure that they use information technology that is Year 2000 compliant;
- closely tracking contractor progress to ensure that work is on schedule;
- creating a special contingency planning unit to make sure disruptions do not result from any unexpected problems; and
- working within the Administration and with the Congress to increase funding for Y2K renovation efforts.

HCFA and its more than 60 contractors, who process and pay nearly one billion Medicare claims each year, are following a rigorous schedule for fixing and testing its systems. Medicare contractors and managed care organizations with Medicare contracts must be Y2K ready by December 31, 1998. HCFA's internal systems renovations have also be completed and tested by December 31, 1998. State Medicaid agencies are expected to be Y2K ready no later than March 31, 1999.

What Is HCFA Doing To Ensure The Work Will Be Completed On Time?
Work at HCFA and its contractors is well underway. HCFA has assessed all systems and have identified those in need of renovation. Most of the necessary renovation has been completed, or soon will be. Testing to verify that the systems will function properly is also underway. Further, HCFA has formed teams to monitor progress on at least a weekly basis and has sent representatives to 17 of the most critical Medicare contractor sites to monitor daily progress.

In addition, HCFA has hired two independent firms. The first is an independent verification and validation company (IV&V) to assess HCFA's and its contractors' ability to be Year 2000 compliant. The second is an independent testing organization that will confirm that all of the key HCFA systems will properly function in the year 2000.

The independent validation and verification (IV&V) experts recommended that HCFA require contractors to concentrate their efforts and resources exclusively on achieving Year 2000 compliance. The IV&V firm recommended that contractors stop making any "parallel" changes in their systems, such as those required to carry out some provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Balanced Budget Act of 1997 (BBA). Based on these recommendations, HCFA determined that it must clear the decks of all major systems changes during the critical months right before and after the new year to concentrate on required extensive testing.

Some Changes To Systems Have Been Suspended
In April, final transitions to shared, uniform systems for Medicare Part A and Part B contractors were postponed to devote those programming resources to Year 2000 compliance. As a result, $20 million

in FY 1998 appropriated funds were redirected to Year 2000 compliance work.

Some Provisions Of The HIPAA And BBA May Have To Be Postponed
Some projects involve extensive computer and information system changes and are scheduled to be carried out during the time that systems must be frozen for final testing. Reluctantly, HCFA anticipates that it will have to suspend some BBA provisions until Year 2000 compliance can be assured. Provisions that may not be implemented timely include:

- Calendar and Fiscal Year 2000 payment updates;
- hospital outpatient prospective payment (will continue to pay under current methods);
- home health prospective payment;
- consolidated billing for skilled nursing facility residents receiving Part B services;
- collection of outpatient and physician encounter data;
- verification of social security numbers of new practitioners in the provider enrollment form; and
- implementation of the ambulance fee schedule.

Will HCFA Systems Function In The Year 2000?
Yes, HCFA will do everything it must to ensure that its mission critical systems and those of its contractors will function in the Year 2000. Hospitals and physicians will continue to be paid and critical information will continue to be available. HCFA has also launched a provider outreach effort to assist medical providers in making their diagnostic equipment and office systems Y2K compliant. Being ready for the Year 2000 will not be easy, but HCFA and its partners are meeting the Y2K challenge.

How Providers May Be Affected by the Year 2000 Challenge

The Year 2000 or Y2K conversion presents one of the greatest information system challenges since the inception of the Medicare program. This conversion is critical to smooth processing of health care claims for the 70 million beneficiaries enrolled in these programs.

Many computers use just two digits to record the year. If no action is taken, these computers may recognize A00" as 1900 rather than 2000, resulting in many potential problems for the providers and their patients.

Many provider practices will be affected, either directly or indirectly, by the year 2000 challenge. Taking proactive steps to identify and address potential impacts will be key to the success in meeting the needs of the Medicare beneficiaries. Some examples of how providers may be affected are:

Financially - If the provider's computer systems and those other systems that the provider interfaces are not Y2K ready, the transfer of information, including claims processing information, could be affected. Consequently, the provider's cash flow could also be affected. If the claims are billed to multiple entities (e.g., Medicare, Medicaid, private insurance companies, and managed care organizations), the provider could face some problems if the Y2K readiness with each of these entities is not ensured.
If a provider relies on another entity (e.g., a billing service or clearinghouse) to handle the claim filing

procedures and the entity is not Y2K ready, it could add additional cost to the provider's business. This is particularly true if the payment for the services is based on the number of claims filings, since the billing vendor may file the claims more than once.

Legally - A provider may be held liable by his or her patients, customers, or business partners if there is a Y2K malfunction that causes personal or financial injuries. Neither the Health Care Financing Administration (HCFA) nor the Medicare contractors will assume any responsibility for the provider's Y2K compliance.

What Providers Can Do

There are key steps providers can take to become Y2K ready and many excellent sources of information available to help providers. Below are a few suggestions to consider. These suggestions are not intended to replace other steps and actions that providers may be taking towards their readiness plan.

Becoming aware of how the year 2000 can affect many systems. Anything dependent on a microchip or date entry could be affected. Entities that a provider depends on or who depend on the provider need to be identified. From a systems perspective, an inventory of both the hardware and software programs may be required. A list of the critical (cannot live without) items needs to be identified.

Assessing the readiness of everything on the list. Providers can do this by contacting their hardware or software vendor or accessing key information from various web sites. A list of important web site addresses can be found on page 13. Maintenance and service contractors can help providers in determining readiness as well as system upgrades and or replacement options. In addition, there are many organizations offering services to assess business readiness. State associations and businesses can also provide assistance, particularly in the areas of biomedical equipment and medical devices.

If a particular software program or form is not Y2K ready, providers need to decide whether to invest in the upgrade or the software replacement. In making this decision, providers need to be aware of the potential challenges that could be faced if the changes or upgrades are not made, particularly to programs that support the key business processes.

Testing the existing and newly purchased systems and software. **The assumption that a system or a software program is Y2K ready cannot be made just because someone said it is**. During the testing process, test plans and test output results should be maintained just in case a problem surfaces later.

Developing contingency plans for the continuity of business in the event that some equipment or system fails and by focusing on the issues and situations that would be most problematic for the providers and the patients. For example, what will providers do if...

- Claims cannot be sent in the right format to an insurer;
- Laboratory or diagnostic facilities, where providers refer patients, cannot identify and accurately report to an insurer the dates providers submit on the order forms;
- Output from monitoring and reporting equipment is not accurate or complete;
- Electronic remittances from Medicare or Medicaid are not retrievable;
- Accounts receivable systems do not work properly;

- Checks cannot be deposited in the bank or credited accurately; or
- Payroll systems do not function appropriately.

It is important to keep in mind the Y2K challenge is very broad. A checklist with a few examples of systems that may be affected by the Y2K challenge can be found below.

Sample Provider Y2K Readiness Checklist

This checklist is intended as a supplemental guide in helping providers to determine their Y2K readiness. This list may be used along with other diagnostic and reference tools that providers may have obtained for this purpose. Providers may consider all types of equipment, systems, procedures, etc., that may in some way be time dependent and thereby affected by the Y2K "bug". This information is not an all inclusive list.

ITEM	Y2K READY	NOT Y2K READY
Answering machines		
Bank debit/credit card expiration dates		
Banking interface		
Billing Requirements (All Payers)		
Building access cards		
Claim forms (All Players)		
Clocks		
Computer hardware (list)		
Computer software (list)		
Custom applications (list)		
Diagnostic equipment (list)		
Elevators		
Fire alarm		
Indoor lighting		
Insurance/pharmacy coverage dates		
Membership cards		
Monitoring equipment (list)		
Order forms		
Outdoor lighting		
Physician referral forms		
Safety vaults		
Smoke alarm		
Spreadsheets		
Sprinkler system		
Television/VCR equipment		
Telephone system		
Treatment equipment (list)		

Y2K World Wide Web Site References

The following table lists several world wide web sites that may be helpful in determining the Y2K readiness and sites that offer related services and information.

INFORMATION	**ADDRESS... HTTP://WWW.**
Healthcare Related issues	Rx2000.org
Commercial off the Shelf Software (COTS) - compliance information	Y2K.policyworks.govmitre.org/technology/y2k
Specific products and information regarding compliance Acer America (800-637-7000)	acer.com
AST Computer (800-727-1278)	ast.com
Compaq Computer (800-OK-COMPAQ)	compaq.com
Dell computer Corporation (800-560-8324)	dell.com
Gateway2000 (800-846-2301)	gateway.com
Hewlett-Packard (800-752-0990)	hp.com
Hitachi PC (800-555-6820)	hitachipc.com
IBM (800-772-2227)	us.pc.ibm.com
Intel (800-538-3373)	intel.com
Micron Technology (800-349-6972)	micron.com
Microsoft	microsoft.com/year2000
NEC Computer Systems (800-456-9327)	nec.com
Packard-Bell (800-733-4411)	packardbell.com
Sony Electronics (800-352-7669)	sel.sony.com
Texas Instruments (800-848-3927)	ti.com
Toshiba (800-999-4273)	toshiba.com

INFORMATION	ADDRESS... HTTP://WWW.
Commercial sector information	year2000.com
Year 2000 Tools - A simple, complete, and free PC hardware Year 2000 diagnostic	hp.com/year2000/cure.htmlrightime.com
The Complete Y2K website for COBOL	pirkle-websites.com
The Computer Network	cnet.com
Federal Government HCFA (Health Care Financing Administration)	hcfa.gov/y2k
Year 2000 provider outreach materials - This is a recommended place to start when researching information available from the Federal Government and its partners/contractors.	hcfa.gov/y2k/prmemorv.htm fda.gov/cdrh/yr2000/year2000.html
Federal communications commission - information for consumers and industry	fcc.gov/year2000
Presidents Council on the Year 2000 conversion	y2k.gov
U.S. Small Business Administration	sba.gov/y2k
General Services Administration (GSA)	itpolicy.gsa.gov.mks.yr2000/y2khome.htm
Information technology (IT) - Information Technology Association of America	itaa.org/year2000.htm
The Health Alliance of Pennsylvania - provides statewide leadership in implementing the Pennsylvania Healthcare vision 2000.	hap2000.org
Y2K Milestone markers	everything2000.com
Real Time Solutions, Limited - Professional Assistance for IT problems	rtsl.com rts2000.demon.co.uk
Direct access services - Provides Y2K information and solutions for the millennium	careconnect.com
Contingency planning of all health, safety, basic, and essential service related systems	millennia-bcs.com

INFORMATION	ADDRESS... HTTP://WWW.
The Y2K information center - provides a forum for disseminating information about the year 2000 problem for discussion or possible solutions	year2000.com
An on-line magazine dedicated to providing the latest information on handling Year 2000 projects and issues	y2kjournal.com
Electronic Data Interchange (EDI)	hcfa.gov/medicare/edi/edi.htm
Biomedical Equipment & Engineering	is.ufl.edu/bawb015h.htm

Medicare + Choice Scams

Fraud, waste and abuse is costing the Medicare program billions of dollars each year — money from taxpayers which is used to pay for illegitimate claims. Although Medicare contractors, the federal government, and various law enforcement agencies are working hard to deter fraud and abuse in the Medicare program, health care providers and Medicare recipients can also join in the fight against fraud, waste and abuse.

Medicare contractors have been notified of Medicare + Choice scams which are emerging in certain states. (Medicare + Choice is an alternative health benefit program from the traditional Medicare program.) There are three scams which have been identified:

- A well-dressed man is going door to door and telling Medicare beneficiaries that he will "change over" their Medicare benefits for $60. He is also asking the beneficiaries for their Social Security numbers.
- Medicare beneficiaries are receiving calls from individuals who attempt to make appointments to visit the beneficiary's home that evening to "fix their Medicare" on their Medicare card.
- Medicare beneficiaries are receiving calls from individuals offering to help them with their Medicare and asking for their credit card numbers.

We are asking for your assistance in protecting the Medicare program and its beneficiaries from these scams. Please notify your patients about these scams and remind them of the following:

- Medicare beneficiaries should guard their Social Security and Medicare numbers as securely as they would guard a credit card number.
- No Medicare official charges to "fix" Medicare problems.
- No Medicare official makes home visits.

If you or your patients encounter any of these scams or any other fraud, please call the OIG Fraud Hotline at (800) HHS-TIPS or to the Medicare Part A Customer Service Department at (904) 355-8899.

Medicare Part A 1999 Bulletins Available by Subscription

The Medicare Part A 1999 Bulletins, service by First Coast Service Option, Inc., are available by subscription to non-provider entities or providers who need additional copies at other office locations. The cost of the annual calendar year subscription for 1999 is $125 and includes all bulletins published from January 1, 1999, through December 31, 1999.

Many non-provider business operations (e.g., billing agencies, consultants, software vendors, etc.) have expressed interest in purchasing Medicare Part A bulletins published by FCSO. Therefore, again this year, these publications are being made available by subscription.

Providers serviced by First Coast Service Option, Inc. as the Medicare Part A fiscal intermediary, will continue to receive one single free copy of Part A bulletin publications, addressed to the business office manager. Providers are encouraged to copy/reproduce these bulletins for internal distribution within their facilities. However, some providers expressed a desire to purchase bulletin subscriptions. These purchased subscriptions may be addressed and mailed directly to specific individuals/areas within a provider facility, (e.g. Medical Records, Finance, District-Part Units, Clinical Staff, etc.).

Please complete and mail the attached order form, along with a check or money order payable to **First Coast Service Option, Inc.,-Account # 756130** to begin receiving a copy of the Medicare Part A Bulletin publications.

Medicare Part A Bulletin! - 1999 Subscription Form

The Medicare Part A 1999 Bulletins are available by subscription. The cost of the annual calendar year subscription for 1999 is $125, and includes all bulletins published from January 1, 1999 through December 31, 1999.

Providers serviced by First Coast Service Options, Inc. as the Medicare Part A fiscal intermediary will continue to receive one single free copy of Part A bulletins. Providers are encouraged to copy/reproduce our bulletins for additional distribution within their facilities. In addition, text files of each publication are available free of charge through the Medicare Online bulletin board system (BBS).

Subscriber's name: ______________________________

Name of Company/Organization: ______________________________

Complete Mailing Address (please type or print legibly)

____

____

____

Telephone Number: ______________________________

Fax Number: ______________________________

Number of annual subscriptions: ______________ @ $125 each = ______________

* Please enclose a check or money order payable to **First Coast Service Options, Inc. - Account #756130** for the following amount:

Mail the order form, *along with a check or money order*, to:

First Coast Service Option, Inc.
Medicare Education and Outreach - Bulletin Subscription
P. O. Box 2078
Jacksonville, Florida 32231-0048

Bulletins published by Medicare Part A are intended to provide information specific to providers serviced by this fiscal intermediary and may not prove effective for other payers/entities.