Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

FIRST COAST SERVICE OPTIONS, INC.
A CMS Contracted Intermediary & Carrier

The *Medicare A Bulletin* should be shared with all health care practitioners and managerial members of the provider/supplier staff.

Publications issued after October 1, 1997, are available at no-cost from our provider Web site at *www.floridamedicare.com.*

Routing Suggestions:

- ☐ Medicare Manager
- ☐ Reimbursement Director
- ☐ Chief Financial Officer
- ☐ Compliance Officer
- ☐ DRG Coordinator
- ☐ _____
- ☐ _____
- ☐ _____

Table of Contents

Medicare A Bulletin

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Questions concerning this publication or its contents may be directed in writing to:

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P.O. Box 45270
Jacksonville, FL
32232-5270

A PHYSICIAN'S FOCUS

The Changing Landscape of Medicare Medical Policy: NCDs and LMRPs to LCDs

A major aspect of the Medicare program is the making of policy concerning what procedures or services are covered by, and therefore reimbursable by Medicare. First Coast Service Options, Inc. (FCSO) is projected to process over 90 million claims for the Medicare program in fiscal year 2004. In order for a procedure or service to be covered by Medicare it must: (1) fit into a statutory benefit category; (2) not be specifically excluded from coverage; and (3) be "reasonable and necessary" for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member.

The decision as to which service or item will be covered by Medicare is generally made in two ways; either by the *Centers for Medicare & Medicaid Services* (CMS) through national coverage determinations (NCDs) and other coverage provisions in interpretive manuals or by *local Medicare contractors* through local medical review policies (LMRPs), now called local coverage determinations (LCDs). CMS developed NCDs for identifying nationwide Medicare coverage. An NCD is a determination that a specific device, procedure, treatment or diagnostic service is or is not covered by Medicare. It may also state specific conditions or limitations on coverage. NCDs are national policies and are binding on all Medicare contractors. Once CMS issues an NCD for an item or service, it must be followed by all Medicare contractors and supersedes any LCD.

CMS published in the September 26, 2003, *Federal Register* new policies and procedures for requesting NCDs, as well as requesting reconsideration of an NCD, and steps for challenging an NCD under the Benefits Improvement and Protection Act (BIPA). NCDs cannot be appealed to an administrative law judge, however a Medicare beneficiary can obtain review of an NCD by CMS, and any party may request reconsideration of an NCD.

For local contractor decisions, CMS has directed that LMRPs be converted to LCDs. The difference between LMRPs and LCDs is that LCDs consist only of "reasonable and necessary" information, while LMRPs address benefit categories, exclusive provisions, and coding provisions. The "reasonable and necessary" information from the LMRP will be converted to an LCD with the remaining information (benefit category, statutory exclusions, and billing and coding instructions) either converted to a supplemental instruction article or deleted at the discretion of the contractor. Unlike NCDs, an aggrieved party may challenge an LCD provisions to an administrative law judge, regardless of whether the service has been received. A challenge to an LCD can result in the upholding of the LCD, a limited overturn, revision, or deletion of an LCD.

Over the next two years all Medicare contractors will convert all existing local medical review policies into local coverage determinations. Until the conversion is complete the term LCD will refer to both (1) reasonable and necessary provisions of an LMRP and, (2) an LCD that contains only reasonable and necessary language by definition.

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About *The Medicare A Bulletin*

The *Medicare A Bulletin* is a comprehensive magazine published quarterly for Medicare Part A providers in Florida. In accordance with the Centers for Medicare & Medicaid Services (CMS) notification parameters, the approximate delivery dates are:

Publication Name	Publication Date	Effective Date of Changes
First Quarter 2004	Mid-November 2003	January 1, 2004
Second Quarter 2004	Mid-February 2004	April 1, 2004
Third Quarter 2004	**Mid-May 2004**	**July 1, 2004**
Fourth Quarter 2004	Mid August 2004	October 1, 2004

Important notifications that require communication in between these dates will be posted to the First Coast Service Options, Inc. (FCSO) Florida provider education Web site *http://www.floridamedicare.com*. In some cases, additional unscheduled special issues will also be published.

Who Receives the *Bulletin*?

Anyone may view, print or dowload the *Bulletin* from our provider education Web site. Providers who cannot obtain the *Bulletin* from the Internet are required to register with us to receive a complimentary hardcopy (please see the hardcopy registration form on page 90).

Distribution of the *Medicare Part A Bulletin* in hardcopy format is limited to one copy per medical facility that has billed at least one Part A claim to the fiscal intermediary in Florida during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, *if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed hardcopy registration form to us*.

For additional copies, providers may purchase a separate annual subscription for $65.00. A subscription order form may be found in the Educational Resources section in each issue. Issues published since January 1997 may be downloaded from the Internet free of charge.

We use the same mailing address for *all* correspondence, and cannot designate that the *Bulletin* be sent to a specific person/department within a medical facility. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare Provider Registration department. Please remember that address changes must be done using the appropriate Form CMS-855.

What Is in the *Bulletin*?

The *Bulletin* is divided into sections addressing general and facility-specific information and coverage guidelines:

- The publication starts with a column by the Intermediary Medical Director.
- Following an administrative section are usually general information and coverage sections with informational and billing issues, processing guidelines, and medical coverage applicable to all Medicare Part A providers and facilities.
- Coverage guidelines and billing issues targeting specific facilities or Part A providers are usually included in individual sections named under the applicable facility type. These facility-specific sections are in the *Bulletin* only when an article in that category is published (for example, if no CORF/ORF information is in the issue, that section is omitted.)
- As needed, the *Bulletin* contains Electronic Data Interchange and Fraud and Abuse sections.
- The Local Medical Review Policy (LMRP) section contains notification of revisions to finalized medical policies and additions, revisions, and corrections to previously published LMRPs. In addition, this section may contain information on widespread probe reviews conducted by the fiscal intermediary. Whenever possible, the LMRP section will be placed in the center of the *Bulletin* to allow readers to remove it separately, without disturbing the rest of the publication.
- The Educational Resources section includes educational material, such as seminar schedules, Medicare provider education Web site information, and reproducible forms.
- An index and important addresses and phone numbers are in the back of every issue.

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

Articles included in each *Medicare A Bulletin* represent formal notice that specific coverage policies have or will take effect on the date given. Providers who receive each issue are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

Do You Have Comments?

The publications staff welcomes your feedback on the *Bulletin* and appreciates your continued support. Please mail comments to:

Editor, *Medicare A Bulletin* – 10T
Medicare Communication & Education
P.O. Box 45270
Jacksonville, FL 32232-5270

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare intermediary. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education Web site *http://www.floridamedicare.com*. It's very easy to do. Simply go to the Web site, click on the "Join our electronic mailing list" bar and follow the prompts.

GENERAL INFORMATION

Implementation of New Medicare Redetermination Notice

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Providers Affected

All Medicare physicians, providers, and suppliers.

Provider Action Needed

STOP – Impact to You

The first level of appeal for fee-for-service has a new name. Starting in October, first level appeals will be called "redeterminations." You and your patients will receive a formal decision notification letter—the Medicare Redetermination Notice (MRN)—for any decision made on a request for redetermination made on or after October 1, 2004.

CAUTION – What You Need to Know

Contractors who judge these redetermination appeals must make their decisions within 60 days as a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and must then notify the providers and beneficiaries involved via the Medicare redetermination notice (MRN) (unless the decision is to pay the claim). The MRN describes the redetermination process, explains the results of the Medicare appeal, and provides information about how to file an appeal regarding Medicare's decision.

GO – What You Need to Do

The newly initiated redetermination appeal process provides information in a more concise and understandable manner and has been well received by Medicare beneficiaries and providers in consumer testing. The appeal process provides for timely notification of beneficiaries and providers via the MRN. Be sure to understand how these new procedures affect your appeal rights.

Background

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), section 521 amended the Medicare claim appeal process. Section 1869 (a)(3)(C)(ii) required contractors to mail a written notification of the redetermination decision to the parties of an appeal. This section was then amended by MMA [Sections 1869 (a)(5) and 1869 (a)(4)(B)] to include specific requirements for the notices themselves. The requirements ensure that claim appellants receive complete, accurate, and understandable information about their redetermination decisions, as well as information explaining the process of further appeals.

CMS has provided a model cover letter and a Medicare redetermination notice to serve as guidelines for Medicare carriers and intermediaries who make the redeterminations. The MMA also ensures that redetermination decisions are made in a timely manner by requiring that 100 percent of redeterminations must be completed and mailed within 60 days of the receipt of the request. [Section 940(a)(1)]

Additional Information

The MRN must be written in language that is clear and understandable to the beneficiary and must be printed legibly on white paper using black ink. The MRN must include specific required elements such as the sections outlined below:

- An *Introductory* section.
- A *Summary Statement* about the appeal decision.
- A *Summary of the Facts* section including information specific to the appeal and background information.
- A *Decision* section stating whether the claim is covered by Medicare and whether the beneficiary is responsible for payment.
- An *Explanation of the Decision* section outlining the logic and specific reasons that led to the redetermination. This must include relevant clinical or scientific evidence used in making the redetermination.
- A *Who is Responsible for the Bill* section with information on limitation of liability, waiver of recovery, and physician/supplier refund requirements.
- A *What to Include in Your Request for Independent Appeal* section to explain what policy was used to make the decision and identify specific documentation required to appeal at the independent appeal level. It must also state that if this documentation is not introduced at the next level, it may not be introduced in subsequent appeals unless there is good cause that precluded inclusion of such evidence before.
- An *Additional Relevant Information* section to present any additional relevant information, not to include any sensitive medical information.
- A section on *Important Information About Your Appeal Rights* including contact information and an explanation of the next level of the appeal process.

The official instruction, including a copy of a model MRN, issued to your carrier regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R97CP.pdf*. ❖

Related Change Request (CR) Number: 2620
Related CR Release Date: February 6, 2004
Related CR Transmittal Number: R97CP
Effective Date: October 1, 2004
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 97, CR 2620

Religious Nonmedical Health Care Institution Benefit

The religious nonmedical health care institution (RNHCI) benefit is available under Part A and is unique among Medicare benefits. A specialty intermediary, currently Riverbend GBA, processes claims for RNHCI services. For a RNHCI to receive payment under the Medicare program, the beneficiary must make an election to receive benefits. Elections to receive RNHCI benefits under Medicare are framed in terms of "excepted" and "nonexcepted" medical treatment.

- **"Excepted"** medical treatment is defined as medical care or treatment that is received involuntarily or is required under federal, state or local law.
- **"Nonexcepted"** medical treatment is defined as medical care or treatment other than excepted medical treatment.

Examples of *excepted* medical care include, but are not limited to the following:

- A beneficiary that receives vaccinations required by a State or local jurisdiction. This is compliant behavior to meet government requirements and not considered as voluntarily seeking medical care or services; or
- A beneficiary who is involved in an accident and receives medical attention at the accident scene, or in transport to the hospital, or at the hospital before being able to make their beliefs and wishes known; or
- A beneficiary who is unconscious and receives emergency care and is hospitalized before regaining consciousness or being able to locate his or her legal representative.

Examples of *nonexcepted* medical care could include but are not limited to the following:

- A beneficiary receiving medical diagnosis and/or treatment for persistent headaches and/or chest pains.
- A beneficiary in an RNHCI who is transferring to a community hospital to have radiological studies and the reduction of a fracture.
- A beneficiary with intractable back pain receiving medical, surgical, or chiropractic services.

To elect religious nonmedical health care services, the beneficiary or his or her legal representative must attest that the individual is conscientiously opposed to acceptance of nonexcepted medical treatment, and the individual's acceptance of such treatment would be inconsistent with the individual's sincere religious beliefs. The signed election must include a statement that the receipt of nonexcepted medical services would constitute a revocation of the election and may limit further receipt of payment of religious nonmedical health care services. The election is effective on the date it is signed and remains in effect until revoked.

Revocation of Election

A beneficiary may revoke an election in writing or by receiving nonexcepted medical care. After an initial revocation, the individual may again file a written election to receive the religious nonmedical health care benefit. This second election takes effect immediately upon its execution. It is rare for a beneficiary to revoke the election by submitting a written revocation request to Medicare. When made, only the specialty intermediary processes these written revocations. Far more commonly, beneficiaries revoke the election simply by receiving nonexcepted medical services and requesting Medicare payment for those services.

Any nonspecialty contractor may receive claims for nonexcepted medical services. To process these claims, the nonspecialty fiscal intermediary must determine whether the care received is excepted (leaving the election intact) or whether it is nonexcepted (causing a revocation of the RNHCI election). First Coast Service Options, Inc. (a nonspecialty intermediary) will request this information from providers furnishing services to beneficiaries enrolled in the RNHCI benefits.

Action Required by Providers

Claims billed for services furnished to beneficiaries enrolled in the RNHCI benefit will suspend under reason code 58749. The billing provider will receive an additional information request letter to indicate whether the services furnished were "excepted" or "nonexcepted" care. A response to this letter is required to continue processing the claim.

If you received this letter, please complete the information requested by checking "excepted" or "nonexcepted" care and mail the letter within 30 days to:

RNHCI Response – Part A Claims
Post Office Box 2711
Jacksonville, FL 32231

Note: Do not attach any documentation with this response. **Please check the appropriate response on the additional information request letter.**

Section 1821 of the Social Security Act contains the statutory basis for the RNHCI benefit. Medicare regulations pertaining to RNHCI are found in 42 CFR 403 Subpart G.

The terms *"excepted"* and *"nonexcepted"* care represent mutually exclusive conditions under section 1821 of the Social Security Act. ❖

Source: CMS Transmittal A/B-03-145, CR 2881

New Part B Annual Deductible 2005

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Providers Affected

Physicians, suppliers, and providers.

Provider Action Needed

Physicians, suppliers, and providers should note that, effective January 1, 2005, the Supplementary Medical Insurance (SMI) or Medicare Part B deductible will be $110. These providers should assure that their billing processes are adjusted to handle this change in the Medicare Part B deductible.

Background

Medicare Part B helps beneficiaries pay for physician's services, diagnostic tests, ambulance services, durable medical equipment, and other health services, and the beneficiary is responsible for the first $100.00 deductible of Medicare Part B approved charges each calendar year, i.e. their annual deductible.

For calendar years 1991 through 2004, the Medicare Part B annual deductible has been $100.

Beginning in 2005, the Medicare Part B deductible will be $110 (based on Section 629 of the Medicare Prescription Drug, Improvement, and Modernization Act [MMA]).

Implementation

This change is effective on January 1, 2005, and the implementation date in Medicare claims processing systems will be January 3, 2005.

Related Instructions

The Medicare General Information, Eligibility, and Entitlement Manual Chapter 3 (Deductibles, Coinsurance Amounts, and Payment Limitations), Section 20 (Supplementary Medical Insurance [Part B]), Subsection 20.2 (Part B Annual Deductible) has been revised and is included below with changes bolded and italicized.

20.2 - Part B Annual Deductible – (Rev.)

In each calendar year, a cash deductible must be satisfied before payment can be made under SMI. (See 20.4 of this chapter for exceptions.)

- ***For 2005, and until further notice, the deductible is $110.***
- ***From 1991 through 2004,*** the deductible is $100.
- From 1982 through 1990, the deductible was $75.
- From 1973 through 1981, the deductible was $60.
- From 1966 through 1972, the deductible was $50.

Expenses count toward the deductible on the basis of incurred, rather than paid expenses, and are based on Medicare allowed amounts. ***Noncovered*** expenses do not count toward the deductible. Even though an individual is not entitled to Part B benefits for the entire calendar year (i.e., insurance coverage begins after the first month of a year or the individual dies before the last month of the year), he or she is still subject to the full deductible for that year. Medical expenses incurred in the portion of the year preceding entitlement to medical insurance are not credited toward the deductible.

The date of service generally determines when expenses were incurred, but expenses are allocated to the deductible in the order in which the bills are received. Services that are not subject to the deductible cannot be used to satisfy the deductible.

Additional Information

You can find the Centers for Medicare & Medicaid Services (CMS) Program Manuals Index at the following CMS Web site: *http://www.cms.hhs.gov/manuals/cmsindex.asp*

Also, the Medicare General Information, Eligibility, and Entitlement Manual is located at the following CMS Web site: *http://www.cms.hhs.gov/manuals/101_general/ge101index.asp*. ❖

Related Change Request (CR) Number: 3121
Related CR Release Date: March 12, 2004
Related CR Transmittal Number: 3
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-1, Transmittal 3, CR 3121

Guidance for Handling Revenue Code 0910

The Centers for Medicare & Medicaid Services (CMS) notified fiscal intermediaries (FIs) that there is a conflict in claims processing instructions that affect certain claims containing psychiatric services billed under revenue code 0910. Currently, Medicare claims processing instructions require particular providers to use revenue code 0910 when reporting certain psychiatric services for purposes of applying the Medicare outpatient mental health treatment limitation and for reporting under the partial hospitalization benefit. However, previous instructions removed revenue code 0910 as an acceptable code, based on a decision made by the National Uniform Billing Committee. As a result, some claims containing psychiatric services billed under revenue code 0910 are not being paid.

To correct this situation, CMS is in the process of developing instructions to replace the use of revenue code 0910. Until these instructions are issued and implemented in a future release, FIs will accept and process claims for psychiatric services reported under revenue code 0910.

Providers will be notified in the near future of the new CMS claim processing instructions and the effective and implementation date. ❖

Source: CMS JSM-161, Dated March 11, 2004

Delays in Medicare Enrollment Applications—Questions and Answers

During the last few months, members of the healthcare community have raised some questions regarding the Medicare provider enrollment process. To response to Medicare providers questions, the Centers for Medicare & Medicaid services (CMS) has prepared the following questions and answers to clarify developments associated with provider enrollment.

Q: Why are providers and suppliers experiencing delays associated with processing their provider/supplier applications?

A: On November 3, 2003, Medicare carriers began using a new electronic database for recording and retaining enrollment data for providers/suppliers. This electronic database is known as the Provider Enrollment, Chain and Ownership System (PECOS). The PECOS system is the electronic implementation of a policy decision made by CMS in 1995, as a result of a CMS fraud and abuse initiative, "Operation Restore Trust," to create a national, uniform business process for provider/supplier enrollment.

The PECOS system was implemented for Medicare carriers on November 3, 2003; fiscal intermediaries began using the system in July 2002. As of this date, carriers were instructed to process any new enrollments and any changes in enrollment applications through PECOS. While some carriers have backlogs that must be reduced, other carriers have handled the transition to PECOS with less difficulty.

In addition to issues directly related to PECOS implementation, there have been unanticipated CMS data center infrastructure issues that have caused system outages.

These unanticipated outages have made PECOS inaccessible to carrier staffs for certain periods of time.

Another factor is the learning curve staff is experiencing at our carriers. This is a new, uniform business process, most times different from the way carriers processed provider enrollment applications in the past. Ongoing training and support has been provided by CMS but, as with any change of this magnitude, it is anticipated that slowdowns in work processing will occur for a time.

Another factor that has caused delays is the budget process. This fiscal year, CMS' appropriation was held up in Congress. As a result, CMS and its Medicare contractors were operating at a prior year continuing resolution levels until earlier this calendar year.

Q: What is CMS doing to resolve the delays associated with processing provider/supplier applications?

A: CMS recently assembled a senior leadership team with accountability for resolving these delays. This team is focusing on expeditiously resolving delays in processing provider enrollment applications. Steps are being taken to address the backlogs and all options are being considered. Teams of representatives from CMS headquarters and regional offices and the PECOS system developers have been assembled and began conducting site visits to each Medicare carrier beginning the week of March 1, 2004. These teams will have direct responsibility to provide on-site focused customer service to individual carriers to expeditiously resolve any issues related to PECOS and the provider enrollment business process so that delays in processing can be reduced or eliminated.

On the CMS infrastructure front, CMS is working diligently to resolve CMS data system infrastructure issues that are causing outages in access to PECOS. CMS is also in the process of addressing any current funding constraints so that carriers have the necessary resources to address the delays and reduce their inventories. The goal of CMS senior leadership is to have the backlog inventories reduced by the summer of 2004. ❖

Source: CMS JSM-160, Dated March 5, 2004

Medicare Physician Fee Schedule April 2004 Update

The Centers for Medicare & Medicaid Services (CMS) has issued an update to the 2004 Medicare Physician Fee Schedule. The following are revisions to some fee schedules effective April 5, 2004, for services furnished **on or after January 1, 2004.**

The 2004 outpatient fee schedules were published in the Second Quarter 2004 *Medicare A Bulletin* (pages 65-85).

Outpatient Rehabilitation Services

Code/Mod	Fee 01/02	Fee 03	Fee 04
29086	59.31	63.18	66.30
29355	126.77	135.88	144.29
29425	87.44	93.92	99.85

Orthotic/Prosthetic Devices

Code/Mod	Fee
A4366	1.30
A4450	0.11
A4452	0.40
L3911	18.27

Skilled Nursing Facility Services

Code/Mod	Fee 01/02	Fee 03	Fee 04
76511	53.82	59.03	62.44
76512	55.95	61.80	65.91
76513	59.13	65.22	69.45
76516	45.70	50.29	53.40
76519	48.88	53.71	56.94
76529	44.41	49.06	52.34
89220	15.08	16.54	17.50
89230	16.49	18.06	19.07
92613	42.65	44.67	46.70
94240	24.27	26.91	28.83
96412	47.26	51.68	55.15

Source: CMS Pub 100-4 Transmittal 105, CR 3128

Elimination of the 90-day Grace Period for HCPCS Codes

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All physicians, providers, and suppliers who use Healthcare Common Procedure Coding System (HCPCS) codes in billing Medicare carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs).

Provider Action Needed

STOP – Impact to You

Effective January 1, 2005, Medicare providers will no longer have a 90-day grace period to use discontinued HCPCS codes for services rendered in the first 90 days of the year. Use of such codes to bill services provided after the date on which the codes are discontinued will cause your claims to be returned and not paid. **In essence, HCPCS codes must be valid at the time the service is rendered.**

CAUTION – What You Need to Know

Providers should be aware that **effective January 1, 2005**, carriers, DMERCs, and FIs will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31 of the current year (beginning in 2005) that are submitted prior to April 1.

GO – What You Need to Do

To ensure prompt and timely payment of claims, use the new HCPCS for 2005 beginning with services rendered on or after January 1, 2005, and stop using discontinued codes at that time. Each year thereafter, be sure to adopt the new codes.

Background

The Healthcare Common Procedure Coding System (HCPCS) consists of the following two levels of codes:

- Level I codes that are copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4); and
- Level II codes that are five-position alpha-numeric codes approved and maintained jointly by the Alpha-Numeric Panel (consisting of the Centers for Medicare & Medicaid Services (CMS), the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). The D code series in Level II HCPCS is copyrighted by the American Dental Association.

Medicare has permitted a 90-day grace period after implementation of an updated HCPCS code set to familiarize providers with the new codes and to learn about the discontinued codes. For example, the 2004 HCPCS codes became effective for dates of service on or after January 1, 2004, and Medicare contractors are able to apply a three-month grace period for all applicable discontinued HCPCS codes. This means that carriers will accept the 2003 discontinued HCPCS codes and the new 2004 HCPCS codes from physicians, suppliers, and providers during the January 2004-March 2004 grace period. This 90-day grace period applies to claims received by the carrier prior to April 1, 2004, which contain the 2003 discontinued codes for dates of service January 1, 2004, through March 31, 2004.

However, the Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Set Rule requires providers to **use the medical code set that is valid at the time that the service is provided**.

Therefore CMS will no longer be able to allow a 90-day grace period for providers to learn about the discontinued HCPCS codes. Providers should be aware that effective January 1, 2005, carriers, DMERCs, and fiscal intermediaries will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31 of the current year (beginning in 2005) that are submitted prior to April 1. In addition, effective January 1, 2005, CMS will no longer allow a 90-day grace period for discontinued codes resulting from any mid-year HCPCS updates.

In order for providers to know about the new, revised, and discontinued numeric CPT-4 codes for the upcoming year, they should obtain the American Medical Association's CPT-4 coding book that is published each October. CMS posts on its Web site the annual alpha-numeric HCPCS file for the upcoming year. The CMS Web site to view the annual HCPCS update is *http://www.cms.hhs.gov/providers/pufdownload/anhcpcdl.asp*.

Physicians, providers, and suppliers should be aware that Medicare systems will begin to reject such discontinued codes, beginning on January 1, 2005, if the codes were not effective on the date of service.

Such claims will be returned to the submitter for correction.

This is a HIPAA compliancy issue.

Implementation

July 6, 2004. While this is the date on which Medicare's claim processing systems will be changed to enforce these new rules, the systems will not apply these rules until January 1, 2005.

Related Instructions

The Medicare Claims Processing Manual, Chapter 23, Section 20 (Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS)), Subsection 20.4 (Deleted HCPCS Codes/Modifiers) was revised and is included below (changes bolded and italicized). Also, **sentences that referred to the three month HCPCS grace period** have been deleted from subsections 40.1 (Access to Clinical Diagnostic Lab Fee Schedule Files) and 50 (Fee Schedules Used by All Intermediaries and Regional Home Health Intermediaries (RHHIs)).

Elimination of the 90-day Grace Period for HCPCS Codes (continued)

20.4 – Deleted HCPCS Codes/Modifiers (Rev. 1, 10-01-03)

B3-4509.3, HO-442.2

Claims for services in a prior year are reported and processed using the HCPCS codes/modifiers in effect during that year. For example, a claim for a service furnished in November 2002 but received by a carrier/DMERC/intermediary in 2003 should contain codes/modifiers valid in 2002 and is processed using the prior year's pricing files.

HCPCS codes (Level I CPT-4 and Level II alpha-numeric) are updated on an annual basis. Each October, CMS releases the annual HCPCS file to carriers/DMERCs/FIs. The HCPCS file contains the CPT-4 and the alpha-numeric updates. Contractors are notified of the release date via a one-time notification instruction. The file contains new, deleted, and revised HCPCS codes, which are effective on January 1 of each year. With each annual HCPCS update, CMS has permitted a 90-day grace period for billing discontinued HCPCS codes for dates of service January 1 through March 31 that were submitted to Medicare contractors by April 1 of the current year.

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical codes sets must be date of service compliant. Since HCPCS is a medical code set, effective January 1, 2005, CMS will no longer provide a 90-day grace period for providers to use in billing discontinued HCPCS codes. The elimination of the grace period applies to the annual HCPCS update and to any mid-year coding changes. Any codes discontinued mid-year will no longer have a 90-day grace period.

Contractors must eliminate the 90-day grace period from their system effective with the January 1, 2005, HCPCS update. Contractors will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31. Providers can purchase the American Medical Association's CPT-4 coding book that is published each October that contains new, revised, and discontinued CPT-4 codes for the upcoming year. In addition, CMS posts on its Web site the annual alphanumeric HCPCS file for the upcoming year at the end of each October. Providers are encouraged to access CMS Web site to see the new, revised, and discontinued alpha-numeric codes for the upcoming year. The CMS Web site to view the annual HCPCS update is *http://www.cms.hhs.gov/providers/pufdownload/anhcpcdl.asp*.

Carriers and DMERCs must continue to reject services submitted with discontinued HCPCS codes.

FIs must continue to return to the provider (RTP) claims containing deleted codes.

See the Medicare Claims Processing Manual, Chapter 22, "Remittance Notices to Providers."

For more information on HCPCS, visit the CMS Website at: *http://cms.hhs.gov/medicare/hcpcs*.

For more information on HIPAA and its impact on claims submission, please visit the CMS HIPAA Web site at: *http://www.cms.hhs.gov/hipaa/hipaa2/default.asp*. ❖

Related Change Request (CR) Number: 3093
Related CR Release Date: February 6, 2004
Related CR Transmittal Number: R89CP
Effective Date: January 1, 2005
Implementation Date for Medicare Systems: July 6, 2004
Source: CMS Pub 100-4 Transmittal 89, CR 3093

New Payment Allowance Percentages for DMERC Drugs

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Suppliers and other providers who bill for certain drugs and biologicals not paid on a cost or prospective payment basis.

Provider Action Needed

Affected providers and suppliers should note that this instruction adds a payment limit percentage for the drug capecitabine (Xeloda®).

Background

Effective January 1, 2004, the payment limit allowance for HCPCS J8520 (capecitabine, 150 mg) and HCPCS J8521 (capecitabine, 500 mg) will be 90 percent of the April 1, 2003, average wholesale price (AWP). While this change is effective for these codes as of January 1, 2004, Medicare does not plan to search their files to make any adjustment to claims already processed, unless the provider brings such claims to the attention of their DMERC (durable medical equipment medical carriers) or fiscal intermediary (FI).

Implementation

The implementation date for this instruction is March 26, 2004.

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to:

http://www.cms.hhs.gov/manuals/pm_trans/R131CP.pdf

If you have any questions, please contact your DMERC/FI at their toll-free number, which may be found at:

http://www.cms.hhs.gov/medlearn/tollnums.asp. ❖

Related Change Request (CR) Number: 3153
Related CR Release Date: March 26, 2004
Related CR Transmittal Number:131
Effective Date: January 1, 2004
Implementation Date: March 26, 2004

Source: CMS Pub 100-4 Transmittal 131, CR 3153

Clarification on Billing Noncovered Charges to Fiscal Intermediaries

The Centers for Medicare & Medicaid Services (CMS) has issued clarification to previously issued, CR (change request) 2634, transmittal 25, summarizing existing instructions related to billing of noncovered charges by providers submitting fee-for-service claims to Medicare fiscal intermediaries (FIs). This clarification addresses among other issues, instructions in the advance beneficiary notice (ABN) area, and the confirmation of policy regarding ambulance charges receiving a subsidy. While inpatient facilities have been able to bill these charges for some time, Medicare systems have only had end-to-end capacity to process noncovered charges for outpatient providers on claims with other covered charges since April 2002. These guidelines provide more specific instructions on certain aspects of billing, and apply broader concepts to all bill types, especially in association with liability related notices such as the advance beneficiary notice (ABN).

Guidelines and regulations for billing noncovered charges to fiscal intermediaries are available on the CMS Online Manual System, Pub. 100-4, Medicare Claim Processing, Chapter One, Section 60, *http://www.cms.hhs.gov/manuals/104_claims/clm104c01.pdf*. Clarifications to previously issued CR 2634, transmittal 25 are available on CMS Web site at *http://www.cms.hhs.gov/manuals/pm_trans/R133CP.pdf*.

Hospital and skilled nursing facilities (SNFs) need to be aware of the new options for billing in association with the SNF ABN when custodial care or termination of the benefits is involved, and other billing updates related to the currently voluntary SNF ABN.

Providers need to be aware as to the correct billing procedures for submitting ambulance mileage charges on their claiams when subsidies are involved, and when the beneficiary dies during transport. See Table 7 – New Instructions for Noncovered Charges *for Mileage* on Ambulance Claims under CR 3115.

Clarifications have been made to the following subsections of Section 60:

60.1 General Information on Noncovered Charges

60.1.1 Notification Requirements Related to Noncovered Charges Prior to Billing

60.1.2 Services Excluded by Statute

60.1.3 Claims With Condition Code 21

60.1.4 Summary of All Types of No Payment Claims

60.1.5 General Operational Information on Noncovered Charges

60.2 Noncovered Charges on Inpatient Bills

60.3.1 Traditional Demand Bills (Condition Code 20)

60.3.2 General Demand Billing Instructions, Inpatient and Outpatient (Other than HH PPS and Part A SNF)

60.3.3 Summary of Methods for Demand Billing

60.4 Noncovered Charges on Outpatient Bills

60.4.1. Billing With an ABN (Use of Occurrence Code 32) Comparable to Traditional Demand Bills

60.4.2 Line-Item Modifiers Related to Reporting of Noncovered Charges When Covered and Noncovered Services Are on the Same Claim

60.4.3. Clarifying Instructions for Outpatient Therapies Billed as Noncovered, on Other Than HH PPS Claims, and for Critical Access Hospitals (CAHs) Billing the Same HCPCS Requiring Specific Time Increments

60.4.4 New Instructions for Noncovered Charges for Mileage on Ambulance Claims

60.4.5 Clarification of Liability for Preventive Screening Benefits Subject to Frequency Limits

Billing noncovered charges to fiscal intermediaries under these new and revised guidelines are effective for claims submitted on or after April 1, 2004, for services furnished on or October 1, 2000, within the timely filing period. ❖

Source: CMS Pub. 100-04, Transmittal 133, CR 3115

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Medicare Incentive Payments for Physician Care in Underserved Areas

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Providers Affected

Psychiatrists

Provider Action Needed

Physicians, including psychiatrists, should note that if they furnish services in primary medical care health professional shortage areas (HPSAs), are eligible to receive ten percent bonus payments.

Psychiatrists furnishing services in mental care HPSAs are also eligible to receive ten percent bonus payments.

STOP – Impact to You

This instruction relates to the amount of payment psychiatrists receive if they provide services in a mental care HPSA.

CAUTION – What You Need to Know

Physicians, including psychiatrists, are eligible to receive ten percent bonus payments if they furnish services in primary medical care HPSAs. Psychiatrists furnishing services in mental care HPSAs are also eligible to receive ten percent bonus payments.

GO – What You Need to Do

Psychiatrists who qualify for these bonus payments are eligible to submit claims for services furnished in mental care HPSAs, effective for claims with dates of service on or after July 1, 2004.

Background

Under current law, Medicare pays a bonus to physicians for providing health care services in certain HPSAs. In light of recent physician inquiries, the Centers for Medicare & Medicaid Services has issued instructions to clarify which types of geographic HPSA (primary medical care, dental and mental health) are applicable to the Medicare bonus payment program that provides a ten percent bonus payment.

Currently, the Health Resources and Services Administration (HRSA), part of the Department of Health & Human Services, is responsible for designating several types of HPSAs, including HPSA designations based on:

- **Areas** with shortages of primary care physicians, dentists or psychiatrists, referred to as **geographic-based HPSAs**; and
- **Underserved populations** within an area, referred to as **population-based HPSAs**.

Federal law for Medicare bonus payments recognizes geographic-based, primary medical care, and mental care HPSAs as eligible areas for receiving bonus payments. Consequently, physicians, including psychiatrists, furnishing services in a primary medical care HPSA, are eligible to receive bonus payments.

In addition, psychiatrists furnishing services in mental care HPSAs are eligible to receive bonus payments. Dental HPSAs remain ineligible for the bonus payment program due to the fact that Medicare does not cover dental services for its beneficiaries.

This change would only affect psychiatrists furnishing services in mental care HPSAs that do not overlap with primary care HPSAs. In other words, these stand-alone mental care HPSAs are now eligible areas, as of July 1, 2004, for psychiatrists to receive bonus payments.

With respect to psychiatrist services in mental care HPSAs, CMS will furnish quarterly lists of **mental care HPSAs to Medicare carriers so they can** implement this change, which is **effective for claims with dates of service on or after July 1, 2004**. Should an area be both a mental care HPSA and a nonmental care HPSA, only one ten percent bonus payment will apply to a single service.

Also, it is important for physicians and psychiatrists to note that the bonus is paid for services in HPSA areas only if those services are actually provided in the HPSA area. For example, if the physician has an office in a HPSA area, but provides the service in the patient's home, which is outside the service area, the bonus is not payable.

Implementation

The implementation date is July 6, 2004, for the mental care HPSAs and the change for such services will apply effective for dates of service on or after July 1, 2004. For services provided in primary medical care HPSAs, this instruction is meant for clarification and informational purposes only.

Additional Information

The Medicare Claims Processing Manual, Chapter 12 (Physicians/Nonphysician Practitioners), Section 90 (Physicians Practicing in Special Settings), Subsection 90.4 (Billing and Payment in a Health Professional Shortage Areas (HPSAs) has been revised, and sections have been deleted. You can find this manual at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

Once at that site, scroll down to Chapter 12 and select the version of the file you would like to view. Also, to see the specific instruction issued to your Medicare carrier, visit: *http://www.cms.hhs.gov/manuals/pm_trans/R78CP.pdf*. ❖

Related Change Request (CR) Number: 3108
Related CR Release Date: February 6, 2004
Related CR Transmittal Number: R78CP
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 78, CR 3108

New Condition and Value Codes for Completion of Form CMS-1450

The National Uniform Billing Committee (NUBC) has approved the use of new condition and value codes with effective dates of October 1, 2003, and January 1, 2004. Additionally, all codes approved by the NUBC and that were not in the Claims Processing Manual have been added to these instructions to comply with HIPAA implementation.

General Instructions for Completion of Form CMS-1450 for Billing

Effective June 5, 2000, CMS extended the claim size to 450 lines. For hardcopy Form CMS-1450 (UB-92), this means that the fiscal intermediary accepts claims of up to nine pages. For electronic format (UB-92 flat file), the new requirements are described on CMS Web site at *http://cms.hhs.gov/providers/edi/ub92v6.rtf*.

Effective October 16, 2003, all state fields were discontinued and reclassified as reserved for national assignment.

Additions and revisions to the general instructions for completing Form CMS-1450 are listed below.

Untitled – Form Locator (FL) 1

Provider Name, Address, and Telephone Number

Required. The minimum entry is the provider name, city, state, and ZIP code. The post office box number or street name and number may be included. The state may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. This information is used in connection with the Medicare provider number (FL 51) to verify provider identity. Phone and/or fax numbers are desirable.

Untitled – FL 2

Not Required. Previously reserved for state use. Discontinued effective October 16, 2003.

Patient Marital Status – FL 16

Not required for Medicare claims; however Medicare accepts all valid values based on HIPAA implementation.

Valid values are:

S = Single
M = Married
P = Life Partner
X = Legally Separated
D = Divorced
W = Widowed
U = Unknown

Condition Codes – FLs 24, 25, 26, 27, 28, 29, 30

Required. The provider enters the corresponding code to describe any of the following conditions that apply to this billing period.

Code	Title	Definition
03	Patient Covered by Insurance Not Reflected Here	Indicates that patient/patient representative has stated that coverage may exist beyond that reflected on this bill.
04	Information Only Bill	Indicates bill is submitted for informational purposes only. Examples would include a bill submitted as a utilization report, or a bill for a beneficiary who is enrolled in a risk-based managed care plan (such as Medicare+Choice) and the hospital expects to receive payment from the plan.
17	Patient is Homeless	The patient is homeless.
18	Maiden Name Retained	A dependent spouse entitled to benefits who does not use her husband's last name.
19	Child Retains Mother's Name	A patient who is a dependent child entitled to benefits that does not have its father's last name.
20	Beneficiary Requested Billing	Provider realizes services are noncovered level of care or excluded, but beneficiary requests determination by payer. (Currently limited to home health and inpatient SNF claims.)
44	Inpatient Admission Changed to Outpatient	For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria. Effective April 1, 2004
45		Reserved for national assignment
46	Non-Availability Statement on File	A nonavailability statement must be issued for each TRICARE claim for nonemergency inpatient care when the TRICARE beneficiary resides within the catchment area (usually a 40-mile radius) of a Uniformed Services Hospital.

New Conditions and Value Codes for Completion of Form CMS-1450 (continued)

Code	Title	Definition
47		Reserved for TRICARE
48	Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs)	Code to identify claims submitted by a "TRICARE – authorized" psychiatric Residential Treatment Center (RTC) for Children and Adolescents.
49-54		Reserved for national assignment
63	Payer Only Code	Reserved for internal payer use only. CMS assigns as needed. Providers do not report this code. Indicates services rendered to a prisoner or a patient in State or local custody meets the requirements of 42 CFR 411.4(b) for payment.
80-99		Reserved for state assignment. Discontinued effective October 16, 2003.

Special Program Indicator Codes Required

The only special program indicators that apply to Medicare are:

Code	Title	Definition
AM	Non-emergency Medically Necessary Stretcher Transport Required	For ambulance claims. Non-emergency medically necessary stretcher transport required. Effective October 16, 2003.
AN	Preadmission Screening Not Required	Person meets the criteria for an exemption from preadmission screening. Effective January 1, 2004.
AO-AZ		Reserved for national assignment

Claim Change Reasons

Code	Title	Definition
G0	Distinct Medical Visit	Report this code when multiple medical visits occurred on the same day in the same revenue center. The visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day, in the morning for a broken arm and later for chest pain. Proper reporting of condition code G0 allows for payment under OPPS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of condition code G0.
G1-GZ		Reserve for national assignment
X0-ZZ		Reserved for state assignment. Discontinued, effective October 16, 2003.

Untitled – FL 31

Not Required. Previously reserved for state use. Discontinued effective October 16, 2003.

Occurrence Codes and Dates – FL 32, 33, 34 and 35

Required. The provider enters code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two alphanumeric digits, and dates are six numeric digits (MMDDYY). When occurrence codes 01-04 and 24 **are entered,** the provider must make sure the entry includes the appropriate value code in FLs 39-41, if there is another payer involved.

Providers must complete fields 32A-35A before completing fields 32B-35B.

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9.

Occurrence span codes have values from 70 through 99 and M0 through Z9.

When FLs 36 A and B are fully used with occurrence span codes, FLs 34 A and B, and 35 A and B may be used to contain the "From" and "Through" dates of other occurrence span codes. In this case, the code in FL 34 is the occurrence span code, and the occurrence span "From" dates is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "Through" date is in the date field.

Other payers may require other codes, and while Medicare does not use them, they may be entered on the bill if convenient.

New Conditions and Value Codes for Completion of Form CMS-1450 (continued)

Code Structure (Only codes affecting Medicare payment/processing are shown.)

Code	Title	Definition
06	Crime Victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
07-08		Reserved for national assignment.
09	Start of Infertility Treatment Cycle	Code indicating the date of start of infertility treatment cycle.
10	Last Menstrual Period	Code indicating the date of the last menstrual period. ONLY applies when patient is being treated for maternity related condition.
13-15		Reserved for national assignment
36	Date of Inpatient Hospital Discharge for a Covered Transplant Procedure(s)	The date of discharge for a hospital stay in which the patient received a covered transplant procedure. Entered on bills for which the hospital is billing for immunosuppressive drugs. **Note:** When the patient received a covered and a non-covered transplant, the covered transplant predominates.
38	Date Treatment Started for Home IV Therapy	Date the patient was first treated at home for IV therapy (Home IV providers – bill type 85x).
39	Date Discharged on a Continuous Course of IV Therapy	Date the patient was discharged from the hospital on a continuous course of IV therapy. (Home IV providers – bill type 85x).
40	Scheduled Date of Admission	The date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)
50-69		Reserved for State Assignment. Discontinued effective October 16, 2003.
A5-AZ		Reserved for national assignment
B4-BZ		Reserved for national assignment
C4-CZ		Reserved for national assignment.
D0-DZ		Reserved for national assignment.
E0		Reserved for national assignment
E1	Birthdate-Insured D	The birthdate of the individual in whose name the insurance is carried.
E2	Effective Date-Insured D Policy	A code indicating the first date insurance is in force.
E3	Benefits Exhausted	Code indicating the last date for which benefits are available and after which no payment can be made to payer D.
E4-EZ		Reserved for national assignment F0 Reserved for national assignment
F1	Birthdate-Insured E	The birthdate of the individual in whose name the insurance is carried.
F2	Effective Date-Insured E Policy	A code indicating the first date insurance is in force.
F3	Benefits Exhausted	Code indicating the last date for which benefits are available and after which no payment can be made to payer E.
F4-FZ		Reserved for national assignment G0 Reserved for national assignment
G1	Birthdate-Insured F	The birthdate of the individual in whose name the insurance is carried.
G2	Effective Date-Insured F Policy	A code indicating the first date insurance is in force.
G3	Benefits Exhausted	Code indicating the last date for which benefits are available and after which no payment can be made to payer F.
G4-GZ		Reserved for national assignment
H0-HZ		Reserved for national assignment
J0-LZ		Reserved for state assignment. Discontinued Effective October 16, 2003.
M0-ZZ		See instructions in FL 36 – *Occurrence Span Codes and Dates*

New Conditions and Value Codes for Completion of Form CMS-1450 (continued)

Occurrence Span Codes and Dates – FL 36

Required for Inpatient Services

The provider enters codes and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alphanumeric digits and dates are shown numerically as MMDDYY.

Code	Definition
X0-ZZ	Reserved for state assignment. Discontinued, effective October 16, 2003.

Value Codes and Amounts – FLS 39, 40, and 41

Required. Code(s) and related dollar amount(s) identify data of a monetary nature that are necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so the provider must refer to specific codes for instructions.

If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are four lines of data, line "a" through line "d." The provider uses FLs 39A through 41A before 39B through 41B (i.e., it uses the first line before the second).

Code	Title	Definition
01	Most Common Semi-Private Rate	To provide for the recording of hospital's most common semi-private rate.
02	Hospital Has No Semi-Private Rooms	Entering this code requires $0.00 amount.
03		Reserved for national assignment
07		Reserved for national assignment
09	Medicare Coinsurance Amount in the First Calendar Year in Billing Period	The product of the number of coinsurance days used in the first calendar year of the billing period multiplied by the applicable coinsurance rate. These are days used in the year of admission. (See Chapter 3.) The provider may not use this code on Part B bills. For Part B coinsurance use value codes A2, B2 and C2.
16	PHS, Other Federal Agency	That portion of a higher priority PHS or other federal agency's payment, made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges. **Note:** A six zero value entry for Value Codes 12-16 indicates conditional Medicare payment requested (000000).
21	Catastrophic	Medicaid-eligibility requirements to be determined at state level.
22	Surplus	Medicaid-eligibility requirements to be determined at state level.
23	Recurring Monthly Income	Medicaid-eligibility requirements to be determined at state level.
24	Medicaid Rate Code	Medicaid-eligibility requirements to be determined at state level.
25	Offset to the Patient-Payment Amount – Prescription Drugs	Prescription drugs paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
26	Offset to the Patient-Payment Amount – Hearing and Ear Services	Hearing and ear services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
27	Offset to the Patient-Payment Amount – Vision and Eye Services	Vision and eye services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
28	Offset to the Patient-Payment Amount – Dental Services	Dental services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
29	Offset to the Patient-Payment Amount – Chiropractic Service	Chiropractic Services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
33	Offset to the Patient-Payment Amount – Podiatric Services	Podiatric services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
34	Offset to the Patient-Payment Amount – Other Medical Services	Other medical services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).

New Conditions and Value Codes for Completion of Form CMS-1450 (continued)

Code	Title	Definition
35	Offset to the Patient-Payment Amount – Health Insurance Premiums	Health insurance premiums paid for out of long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
36		Reserved for national assignment.
45	Accident Hour	The hour when the accident occurred that necessitated medical treatment. Enter the appropriate code indicated below, right justified to the left of the dollar/cents delimiter.
77	Medicare New Technology Add – On Payment	Code indicates the amount of Medicare additional payment for new technology.
80-99		Reserved for state use. Discontinued, effective October 16, 2003.
A2	Coinsurance Payer A	The amount the provider assumes will be applied toward the patient's coinsurance amount involving the indicated payer. For Medicare, use this code only for reporting Part B coinsurance amounts. For Part A coinsurance amounts use value codes 8-11.

Revenue Code – FL42

Required. The provider enters the appropriate revenue codes from the following list to identify specific accommodation and/or ancillary charges. It must enter the appropriate numeric revenue code on the adjacent line in FL 42 to explain each charge in FL 47. Additionally, there is no fixed "Total" line in the charge area. The provider must enter revenue code 0001 instead in FL 42. Thus, the adjacent charges entry in FL 47 is the sum of charges billed. This is the same line on which noncovered charges, in FL 48, if any, are summed.

018x Leave of Absence

Charges (including zero charges) for holding a room while the patient is temporarily away from the provider.

Note: Charges are billable for codes 2–5.

Subcategory	Standard Abbreviations
0 – General Classification	LEAVE OF ABSENCE OR LOA
1 – Reserved	
2 – Patient Convenience –Charges billable	LOA/PT CONV CHGS BILLABLE
3 – Therapeutic Leave	LOA/THERAP
4 – Reserved	Effective April 1, 2004
5 – Hospitalization	LOA/HOSPITALIZATION – Effective April 1, 2004
9 – Other Leave of Absence	LOA/OTHER

034x Nuclear Medicine

Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.
Rationale: A breakdown is provided for the major areas that hospitals or third parties may wish to identify.

Subcategory	Standard Abbreviations
0 – General Classification	NUCLEAR MEDICINE or (NUC MED)
1 – Diagnostic Procedures	NUC MED/DX
2 – Therapeutic Procedures	NUC MED/RX
3 – Diagnostic Radiopharmaceuticals	NUC MED/DX RADIOPHARM – Effective October 1, 2004
4 – Therapeutic Radiopharmaceuticals	NUC MED/RX RADIOPHARM – Effective October 1, 2004
9 – Other	NUC MED/OTHER

063x Pharmacy – Extension of 025x

Code indicates charges for drugs and biologicals requiring specific identification as required by the payer. If HCPCS is used to describe the drug, enter the HCPCS code in FL 44.

Subcategory	Standard Abbreviations
0 – Reserved	Effective January 1, 1998
1 – Single Source Drug	DRUG/SNGLE
2 – Multiple Source Drug	DRUG/MULT
3 – Restrictive Prescription	DRUG/RSTR
4 – Erythropoietin (EPO) less than 10,000 units	DRUG/EPO <10,000 units
5 – Erythropoietin (EPO) 10,000 or more units	DRUG/EPO >10,000 units
6 – Drugs Requiring Detailed Coding (a)	DRUGS/DETAIL CODE
7 – Self-administrable Drugs (b)	DRUGS/SELFADMIN

New Conditions and Value Codes for Completion of Form CMS-1450 (continued)

Note: (a) Charges for drugs and biologicals (with the exception of radiopharmaceuticals, which are reported under revenue codes 0343 and 0344) requiring specific identifications as required by the payer (effective October 1, 2004). If HCPCS codes are used to describe the drug, enter the HCPCS code in FL 44. The specified units of service to be reported are to be in hundreds (100s) rounded to the nearest hundred (no decimal).

068x Trauma Response

Charges for a trauma team activation.

Subcategory	Standard Abbreviations
0 – Not Used	
1 – Level I	TRAUMA LEVEL I
2 – Level II	TRAUMA LEVEL II
3 – Level III	TRAUMA LEVEL III
4 – Level IV	TRAUMA LEVEL IV
9 – Other Trauma Response	TRAUMA OTHER

Usage Notes:

1. To be used by trauma center/hospitals as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving trauma activation.
2. Revenue category 068x is used for patients for whom trauma activation occurred. A trauma team activation/ response is a "Notification of key hospital personnel in response to triage information from pre-hospital caregivers in advance of the patient's arrival."
3. Revenue category 068x is for reporting trauma activation costs only. It is an activation fee and not a replacement or a substitute for the emergency room visit fee; if trauma activation occurs, there will normally be both a 045x and 068x revenue code reported.
4. Revenue Category 068x is not limited to admitted patients.
5. Revenue Category 068X must be used in conjunction with FL 19 Type of Admission/Visit code 05 ("Trauma Center"), however FL 19 code 05 can be used alone.
   Only patients for who there has been **pre-hospital** notification, who meet either local, state or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response, can be billed the trauma activation fee charge. Patients who are "drive-by" or arrive without notification cannot be charged for activations, but can be classified as trauma under Type of Admission Code 5 for statistical and follow-up purposes.
6. Levels I, II, III or IV refer to designations by the state or local government authority or as verified by the American College of Surgeons.
7. Subcategory 9 is for state or local authorities with levels beyond IV.

096x Professional Fees

Charges for medical professional fees that hospitals or third-party payers are required to identify separately on the billing form. Services that were not identified separately prior to uniform billing implementation should not be separately identified on the uniform bill.

Subcategory	Standard Abbreviations
0 – General Classification	PRO FEE
1 – Psychiatric	PRO FEE/PSYCH
2 – Ophthalmology	PRO FEE/EYE
3 – Anesthesiologist (MD)	PRO FEE/ANES MD
4 – Anesthetist (CRNA)	PRO FEE/ANES CRNA
9 – Other Professional Fees	OTHER PRO FEE

097x Professional Fees – Extension of 096x

Subcategory	Standard Abbreviations
1 – Laboratory	PRO FEE/LAB
2 – Radiology – Diagnostic	PRO FEE/RAD/DX
3 – Radiology – Therapeutic	PRO FEE/RAD/RX
4 – Radiology – Nuclear Medicine	PRO FEE/NUC MED
5 – Operating Room	PRO FEE/OR
6 – Respiratory Therapy	PRO FEE/RESPIR
7 – Physical Therapy	PRO FEE/PHYSI
8 – Occupational Therapy	PRO FEE/OCUPA
9 – Speech Pathology	PRO FEE/SPEECH

New Conditions and Value Codes for Completion of Form CMS-1450 (continued)

098x Professional Fees – Extension of 096x and 097x

Subcategory	Standard Abbreviations
1 – Emergency Room	PRO FEE/ER
2 – Outpatient Services	PRO FEE/OUTPT
3 – Clinic	PRO FEE/CLINIC
4 – Medical Social Services	PRO FEE/SOC SVC
5 – EKG	PRO FEE/EKG
6 – EEG	PRO FEE/EEG
7 – Hospital Visit	PRO FEE/HOS VIS
8 – Consultation	PRO FEE/CONSULT
9 – Private Duty Nurse	FEE/PVT NURSE

Service Date – FL 45

Required Outpatient. Effective June 5, 2000, community mental health centers and hospitals (with the exception of critical access hospitals, Indian health service hospitals and hospitals located in American Samoa, Guam and Saipan) report line item dates of service on all bills containing revenue codes, procedure codes or drug codes. This includes claims where the "from" and "through" dates are equal. This change is due to a HIPAA requirement.
Not Required for Inpatient. Claims will not be rejected if the date of service is on an inpatient claim.

Units of Service – FL 46

Required. Generally, the entries in this column quantify services by revenue code category, (e.g., number of days in a particular type of accommodation, or pints of blood). However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed. Providers have been instructed to provide the number of covered days, visits, treatments, procedures, tests, etc., as applicable for the following:

- Accommodations – 0100s-0150s, 0200s, 0210s (days)
- Blood pints – 0380s (pints)
- DME – 0290s (rental months)
- Emergency room – 0450, 0452, and 0459 (HCPCS code definition for visit or procedure)
- Clinic – 0510s and 0520s (HCPCS code definition for visit or procedure)
- Dialysis treatments – 0800s (sessions or days)
- Orthotic/prosthetic devices – 0274 (items)
- Outpatient therapy visits - 0410, 0420, 0430, 0440, 0480, 0910, and 0943 (Units are equal to the number of times the procedure/service being reported was performed.)
- Outpatient clinical diagnostic laboratory tests – 030x-031x (tests)
- Radiology – 032x, 034x, 035x, 040x, 061x, and 0333 (HCPCS code definition of tests or services)
- Oxygen – 0600s (rental months, feet, or pounds)
- Drugs and biologicals – 0636 (including hemophilia clotting factors)

Untitled – FL 56

Previously reserved for state use. Discontinued effective October 16, 2003.

Untitled – FL 57

Previously reserved for state use. Discontinued effective October 16, 2003. ❖

Source: CMS Pub 100-4 Transmittal 81, CR 3012

Consolidation of Claim Crossover Process: Additional Common Working File Functionality

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All Medicare providers.

Provider Action Needed

Medicare physicians, suppliers, and providers should note that this instruction communicates changes to the existing Medicare claims crossover process. CMS is implementing a new initiative known as the "Coordination of Benefits Agreement (COBA) consolidated crossover process." This article provides guidance on the new COBA crossover strategy, including a new claim-based Medigap and Medicaid crossover process to be implemented by Medicare carriers and DMERCs on October 4, 2004. It is especially important to understand that the new claim-based COBA IDs being issued by CMS to Medigap insurers and state Medicaid agencies must be submitted on incoming claims in certain defined instances, as explained later in this article.

Background

The Centers for Medicare & Medicaid Services (CMS) Coordination of Benefits (COB) program identifies the health benefits available to a Medicare beneficiary and coordinates the payment process to ensure appropriate payment of Medicare benefits. The program offers an automatic crossover service to other insurers, or trading partners, that may pay benefits after the Medicare claim has been processed. The trading partner is charged a fee-per-

Consolidation of Claim Crossover Process: Additional Common Working File Functionality (continued)

claim that is crossed by Medicare. COB trading partners include:

- Medicare supplemental insurers (i.e., non-Medigap plans),
- Title XIX State Medicaid Agencies, and
- Medigap insurers.

In order to better service its customers, CMS is streamlining the claims crossover process and is consolidating the claims crossover function under one contractor, the Medicare Coordination of Benefits Contractor (COBC).

As part of this streamlined process, COB trading partners, who are eligible to receive Medicare paid claims directly from CMS for purposes of calculating their secondary liability, will no longer have to sign separate agreements with individual Medicare carriers and intermediaries. Instead, each COB trading partner will:

- Enter into one national Coordination of Benefits Agreement (COBA) with CMS' COBC, and
- No longer need to prepare and send separate eligibility files to Medicare intermediaries or carriers, nor receive numerous crossover files. They will instead submit one eligibility file periodically and will regularly receive a consolidated file of claims data for those eligibles.

These changes are the result of input from affected stakeholders in the health insurance industry and will result in a more effective implementation of the COBA process and more effective processes for Medicare providers to receive claim payments that are secondary to Medicare benefits. In addition, the revised COBA process will ensure that CMS fulfills the requirements imposed by the HIPAA ANSI-X12 835 (electronic remittance advice [ERA]) Implementation Guide with respect to communication of crossover information to its Medicare providers and suppliers.

Eligibility-Based Crossover Process

As previously mentioned, national COBAs will now be executed with the COBC by the trading partners, and trading partners will send COB eligibility files to the COBC. Trading partners that provide eligibility files will be assigned COBA IDs to facilitate the crossover process.

For an eligibility file-based crossover, the COBA ID of the trading partner, along with all other eligibility file data elements associated to an individual beneficiary, will be stored in Medicare's common working file (CWF) in the recently established beneficiary other insurance (BOI) auxiliary record. CWF will also house the COBA insurance file that will contain specific information associated to the trading partner that is identified on the BOI auxiliary record. As Medicare claims are processed, CWF will be equipped to apply each COB trading partner's claims selection criteria against the Medicare claims and provide information to the Medicare carrier or intermediary to enable those entities to place appropriate crossover claims information on the HIPAA ANSI X12N 835 Electronic Remittance Advice sent to providers and suppliers.

Claim-Based Crossover Process

For those Medigap and Medicaid insurers that do not provide COB eligibility files identifying beneficiaries that are insured by their plans, a claim-based crossover process will be implemented by October 4, 2004. Unique five-digit COBA IDs will be assigned by the COBC to Medigap and Medicaid insurers that do not provide eligibility files to the COBC.

Medicare providers and suppliers will receive a listing of all Medigap and Medicaid insurers that have been assigned unique claim-based COBA IDs and will be responsible for entering the unique claim-based COBA IDs on each claim submitted to Medicare to initiate the crossing over of claims to the Medigap or Medicaid insurer for supplemental payment to the provider or supplier.

Through this instruction, Medicare claims processing systems will also be modified to house Medigap and Medicaid claim-based COBA IDs and the associated Medigap or Medicaid information necessary for the Medicare carrier or DMERC to prepare an ERA and send the claim to the COBC to cross to the Medigap or Medicaid insurer. The Part B or DME provider or supplier is required to include a claim-based COBA ID on incoming Medicare claims where:

- The beneficiary presents (or has presented) some evidence of his/her coverage under a Medigap plan or eligibility for Medicaid benefits and a corresponding COBA ID for the identified Medigap insurer or State Medicaid Agency can be located on CMS' COBA claim-based ID listing;
- The provider or supplier participates in the Medicare Program. Note that this condition applies both to Medigap and Medicaid claim-based crossover; and
- The beneficiary assigns (or has assigned) his/her Medigap benefits to the provider or supplier.

Implementation

July 6, 2004.

Because of this instruction's impact on providers and suppliers, carriers and DMERCs will not be required to implement the COBA claim-based crossover requirements described in this instruction until October 4, 2004. Effective October 4, 2004, all participating Part B and DME providers and suppliers will cease including the carrier or DMERC-issued Medigap or Medicaid ID on incoming claims. Instead, they will begin to include the claim-based COBA ID, which will be assigned by Medicare's COBC, on incoming claims. When Part B or DME providers or suppliers check the claim-based COBA ID listing and locate the beneficiary's identified Medigap plan, they shall include the Medigap claim-based COBA ID on the incoming claim if: 1) the provider or supplier participates in the Medicare Program; and 2) the beneficiary assigns (or has assigned) his/her rights to benefits to the provider or supplier. When Part B or DME providers or suppliers that participate in the Medicare Program check the claim-based COBA ID listing and locate the State Medicaid Agency that pays benefits for the beneficiary, they shall include the Medicaid claim-based COBA ID on the incoming claim.

As of October 4, 2004, CMS will require participating Part B and DME providers and suppliers to include the CMSissued Medigap or Medicaid claim-based COBA ID on their submitted claims to Medicare if they wish to have their patients' Medicare claims crossed over to the Medigap or

Consolidation of Claim Crossover Process: Additional Common Working File Functionality (continued)

Medicaid insurer that does not supply an eligibility file for their insureds.

(Section 70.6 of Chapter 28 of the Medicare Claims Processing Manual [Pub 100-04] has complete details concerning this requirement, as well as other coordination of benefits procedures.)

Additional Information

You can find the CMS Program Manuals Index at the following CMS Web site: *http://www.cms.hhs.gov/manuals/cmsindex.asp*.

Also, the Medicare Claims Processing Manual (Pub 100-04) is located at the following CMS Web site: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*

Chapter 28 of that manual may be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104c28.pdf*.

Additional Coordination of Benefits information may be found at: *http://www.cms.hhs.gov/manuals/105_msp/msp105c04.pdf*. ❖

Related Change Request (CR) Number: 3109 Related CR Release Date: February 6, 2004
Related CR Transmittal Number: R98CP
Effective Date: July 1, 2004
Implementation Date: July 6, 2004.

Source: CMS Pub 100-4 Transmittal 98, CR 3109

Consolidation of the Claims Crossover Process—Smaller-Scale Initial Implementation

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Providers Affected

All Medicare physicians, providers, and suppliers.

Provider Action Needed

In recent instructions to Medicare carriers, including durable medical equipment carriers (DMERCs) and fiscal intermediaries (FIs), the Centers for Medicare & Medicaid Services (CMS) presented the requirements for a redesigned process for coordination of benefits activities. (For an explanation of these requirements/instructions, see Medlearn Matters article MM3109.)

In CR 3218, CMS is advising the carriers, FIs, and DMERCs that the implementation schedule is being altered and some requirements have changed. Providers need to be aware of how these changes, as described below, may affect them.

The key message is that the impact of this change on providers is delayed from July 6, 2004, until further notice.

Background

CMS is starting the consolidation of the claims crossover process by beginning with a smaller-scale implementation on July 6, 2004. Through this instruction, CMS announces which portions of Transmittal R-98, Change Request (CR) 3109 are:

- Still applicable;
- Which requirements have changed; and
- Which requirements are being moved to the October 4, 2004, systems release or to another future release.

Details regarding the requirements that have changed, and which are being moved to the October 4, 2004, systems release or to another future release, are listed in CR 3218, which can be found at the CMS Web site address that is included in the *Additional Information* section of this article.

A key change is that the entire process will not be implemented on July 6, 2004, as mentioned in CR3109 and Medlearn Matters article MM3109.

Instead, a pilot test will be conducted from July 6, 2004, through October 1, 2004, when approximately eight coordination of benefits agreement (COBA) trading partners will participate as beta-testers in a parallel production crossover environment.

During the parallel production period, the eight COBA trading partners will continue to receive crossover claims from Medicare contractors and will also receive crossover claims as part of the COBA process.

In light of CMS' decision to implement the COBA crossover consolidation project on a smaller scale within a parallel environment, Medicare carriers/FIs/DMERCs will continue to follow their current processes for the printing of Medicare summary notice (MSN) and electronic remittance advice (ERA) crossover messages throughout the period from July 6, 2004, to October 1, 2004.

Medicare contractors will also continue to charge all trading partners to whom they cross Medicare claims.

During the parallel production period, CMS' Medicare coordination of benefits contractor (COBC) will **not** be charging the trading partners that participate in the COBA beta-site testing for claims that it crosses to them.

The eligibility-based crossover process will begin to be implemented on a larger scale on October 4, 2004.

Also on October 4, 2004, the initial eight COBA beta-site testers will be converted to full production and will begin to be charged for claims that the COBC crosses over to them.

Consolidation of the Claims Crossover Process—Smaller-Scale Initial Implementation (continued)

CMS' claim-based COBA crossover process is being delayed until a future systems release**.**

This process previously had a major impact on the provider community as of October 2004 and that will not occur in October 2004 as previously planned.

Implementation

The implementation date for this instruction is July 6, 2004. This means that only those participating in the pilot phase are affected on that date. All other trading partners will not be affected until October 1, 2004, at the earliest. Additional instructions will be issued as new implementation dates are established for moving from the pilot phase to full implementation.

Additional Information

The official instruction issued to your Medicare contractor regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R138CP.pdf*.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp***.**

Also, Transmittal R-98, CR 3109, Consolidation of the Claims Crossover Process: Additional Common Working File (CWF) Functionality, dated February 6, 2004, can be found at the following CMS Web site: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3109.pdf***.**

CR 3218 supercedes CR 3109 and deletes the impact on provider requirements listed in requirements 20 and 21 in CR 3109. Consolidated claim-based crossovers have been delayed until further notice. The claim-based crossover process remains unchanged at the Medicare contractors. ❖

Related Change Request (CR) Number: 3218
Related CR Release Date: April 9, 2004
Related CR Transmittal Number: 138
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 138, CR 3218

Medicare Secondary Payer Policy for Hospital Reference Lab Services and Independent Reference Lab Services

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals, including critical access hospitals, and independent reference laboratories

Provider Action Needed

STOP

Hospitals are no longer required to collect Medicare secondary payer (MSP) information because independent reference labs no longer need the information to bill Medicare for reference laboratory services.

CAUTION

This applies to all hospitals, including critical access hospitals.

GO

Please incorporate this policy change into your billing processes.

Background

Section 943 of the Medicare Prescription Drug, Improvement & Modernization Act of 2003 (MMA) mandates that:

> The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to Medicare secondary payer provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

Prior to the enactment of MMA, hospitals were required to collect MSP information every 90 days in order to bill Medicare for reference lab services. However, the Centers for Medicare & Medicaid Services (CMS) will not require independent reference laboratories to collect MSP information in order to bill Medicare for reference laboratory services as described in subsection (b) of Section 943 of MMA. Therefore, CMS will not require hospitals to collect MSP information in order to bill Medicare for reference laboratory services as described in subsection (b) of Section 943.

Effective Date

This change is effective for reference laboratory service claims with dates of service of December 8, 2003, or later.

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

From that Web page, look for CR 3064 in the CR NUM column on the right, and click on the file for that CR. ❖

Related Change Request (CR) Number: 3064
Related CR Release Date: February 27, 2004
Related CR Transmittal Number: 11
Effective Date: December 8, 2003
Implementation Date: March 29, 2004

Source: CMS Pub 100-5 Transmittal 11, CR 3064

Ambulance Services—Implementation of Section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Providers Affected

Ambulance suppliers.

Provider Action Needed

STOP – Impact to You

The new Medicare Prescription Drug, Improvements, and Modernization Act of 2003 (MMA) makes a number of important changes to Medicare payment for ambulance services rendered on or after July 1, 2004.

CAUTION – What You Need to Know

During the five-year period, July 1, 2004 – December 31, 2009, the fee schedule will include certain temporary increases in payments.

GO – What You Need to Do

Make sure your billing staff understands the new changes and bill according to those changes to assure receipt of accurate payment.

Background

The MMA provides several changes to the payment for ground ambulance services under Section 414 of the Act. Specifically, this section establishes a floor amount for the fee schedule portion of the payment, provides increased payments for urban and rural services, adds an increased payment for ambulance transports originating in certain low density population areas, and provides a 25 percent bonus on the mileage rate for ground transports of 51 miles or greater. These payment changes apply to ground transports only; the air ambulance base rates and mileage rates remain unchanged. More details on these changes are as follows:

Regional Ambulance FS Payment Rate Floor for Ground Ambulance Transports

To discuss these changes further, we begin with the provision regarding the regional ambulance fee schedule (FS) payment rate floor for ground transport services. For services furnished during the period of July 1, 2004, through December 31, 2009, the base rate portion of the payment under the ambulance FS for ground transports is subject to a minimum amount. This minimum depends upon the area of the country in which the service is furnished. Basically, the country is divided into 9 census divisions and each of those divisions has a regional FS that is constructed using the same methodology as the national FS. Where the regional FS is greater than the national FS, the base rates for ground ambulance transports are determined by a blend of the national FS rate and the regional rate in accordance with the following schedule:

Year	National FS Percentage	Regional FS Percentage
July 1, 2004 – December 31, 2004	20%	80%
CY 2005	40%	60%
CY 2006	60%	40%
CY 2007 – CY 2009	80%	20%
CY 2010 and thereafter	100%	0%

Where the regional rate is not greater than the national rate, there is no blending and only the national FS amount applies.

Adjustment to the Ground Mileage Payment Amount for Miles Greater than 50

For services furnished during the period July 1, 2004, through December 31, 2008, a 25 percent increase is applied to the appropriate ambulance FS mileage rate for each mile of a transport (both urban and rural points of pickup [POP]) that exceeds 50 miles (i.e., 51 miles or greater) when the beneficiary is onboard the ambulance.

Adjustments for FS Payment Rate for Certain Rural Ground Ambulance Transports

For services furnished during the period July 1, 2004 through December 31, 2009, the base rate of the payment under the FS for ground ambulance transports furnished in certain rural areas is increased by an amount determined by the Centers for Medicare & Medicaid Services (CMS). This increase applies where the POP is in a rural county (or Goldsmith Area) that is comprised by the lowest quartile by population of all such rural areas arrayed by population density.

Adjustments for FS Payment Rates for Ground Ambulance Transports

The payment rates under the FS for ground ambulance transports (both the FS base rates and the mileage amounts) are increased for services furnished during the period of July 1, 2004, through December 31, 2006. For services furnished where the POP is urban, the rates are increased by 1 percent, and for services furnished where the POP is rural, the rates are increased by two percent.

Important Dates

These changes will sunset on different dates but all apply beginning with services furnished on July 1, 2004.

Additional Information

For further information, you may wish to view the actual instruction issued to your Medicare contractor. That instruction can be seen at: *http://www.cms.hhs.gov/manuals/pm_trans/R88CP.pdf*. ❖

Related Change Request (CR) Number: 3099
Related CR Release Date: February 6, 2004
Related CR Transmittal Number: R88CP
Effective Date: July 1, 2004
Implementation Date: July 5, 2004

Source: CMS Pub 100-4 Transmittal 88, CR 3099

Electrical Stimulation and Electromagnetic Therapy for the Treatment of Wounds

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, therapists, federally qualified health centers, rural health clinics, hospitals, and critical access hospitals.

Provider Action Needed

STOP – Impact to You

Effective July 1, 2004, under specific conditions Medicare will cover electromagnetic therapy for wound treatment for the same settings and conditions in which electrical stimulation (ES) for wound treatment is currently covered.

CAUTION – What You Need to Know

Be aware of the conditions under which Medicare will cover this procedure.

GO – What You Need to Do

You may file claims with Medicare for electromagnetic therapy for the treatment of certain wounds for services rendered on or after July 1, 2004. Be sure to use the correct HCPCS and revenue codes as specified below to assure timely and correct payment.

Background

Medicare conducted a reconsideration review of electromagnetic therapy used for the treatment of certain wounds. They found that wounds treated using either electrical stimulation (ES) therapy or electromagnetic therapy resulted in similar improvements. Therefore, CMS decided to cover electromagnetic therapy for wound treatment for the same settings and conditions in which electrical stimulation for wound treatment is currently covered.

Effective July 1, 2004, Medicare will cover ES or electromagnetic therapy for chronic stage III or stage IV pressure ulcers (ulcers that have not healed within 30 days of occurrence), arterial ulcers, diabetic ulcers, and venous stasis ulcers. Electromagnetic therapy services will be covered only when performed by a physician, physical therapist, or incident to a physician service. No other wound treatment using electromagnetic therapy will be covered.

ES and electromagnetic therapy for wound treatment will be covered only after appropriate standard wound treatment has been tried for at least 30 days with no measurable signs of healing. Additionally, the treating physician must evaluate wounds that are undergoing treatment by electromagnetic therapy **at least monthly.**

Medicare will not continue to cover the treatment if the wound shows no measurable signs of improvement within any 30-day period of treatment. Additionally, ES or electromagnetic therapy must be discontinued when the wound demonstrates a 100 percent epitheliliazed wound bed. Unsupervised therapy for wound treatment will not be covered, nor will ES and electromagnetic therapy be covered as an initial treatment modality.

Additional Information

The applicable Healthcare Common Procedure Coding System (HCPCS) code for electromagnetic therapy is as follows:

G0329 Electromagnetic Therapy, to one or more areas for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care.

Effective date: July 1, 2004.

Note: Medicare will not cover the device (Code E0761) used for electromagnetic treatment of wounds, nor will Medicare cover unsupervised home use of electromagnetic therapy.

The following revenue codes must be used in conjunction with the HCPCS code identified:

Revenue	Code Description
420	Physical therapy
430	Occupational therapy
520	Federal qualified health center
521	Rural health center
977, 978	Critical access hospital – method II CAH professional services only.

The official instruction issued to your carrier regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3149 in the CR NUM column on the right, and click on the file for that CR.

The CR includes the revised portions of the Medicare National Coverage Determinations Manual, which further explain this change. ❖

Related Change Request (CR) Number: 3149
Related CR Release Date: March 19, 2004
Related CR Transmittal Number: 7
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 124, CR 3149

First Update to the 2004 Medicare Physician Fee Schedule Database

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, suppliers, and providers.

Provider Action Needed

Physicians, suppliers, and providers should note the changes to the Medicare Physician Fee Schedule Database, and identify those changes that impact their practice.

Background

The Centers for Medicare and Medicaid Services (CMS) issued payment files to carriers based upon the November 7, 2003, and January 7, 2004, Final Rules. This update of the fee schedule corrects mistakes that were in those payment files. Details of the changes may be found in the actual change request that was released and which is available at:
http://www.cms.hhs.gov/manuals/pm_trans/R105CP.pdf.

Also, note the following requirements:

- Unless otherwise stated, changes will be retroactive to January 1, 2004.
- Carriers and intermediaries **will not search their files to either retract payment for claims already paid or to retroactively pay claims based on the corrected rates**. **However, carriers will adjust claims brought to their attention by the provider**.

Implementation

The implementation date is April 5, 2004.

Additional Information

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp. ❖

Related Change Request (CR) Number: 3128
Related CR Release Date: February 20, 2004
Effective Date: January 1, 2004
Implementation Date: April 5, 2004
Transmittal Number: R105CP

Source: CMS Pub 100-4 Transmittal 105, CR 3128

GENERAL COVERAGE

Cardiac Output Monitoring by Thoracic Electrical Bioimpedance

Thoracic electrical bioimpedance (TEB) devices, a form of plethysmography, monitor cardiac output by noninvasively measuring hemodynamic parameters, including:

- stroke volume,
- systemic vascular resistance, and
- thoracic fluid status.

Under the previous coverage determination, effective July 1, 1999, use of TEB was covered for the "noninvasive diagnosis or monitoring of hemodynamics in patients with suspected or known cardiovascular disease." In reconsidering this policy, CMS concluded that this use was neither sufficiently defined nor supported by available clinical literature to offer the guidance necessary for practitioners to determine when TEB would be covered for patient management. Therefore, CMS revised its coverage policy language in response to a request for reconsideration to offer guidance that is more explicit and clarity for coverage of TEB, based on a complete and updated literature review.

Covered Indications

TEB is covered for the following uses:

- Differentiation of cardiogenic from pulmonary causes of acute dyspnea when medical history, physical examination, and standard assessment tools provide insufficient information, and the treating physician has determined that TEB hemodynamic data are necessary for appropriate management of the patient.
- Optimization of atrioventricular (A/V) interval for patients with A/V sequential cardiac pacemakers when medical history, physical examination, and standard assessment tools provide insufficient information, and the treating physician has determined that TEB hemodynamic data are necessary for appropriate management of the patient.
- Monitoring of continuous inotropic therapy for patients with terminal congestive heart failure, when those patients have chosen to die with comfort at home, or for patients waiting at home for a heart transplant.
- Evaluation for rejection in patients with a heart transplant as a predetermined alternative to a myocardial biopsy. Medical necessity must be documented should a biopsy be performed after TEB.
- Optimization of fluid management in patients with congestive heart failure when medical history, physical examination, and standard assessment tools provide insufficient information, and the treating physician has determined that TEB hemodynamic data are necessary for appropriate management of the patient.

In addition, use of TEB for the management of drug-resistant hypertension *may* be covered in cases where it is reasonable and necessary. Drug resistant hypertension is defined as failure to achieve goal BP in patients who are adhering to full doses of an appropriate three-drug regimen that includes a diuretic.

Noncovered Indications

TEB is noncovered when used for patients:

- With proven or suspected disease involving severe regurgitation of the aorta;
- With minute ventilation (MV) sensor function pacemakers, since the device may adversely affect the functioning of that type of pacemaker;
- During cardiac bypass surgery; or
- In the management of all forms of hypertension (with the exception of drug-resistant hypertension as outlined above).

All other uses of TEB not otherwise specified remain noncovered. This national coverage decision was last reviewed January 2004. ❖

Source: CMS Pub 100-3 Transmittal 6, CR 2689

Updated Policy and Claim Processing Instructions for Ambulatory Blood Pressure Monitoring

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, hospitals, critical access hospitals (CAHs), comprehensive outpatient rehabilitation facilities (CORFs), skilled nursing facilities (SNFs), federally qualified health centers (FPHCs), and rural health clinics (RHCs).

Provider Action Needed
STOP – Impact to You

Medicare has expanded payment for ambulatory blood pressure monitoring (ABPM) to include *CPT* code *93788* in addition to the three *CPT* codes already payable. (*CPT* code *93788* is defined as "*ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report.*") ABPM is only payable for patients with suspected "white coat hypertension" (WCH). **Note:** This is designated as an outpatient service; patients admitted to a hospital or residing in institutions (such as SNFs) who receive ABPM are not qualified for coverage. Additionally, if ABPM must be performed more than once for a particular beneficiary, the qualifying criteria (described in the *Background* section) must be met for each subsequent ABPM test.

CAUTION – What You Need to Know

ABPM involves the use of a noninvasive devise to measure blood pressure in 24-hour segments, the results of

Updated Policy and Claim Processing Instructions for Ambulatory Blood Pressure Monitoring (continued)

which are stored in the device and interpreted later by a physician.

To be covered, ABPM must be performed for at least a 24-hour time period; the ICD-9-CM diagnosis code 796.2 (Elevated blood pressure reading without diagnosis of hypertension) must be used; and a physician must interpret the results.

GO – What You Need to Do

Refer to the *Additional Information* section for HCPCS code information by provider type specific to ABPM for suspected WCH for fiscal intermediary and carrier billing instructions, which can be found in the CMS Manual System, Pub-04, Medicare Claims Processing, Chapter 32, Section 10, and in CR 2726, at: *http://www.cms.hhs.gov/manuals/pm_trans/R109CP.pdf*.

Background

The qualifying criteria for white coat hypertension include:

1. Clinic/office blood pressure >140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit;
2. At least two documented separate blood pressure measurements taken outside the clinic/office which are <140/90 mm Hg; and
3. No evidence of end-organ damage.

Additional Information

When a claim for ABPM is made, the diagnosis code 796.2 (Elevated blood pressure reading without diagnosis of hypertension) must be used. Additionally, the effective dates for applicable HCPCS codes for ABPM for suspected WCH are as follows:

CPT Code	Definition	Effective Date
93784	*ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer, including recording, scanning analysis, interpretation and report.*	April 1, 2002
93786	*ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only.*	April 1, 2002
93788	*ABPM, utilizing a system of magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report.*	January 1, 2004
93790	*ABPM, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report.*	April 1, 2002

The above *CPT* codes can be billed by the following providers, for outpatients, as specified below:

- Hospitals (except CAHs) bill on a 13x or 14x type of bill with *CPT* codes *93786* and/or *93788*.
- CORFs bill on a 75x type of bill with *CTP* code *93786* and/or *93788*.
- CAHs bill on an 85x type of bill as follows: (1) for CAHs that elected the standard method, bill *CPT* code *93786* and/or *93788*; and (2) for CAHs that elected the optional method, bill any combination of *CPT* codes *93786*, *93788* and *93790* as appropriate.
- SNFs bill on a 23x type of bill with *CPT* code *93786* and/or *93788*.
- RHCs bill for the professional component as a visit under the all-inclusive rate on a 71x type of bill with rev code 052x.
- FQHCs bill for the professional component as a visit under the all-inclusive rate on a 73x type of bill with rev code 052x.
- Provider-based RHCs/FQHCs bill for the technical component under their base provider's number using the above requirements for their particular base provider type.
- Independent and free-standing RHCs/FQHCs practitioners bill for the technical component to the carrier.

The official instruction issued to your carrier regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R109CP.pdf*

You may also refer to the CMS Mannual System, Pub 03, *Medicare National Coverage Determinations*, *Chapter 1, Section 20.19*, which may be found at: *http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp*. ❖

Related Change Request (CR) Number: 2726
Related CR Release Date: February 27, 2004
Related CR Transmittal Number: 109
Effective Date: April 1, 2004
Implementation Date: April 5, 2004

Source: CMS Pub 100-4 Transmittal 109, CR 2726

Current Perception Threshold/Sensory Nerve Conduction Threshold Test

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, suppliers, and providers.

Provider Action Needed

Providers should be aware that the Centers for Medicare & Medicaid Services has reviewed its policy on sensory nerve conduction threshold test (sNCT) and reaffirms its original national noncoverage decision on sNCT.

Background

Based on a reconsideration of current Medicare policy for sNCT, CMS reaffirms its original national noncoverage policy regarding current perception threshold/sensory nerve conduction threshold test (sNCT). The National Coverage Determination Manual (Pub. 100-03; Chapter 1; Subsection 160.23) has been updated to reflect this most recent noncoverage determination as a result of the reconsideration review.

Please note that the revision to the National Coverage Determination Manual is a national coverage determination (NCD) and NCDs are binding on all Medicare carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans.

Also, under 42 Code of Federal Regulations (CFR) 422.256(b), an NCD that expands coverage is also binding on Medicare+Choice organizations. In addition, an administrative law judge may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

Implementation

The effective and implementation dates of this instruction are April 1, 2004.

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

On that Web page, look for CR2988 in the CR NUM column on the right, and click on the file for that CR. The revised portions of the NCD Manual are included with that CR. ❖

Related Change Request (CR) Number: 2988
Related CR Release Date: March 19, 2004
Related CR Transmittal Number: 8
Effective Date: April 1, 2004
Implementation Date: April 1, 2004

Source: CMS Pub 100-3 Transmittal 8, CR 2988

Ocular Photodynamic Therapy with Verteporfin for Age-Related Macular Degeneration

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All Medicare providers.

Provider Action Needed

STOP – Impact to You

This national coverage determination (NCD) provides for a change in the Medicare coverage policy for the use of ocular photodynamic therapy (OPT) with verteporfin for age-related macular degeneration (AMD). Under certain conditions (described below), OPT with verteporfin for AMD is now covered for additional clinical indications.

CAUTION – What You Need to Know

CMS has determined that, provided certain criteria are met, OPT with verteporfin (*CPT* code *67221 and 67225*, as well as HCPCS code J3395) will now be covered for AMD in two additional clinical instances:

1) subfovial occult lesions with no classic choroidal neovascularization (CNV); and
2) subfoveal minimally classic CNV associated with AMD.

GO – What You Need to Do

Make sure that your billing staffs are aware of these coverage changes.

Background

This NCD is documented in revisions to Chapters 80.2 and 80.3 of Pub. 100-03. Remember that NCDs are binding on all Medicare carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans. An NCD is also binding on Medicare + Choice organizations. Administrative law judges may not review NCDs.

This NCD addresses coverage for the use of OPT with verteporfin in additional clinical instances. OPT with verteporfin continues to be approved for patients with a diagnosis of neovascular AMD with predominately classic subfoveal CNV lesions (where the area of classic CNV occupies = 50 percent of the area of the entire lesion).

Note: Remember that this diagnosis must be determined by a fluorescein angiogram at the initial visit. Also, there are no requirements regarding visual acuity, lesion size, and number of retreatments when treating predominantly classic lesion patients; however, they do require a fluorescein angiogram in subsequent, follow-up visits prior to treatment.

Ocular Photodynamic Therapy with Verteporfin for Age-Related Macular Degeneration (continued)

In addition to this diagnosis, after thorough review and reconsideration of the August 20, 2002, noncoverage policy, CMS has determined that there is enough evidence to conclude that OPT with verteporfin, in certain instances, may be reasonable and necessary for treating subfoveal occult lesions with no classic CNV and subfoveal minimally-classic CNV lesions (where the area of classic CNV occupies <50 percent of the area of the entire lesion).

These two new covered indications are considered reasonable and necessary only when:

- The lesions are small (four disk areas or less in size) at the time of initial treatment or within the three months prior to initial treatment; and
- They have shown evidence of progression within the three months prior to initial treatment. You must confirm this evidence of progression by documenting the deterioration of visual acuity (at least five letters on a standard eye examination chart); lesion growth (an increase in at least one disk area); or the appearance of blood associated with the lesion.

Be aware that the other AMD-related uses of OPT with verteporfin, not already addressed by CMS, will continue to be noncovered. These include, but are not limited to: juxtafoveal or extrafoveal CNV lesions (lesions outside the fovea); inability to obtain a fluorescein angiogram; or atrophic or "dry" AMD.

On the other hand, the use of OPT with verteporfin for other ocular indications, such as pathologic myopia or presumed ocular histoplasmosis syndrome, continue to be eligible for local coverage determinations through individual Medicare contractor discretion.

The following is a short history leading up to the current NCD.

1. Effective July 1, 2001, CMS approved the use of OPT with verteporfin in neovascular AMD patients having predominately classic subfoveal CNV lesions.
2. On October 17, 2001, CMS announced its "intent to cover" OPT with verteporfin for AMD patients with occult subfoveal CNV lesions; however, this decision was never implemented.
3. On March 28, 2002, CMS reviewed the October 17, 2001, intent to cover policy, and determined that the (then) current noncoverage policy for OPT for verteporfin for AMD patients with occult subfoveal CNV should remain in effect.
4. Effective August 20, 2002, CMS issued a noncovered instruction for OPT with verteporfin for AMD patients with occult subfoveal CNV lesions.
5. Now CMS, after through review and reconsideration of the August 2002 decision, has determined that there is enough evidence to conclude that OPT with verteporfin is also reasonable and necessary in these additional clinical instances. Therefore, this NCD, effective April 1, 2004, provides for covering the use of OPT with verteporfin in patients with subfoveal occult lesions with no classic CNV, and subfoveal minimally classic CNV lesions as described above.

Additional Information

You can find additional background information in Pub. 100-03, Chapters 80.2 and 80.3, which are included in the actual instruction issued to Medicare carriers and fiscal intermediaries on this NCD. This instruction can be found in CR3191 at:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

Once at that site, scroll down to find 3191 in the CR NUM column on the right and then click on the file for that number. ❖

Related Change Request (CR) Number: 3191
Related CR Release Date: April 1, 2004
Related CR Transmittal Number: 9
Effective Date: April 1, 2004
Implementation Date: April 1, 2004

Source: CMS Pub 100-3 Transmittal 9, CR 3191

HOSPITAL SERVICES

Outpatient Clinical Laboratory Tests Furnished by Hospitals with Fewer Than 50 Beds in Qualified Rural Areas

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals with fewer than 50 beds in a qualified rural area. Note that the change applies to covered outpatient clinical laboratory tests in such facilities.

Provider Action Needed

Affected hospitals should note that Section 416 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) alters the basis for payments for Medicare outpatient covered clinical laboratory services for hospitals with fewer than 50 beds in qualified rural areas. Such services will be paid on a reasonable cost basis during cost reporting periods beginning with cost reports that start on or after July 1, 2004, but before July 1, 2006.

Background

Generally, Medicare outpatient covered clinical laboratory services are paid based on a fee schedule.

Medicare beneficiaries are not liable for any coinsurance and deductible. Instructions for the calendar year 2004 Medicare clinical laboratory fee schedule were issued in:

- Pub. 100-20, Transmittal 20, Change Request (CR) 2959, *2004 Annual Update for Clinical Laboratory Fee Schedule*; and
- Pub. 100-20, Transmittal 31, CR 3013, *Emergency Revised 2004 Update of the DMEPOS and Clinical Laboratory Fee Schedules*.

MMA Section 416, however, states that payment for tests for Medicare beneficiaries provided by outpatient hospital laboratory testing by a hospital laboratory with fewer than 50 beds in a qualified rural area are paid on a reasonable cost basis for cost reporting periods beginning during the 2-year period that starts on July 1, 2004.

Medicare beneficiaries are ***not*** liable for coinsurance and deductibles during the applicable time period.

Section 416 eliminates the application of the clinical laboratory fee schedule in such cases.

The reasonable costs are determined using the ratio of costs to charges for the laboratory cost center, multiplied by the provider statistical & reimbursement report's (PS&R) billed charges for outpatient laboratory services for cost reporting periods beginning on or after July 1, 2004, but before July 1, 2006.

Please note that a qualified rural area is one with a population density in the lowest quartile of all rural county populations. The Centers for Medicare & Medicaid Services (CMS) central office will determine the qualified rural areas and will identify the lowest 25 percent quartile population density areas.

A file of the eligible ZIP codes will be made available by CMS to Medicare intermediaries on or about **May 15, 2004.**

In determining whether clinical laboratory services are furnished as part of outpatient services of a hospital, the same rules will apply that are used to determine whether clinical laboratory services are furnished as an outpatient critical access hospital service.

For cost reporting periods beginning July 1, 2004, intermediaries will use the designated ZIP codes to identify facilities in their files that are in qualified rural areas and have fewer than 50 beds for the purpose of making these reasonable cost payments required by Section 416 of the MMA.

Implementation

The implementation date for this instruction is July 6, 2004.

Additional Information

The official instruction issued to your intermediary regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R100CP.pdf*.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

Transmittal 20, CR 2959, *2004 Annual Update for Clinical Laboratory Fee Schedule*, can be found at the following Centers for Medicare and Medicaid Services (CMS) Website: *http://www.cms.hhs.gov/manuals/pm_trans/R20OTN.pdf*.

Also, Transmittal 31, CR 3013, *Emergency Revised 2004 Update of the DMEPOS and Clinical Laboratory Fee Schedules*, can be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R31OTN.pdf***.**

Finally, Transmittal A-01-31, CR 1568, *Clinical Diagnostic Laboratory Tests Furnished by Critical Access Hospitals (CAHs)*, can be found at: *http://www.cms.hhs.gov/manuals/pm_trans/A0131.pdf*. ❖

Related Change Request (CR) Number: 3130
Related CR Release Date: February 13, 2004
Related CR Transmittal Number: 100
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 100, CR 3130

Payment for Drug Administration

Infusion therapy, using other than chemotherapeutic drugs, per visit – HCPCS code Q0081 – is a once per encounter (per visit) code that should be used to report ALL services in a single visit, regardless of the number of drugs administered during the visit. If two or more non-chemotherapeutic drugs are administered by infusion, the hospital should bill one (1) unit of Q0081. A second unit of this code would only be billed if the patient left the hospital outpatient department (HOD) after completion of the first administration and then returned later for a separate encounter for administration of another drug. For example, the patient leaves the HOD and returns later in the day suffering from dehydration and requires infusion of fluids and infusion of antiemetics, the hospital would bill Q0081 for those services.

Billing tips to consider when using HCPCS code Q0081:

- Report HCPCS code Q0081 with appropriate revenue code where services are performed (i.e., 761 – treatment room, 45x – emergency room).
- Only bill Q0081 with chemotherapy administration codes (Q0083/Q0084/Q0085) when medical necessity is established.
- Hospitals can bill for IV infusion therapy each day during an outpatient observation stay when a second evaluation and management (E/M) code is billed.
- When two legitimate IV infusion therapy services are provided on the same day at different encounters, the provider may bill the second IV infusion therapy service with modifier 76 or 77.

FCSO expects that there are rare occasions when a Medicare patient will have two visits (supported by the presence of two E/M codes) on the same day and receives IV infusion therapy during both visits. Therefore, FCSO will monitor use of modifiers 76 and 77 billed with Q0081. ❖

Expansion of Transfer Policy Under Inpatient Prospective Payment System

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals paid under the inpatient prospective payment system (IPPS).

Provider Action Needed

Affected hospitals should note that this instruction clarifies the policy of the Centers for Medicare & Medicaid Services (CMS) regarding the transfer of patients between acute inpatient hospitals and it implements a new policy on acute hospital transfer for patients who **leave against medical advice** (LAMA).

Background

A transfer between acute inpatient hospitals occurs when a patient is admitted to a hospital and is subsequently transferred to another hospital for additional treatment once the patient's condition has stabilized or a diagnosis is established. A summary of the transfer policy is below:

- **Transfers Between Inpatient Prospective Payment System (IPPS) Hospitals**
  The full prospective payment is made to the final discharging hospital, and payment to the transferring hospital is based upon a per diem rate. The per diem rate equals the prospective payment rate divided by the average length of stay for the specific diagnosis related group (DRG) into which the case falls and multiplied by the patient's length of stay at the transferring hospital. Also, patients who leave an IPPS hospital against medical advice, but are admitted to another IPPS hospital on the same day, will be treated as transfers, and the transfer payment policy will apply. CMS will implement this policy on July 6, 2004.
- **Transfers from an IPPS Hospital to Hospitals or Units Excluded from IPPS**
  The full inpatient prospective payment is made to the transferring hospital when a patient is transferred to a hospital or unit excluded from IPPS. The receiving hospital is paid on the basis of reasonable costs or prospective payment. (See exceptions in the next section.)
- **IPPS Transfers – Post-acute Care Transfers (Previously Special 10 DRG Rule)**
  For discharges occurring on or after October 1, 1998, a discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in 42 CFR 412.4(c), to one of the qualifying DRGs in the following section and the discharge is made under any of the following circumstances:
  - To a hospital or distinct part hospital unit excluded from the inpatient prospective payment system (under subpart B of 42 CRF 412). Some facilities excluded from IPPS are:
    - Inpatient rehabilitation facilities and units
    - Long term care hospitals
    - Psychiatric hospitals and units
    - Children's hospitals
    - Cancer hospitals.
  - To a skilled nursing facility
  - To home with a written plan of care for the provision of home health services and those services begin within three days after the date of discharge.
- **Qualifying DRGs**
  - The original qualifying DRGs for purposes of the previous section (IPPS Transfers – Postacute Care Transfers) are DRGs:

    14 113 209 210 211
    236 263 264 429 483.

Expansion of Transfer Policy Under Inpatient Prospective Payment System (continued)

- Effective October 1, 2003, DRGs 263 and 264 are deleted from the post-acute care transfer policy.
- Effective for discharges on or after October 1, 2003, the following DRGs were added to the policy:

12	24	25	88	89	90
121	122	127	130	131	239
277	278	294	296	297	320
321	395	468.			

Please note that these systems changes are effective upon the implementation date of July 6, 2004, not the discharge date.

Also note that the Arkansas Part A Standard System (APASS) maintainer and associated fiscal intermediaries (FIs) are waived from implementing this instruction on July 6, 2004, due to their upcoming transition to the Fiscal Intermediary Shared System (FISS) system. However, they must implement this requirement upon transitioning to the FISS system. Barring any unforeseen delays, these transitions to the FISS system will occur before July 6, 2004, and, therefore, this change will apply to all FIs and their providers.

Implementation

The implementation date is July 6, 2004.

Additional Information

CMS Manual System, Publication 100-4, Claim Processing, Chapter 3 – Inpatient Hospital Billing, section 40.2.4 – IPPS Transfers Between Hospitals, will contain these revised instructions at a future date, closer to the date of implementation.

The CMS Web site for the Medicare Claim Processing Manual (Pub 100-4) can be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

The official instruction issued to your fiscal intermediary regarding this change may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R87CP.pdf*.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*. ❖

Related Change Request (CR) Number: 2934
Related CR Release Date: February 6, 2004
Related CR Transmittal Number: R87CP
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 87, CR 2934

Accurate Coding and Payments for Discharge and/or Transfer Policies—Modification of Requirements in CR 2716, CWF Edits

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is making emergency revisions to their claim processing systems to modify some edits previously set forth in PM A-03-065 (CR 2716), published on August 1, 2003, regarding inpatient claims and subsequent post-acute claims. **The anticipated date of these revisions was March 15, 2004.**

Background

As a result of reports from the Office of the Inspector General, CMS had indications that hospitals were incorrectly coding the patient status code field in regards to transfers to post-acute care facilities. In some cases, this resulted in overpayments to the hospital. On January 1, 2004, CMS initiated common working file (CWF) edits to identify incorrectly coded hospital claims. CMS also instructed the Medicare intermediaries to automatically cancel hospital claims with an incorrect code in the patient status field.

It has been brought to our attention that the volume of cancellations is causing financial difficulties for many providers. Many of the cancelled claims would not be subject to a reduction in payment even if incorrectly coded. Post-acute claims that might come in out of sequence also caused some hospital claims to be inappropriately canceled. We are now in the process of revising the edit criteria so that only claims with the potential to be overpaid will be cancelled.

CMS regrets this adverse impact on the hospital community and is working to modify its edits on March 15, 2004. The sequencing issue has already been corrected. Obviously, the impact on hospitals has prompted a number of questions regarding this change and the impact of the previous change. Following are some of the most frequently raised questions and CMS answers.

Questions and Answers

What is currently being done by CMS to remedy this problem?

The Medicare claims processing system has been modified to limit automatic cancellation of inpatient claims only to inpatient hospital claims with a patient status code indicating the patient was sent home upon receipt of a claim from another facility. We have also corrected the issue of canceling claims where a home health claim is received within three days and there may have been an intervening stay (e.g., SNF stay).

What else will be done by CMS?

CMS has established new criteria for an automatic claim cancellation. Once the CWF edits are revised (expected March 15, 2004), the only claims that will be canceled will be inpatient hospital (IPPS) claims paid

Accurate Coding and Payments for Discharge and/or Transfer Policies (continued)

under one of the 29 post acute care DRGs, with an actual length of stay (LOS) less than the average length of stay for the assigned DRG, and where CMS has an indication the patient status code is incorrect. This will greatly reduce the volume of cancellations that have no payment implications. CMS is also developing education materials to instruct hospitals on the coding of patient status. Hospitals will be required to code patient status correctly as CMS intends to expand upon these edits for all hospitals at a later date.

Is there a 14-day reference in the inpatient transfer rule?

No. This reference was incorrectly communicated in CR 2716.

Has the CWF ever edited for the 14-day window for subsequent SNF claims, as referenced in CR 2716?

The CWF has never edited for such a rule. We only edited for SNF claims if the patient was in a SNF on the same day as their discharge from a hospital.

If the effective date for CR 2716 is January 1, 2004, why are some claims that were paid and/or processed prior to January 1, 2004, being cancelled?

The effective date is not date of service specific. Any incoming claim that enters the CWF, on or after the effective date, will initiate a history search and potential cancellation of claims. The new edits will only search for and cancel claims with discharges on or after October 1, 2003.

What hospitals are excluded from these edits?

Hospitals not paid under the inpatient prospective payment system (IPPS) are excluded.

When will these edits take effect?

The expected date is March 15, 2004.

Does CMS realize that hospitals are out of compliance if they change the patient status code on the claim to a transfer as directed by CMS, even if the medical records or hospital physician orders do not support this? Families and personal physicians often place patients in post-acute settings without the hospital having any knowledge.

CMS believes that if a patient is receiving post-acute care on the same day as discharge or within three days of discharge in the case of home health care, the post-acute admission is related to the inpatient stay. Physicians and coding staff must be educated on the impact of correct coding.

What should hospitals be doing with canceled claims?

Hospitals should be correcting the patient status code and resubmitting these claims as soon as possible to receive the appropriate reimbursement.

Can a hospital receive accelerated payments if the impact of CR 2716's implementation is causing financial difficulties?

Hospitals should contact their intermediary to determine if they are eligible for accelerated payments.

Can you provide the current list of valid patient status codes?

Below is the list of patient status (ST) codes with short Medicare descriptions. This is a required field for all Part A inpatient, SNF, hospice, home health agency (HHA), and outpatient hospital services. This code indicates the patient's status as of the "Through" date of the billing period. It is important to note that the patient status code indicates a destination (as in where the patient is discharged or transferred to) and not a level or type of care received.

PS Code	Description
01	Home
02	Short term acute hospital
03	Skilled Nursing Facility (SNF)
04	Intermediate Care Facility (ICF) (also nursing facility with neither Medicare nor Medicaid certification)
05	Inpatient Psychiatric Hospital, Inpatient Psychiatric Distinct Part Unit of a Hospital, Children's Hospital, Cancer Hospital
06	Home Health
08	Home IV Provider
09	Admitted as Inpatient to this Hospital (for use only on Medicare outpatient hospital claims)
20	Expired
30	Still Patient
40	Expired at home (for hospice use only)
41	Expired in a medical facility (for hospice use only)
42	Expired-place unknown (for hospice use only)
43	Federal hospital (such as VA)
50	Hospice-home
51	Hospice-medical facility
61	Medicare Approved Swing Bed*
62	Inpatient Rehabilitation Facility, including rehabilitation distinct part unit of a hospital
63	Long Term Care Hospital
64	Medicaid-only nursing facility
Future 65	Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital. (Providers should continue to use 05 until otherwise notified by CMS-expected 2005.) Instructions are forthcoming.

*****There has been some confusion in the provider community regarding the description of 61. CMS advises providers to use 61 for both discharges/transfers to a Medicare approved swing bed within the hospital's approved swing bed arrangement or to another Medicare approved swing bed in another location. ❖

Effective Date: January 1, 2004

Source: CMS Medlearn Matters Article SE0408

Hospital Discounts Permitted for Indigent, Uninsured, and Underinsured Patients

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Providers Affected

Hospitals.

Provider Action Needed

This special article serves as a reminder to hospitals of existing Medicare policy that permits hospitals to offer discounts to certain patients so long as a few general guidelines are followed in doing so. This article reflects **no change to existing policy.** The Centers for Medicare & Medicaid Services (CMS), however, wants to be certain that hospitals understand existing policies that enable hospitals to provide affordable health care to as many of their patients as possible without compromising long-standing Medicare policies or the appropriate use of Medicare's trust funds.

Background

Recently, several hospital groups and associations raised questions with CMS and some of its fiscal intermediaries (FI) regarding the ability of hospitals to offer discounts to indigent, uninsured, or other low income patients. In addition, they have raised some questions about Medicare's role in the collection of patient debts owed for hospital services.

To address these issues, Secretary Tommy G. Thompson sent a letter to the American Hospital Association on February 19, 2004. A press release was issued by the Department of Health & Human Services containing the text of that letter and may be viewed at: *http://www.os.dhhs.gov/news/press/2004pres/20040219.html*.

Also, CMS has posted a number of questions and answers related to this issue on its Web site. This information may be viewed at: *http://www.cms.hhs.gov/FAQ_Uninsured.pdf*.

CMS hopes this information will help answer hospitals' questions and permit them to move forward in giving discounts wherever possible for those who need and cannot afford care. At the same time, hospitals and other providers must assure that these discounts are offered in accordance with the Medicare guidelines so as to protect the Medicare trust funds for those who rely on Medicare services.

Additional Information

For those who would like more detailed information on the Medicare guidelines related to this issue, please refer to the Medicare Provider Reimbursement Manual for this area. The relevant chapter and sections can be found at: *http://www.cms.hhs.gov/manuals/pub151/PUB_15_1.asp*.

Also, you may direct questions to your FI via their toll free number. Should you need the number for your FI, you may find those posted at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*. ❖

Effective Date: Not applicable; this is a reminder of existing policy.

Source: CMS Special Edition Medlearn Matters Article SE0405

Changes to the FY 2004 Graduate Medical Education Payments as Required by the Medicare Modernization Act of 2003, P.L. 108-173

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals that operate approved graduate medical education (GME) programs

Provider Action Needed

STOP – Impact to You

Changes based on the Medicare Modernization Act of 2003 (MMA) target both direct GME and indirect medical education (IME). Hospitals need to be aware of the changes.

CAUTION – What You Need to Know

These changes are effective for cost reporting periods beginning on or after October 1, 2003; or for services furnished on or after January 1, 2004, or on or after April 1, 2004, depending on the provision.

GO – What You Need to Do

Understand the residency training IME and direct GME changes and take necessary steps to implement the changes.

Background

Sections 502, 711, 712, and 713 of the MMA make a number of changes to the ways in which Medicare pays IME and direct GME. Briefly, these changes are described below.

IME Adjustment

The calculation for the IME adjustment was modified, resulting in a different IME adjustment schedule for patient discharges occurring on or after April 1, 2004. The formula multiplier for the IME adjustment during this period will range from 1.47, starting April 1, 2004, to 1.32 in FY 2007.

Beginning on October 1, 2007, the formula multiplier reverts back to 1.35—where it was prior to April 1, 2004. Please refer to the *Additional Information* section of this document for the specific schedule of formula multipliers.

GME Initial Residency Period Exception

With regard to direct graduate medical education (GME), MMA legislation has granted an exception to the initial residency period for geriatric residency or fellowship

Changes to the FY 2004 Graduate Medical Education Payments (continued)

programs. Section 712 of MMA allows hospitals to receive full direct GME payment for two years "where a particular approved geriatric training program requires a resident to complete two years of training to initially become board eligible in the geriatric specialty."

Thus, effective for cost reporting periods beginning on or after October 1, 2003, hospitals may count geriatric residents' training in an accredited geriatric residency program that is **at least a two-year program** at a full time employee for two years. Please note that the statutory language quoted above would ***not*** allow a hospital to give a one-year extension to a particular resident's initial residency period in the case where the resident trained in only a one-year geriatric residency or fellowship program.

Extension of Update Limitation on High Cost Programs

The Balanced Budget Refinement Act (BBRA) of 1999 established a 'floor' and a 'ceiling' for computations of per resident amounts (PRAs) used for direct GME payments. For purposes of calculating direct GME payments, each hospital-specific PRA is compared to the floor and ceiling to determine whether the hospital-specific PRA should be revised. For more information about the calculation of direct GME payments, please refer to Program Memorandum A-01-38 published on March 21, 2001, which may be viewed at:
http://www.cms.hhs.gov/manuals/pm_trans/A0138.pdf

Section 711 of the MMA provides for changes in the update for the direct GME PRA for the "ceiling hospitals" for FY 2004 through FY 2013. Generally, the provision freezes the inflation update for those hospitals that exceed the ceiling for cost report periods beginning during fiscal years 2004 through 2013. Instructions for calculating the floor and ceiling for cost reporting periods prior to FY 2004 are as stated in Program Memorandum A-01-38.

Compensation of Supervisory Teaching Activities

From January 1, 2004, through December 31, 2004, hospitals will be allowed to count allopathic or osteopathic family practice residents' training in non-hospital settings regardless of the financial arrangement between the hospital and the teaching physician practicing in the non-hospital setting to which the resident is assigned. This one-year moratorium applies to FTE residents in allopathic and osteopathic family practice residency programs that were already in existence as of January 1, 2002, and where the requirement to incur the teaching physician compensation related to direct GME may not have been met. It also only applies to residents who spent that time in patient care activities, if there was a written document was in place indicating that residents from the hospital would be training in the non-hospital site, and the hospital actually incurred the residents' salary cost.

This moratorium applies to family practice residents in prior year cost reports that are settled between January 1, 2004, through December 31, 2004, or for family practice residents actually training in nonhospital settings during January 1, 2004, through December 31, 2004.

Residents training in nonhospital settings other than family practice may be disallowed from cost reports settled during calendar year 2004 if the hospital did **not** properly incur the teaching physician compensation associated with direct GME.

Important Dates

The effective dates are as follows:

Section 502- effective with discharges on or after April 1, 2004.
Section 711- effective with cost reporting periods beginning on or after October 1, 2003.
Section 712- effective for cost reporting periods beginning on or after October 1, 2003.
Section 713- effective January 1, 2004 through December 31, 2004.

Additional Information

The schedule of IME formula multipliers is effective for discharges occurring on or after April 1, 2004, and will be incorporated into the new inpatient PPS PRICER as of April 5, 2004. The values to be used in the calculation of the IME adjustment are as follows:

For discharges occurring on or after:

April 1, 2004 and before October 1, 2004 1.47
Fiscal Year 2005 1.42
Fiscal Year 2006 1.37
Fiscal Year 2007 1.32
October 1, 2007 and after 1.35

The formula multiplier is represented as ***c*** in the following equation used to calculate the IME adjustment factor; the variable ***r*** represents the hospital's resident-to-bed ratio. The formula is the following:

$$c \times [(1+r)^{.405} - 1] = \text{IME adjustment factor}$$

For further details, see the official instruction that CMS issued to your intermediary. The official instruction issued regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

Once at that page, look for CR 3071 in the CR NUM column on the right, and click on the file for that CR. ❖

Related Change Request (CR) Number: 3071
Related CR Release Date: March 12, 2004
Related CR Transmittal Number: 61
Effective Date: See below
Implementation Date: See above

Source: CMS Pub 100-20 Transmittal 61, CR 3071

Clarifications to Certain Exceptions to Medicare Limits on Physician Referrals

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians and specialty hospitals.

Provider Action Needed

Be sure to understand these new rules surrounding physician self-referral ("Stark") prohibition as a result of changes in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

General Information

A. Background: Under section 1877 of the Social Security Act (42 U.S.C. section 1395nn), a physician cannot refer a Medicare patient for certain designated health services (DHS) to an entity with which the physician (or an immediate family member of the physician) has a financial relationship unless an exception applies. Section 1877 also prohibits the DHS entity from submitting claims to Medicare, the beneficiary, or any other entity for DHS that are furnished as a result of a prohibited referral.
The following services are DHS:

- Clinical laboratory services
- Radiology and certain other imaging services (including MRIs, CT scans and ultrasound)
- Radiation therapy services and supplies
- Durable medical equipment and supplies
- Orthotics, prosthetics, and prosthetic devices
- Parenteral and enteral nutrients, equipment and supplies
- Physical therapy, occupational therapy, and speech-language pathology services
- Outpatient prescription drugs
- Home health services and supplies
- Inpatient and outpatient hospital services.

A "financial relationship" includes both ownership/investment interests and compensation arrangements (e.g., contractual arrangements). The statute enumerates various exceptions, including exceptions for physician ownership or investment interests in hospitals and rural providers. Violations of the statute are punishable by the following: denial of payment for all DHS claims; refund of amounts collected for DHS claims; and civil money penalties for knowing violations of the prohibition. Applicable regulations are published at 42 C.F.R. Part 411, Subpart J.

B. Policy: MMA, also known as Public Law 108-173, altered the hospital and rural provider ownership exceptions to the physician self-referral prohibition. Prior to MMA, the "whole hospital" exception allowed physicians to refer Medicare patients to a hospital in which they had ownership/investment interests, as long as the physicians were authorized to perform services at the hospital and their ownership or investment interests were in the hospital itself and not a subdivision of the hospital.

Section 507 of MMA added an additional criterion to the whole hospital exception, specifying that for the 18-month period beginning on December 8, 2003 and ending on June 8, 2005, physician ownership and investment interests in "specialty hospitals" would not qualify for the whole hospital exception. Section 507 further specified that, for the same 18-month period, the exception for physician ownership or investment interests in rural providers would not apply in the case of specialty hospitals located in a rural area. **In other words, for this 18-month period only, a physician may not refer a patient to a hospital in which he/she has an ownership or investment interest if the hospital is a specialty hospital, even if the specialty hospital is in a rural area.**

Definition of a Specialty Hospital

For the purposes of these modifications to the physician self-referral prohibition exceptions only, a "specialty hospital" is defined as a hospital in one of the 50 states or the District of Columbia that is primarily or exclusively engaged in the care and treatment of one of the following:

- Patients with a cardiac condition,
- Patients with an orthopedic condition,
- Patients receiving a surgical procedure, or
- Patients receiving any other specialized category of services that CMS designates.

CMS is not designating at this time any additional specialized services that would cause an institution to be considered a specialty hospital within the meaning of section 507 of MMA. Certain hospitals that offer specialized services are not "specialty hospitals" for purposes of section 507 of MMA. Physician investment in and referrals to the following types of hospitals are **permitted**:

- Psychiatric hospitals
- Rehabilitation hospitals
- Children's hospitals
- Long-term care hospitals
- Certain cancer hospitals
- Existing specialty hospitals that satisfy the grandfathering provision in section 507 of MMA ("grandfathered specialty hospitals").

Grandfathered Specialty Hospitals

A grandfathered specialty hospital is one that the CMS central office determines was in operation or under development as of November 18, 2003, and for which:

(i) the number of physician investors has not increased since that date;
(ii) the specialized services furnished by the hospital have not changed since that date; and
(iii) any increase in the number of beds has occurred only on the main campus of the hospital and does not exceed the greater of 5 beds or 50 percent of the beds in the hospital as of that date.

A physician may invest in and refer to a grandfathered hospital. However, an existing specialty hospital cannot continue to be grandfathered if, after November 18, 2003, the number of physician investors or the type of specialized services it offers has changed, or if the hospital's bed size has increased beyond the 5-bed/50 percent threshold. Consequently, its physician investors cannot refer to the hospital and the hospital cannot submit claims pursuant to any prohibited referrals for the remainder of 18-month period ending on June 8, 2005. In determining whether a

Clarifications to Certain Exceptions to Medicare Limits on Physician Referrals (continued)

specialty hospital was "under development" as of November 18, 2003, the MMA directs CMS to consider whether the following had occurred as of that date:

- Architectural plans were completed;
- Funding was received;
- Zoning requirements were met; and
- All necessary approvals from State agencies were received.

In addition, CMS may consider any other evidence that CMS believes would indicate whether a hospital is under development as of November 18, 2003. If CMS determines that an entity was not under development as of November 18, 2003, it is not a grandfathered specialty hospital. Consequently, physician investors in that hospital may not refer to the hospital until June 8, 2005, and the hospital may not submit any claims for items or services rendered pursuant to a prohibited referral.

Grandfathering Determinations

Interested parties may submit to the CMS central office written requests for a determination that their specialty hospital was under development as of November 18, 2003 (a "grandfathering determination"). Existing specialty hospitals that had a provider agreement in effect as of November 18, 2003, do not need to request a grandfathering determination; the provider agreement will constitute this determination. Grandfathering determination requests should include the following:

- A discussion establishing why the specialty hospital should be considered in operation before or under development as of November 18, 2003;
- Relevant supporting documentation;
- Contact information for an individual with whom CMS can discuss the request; and
- A certification that the information contained in the request and supporting documentation is true and correct and constitutes a complete description of the facts regarding the matter for which a determination is sought.

Upon receiving and reviewing the request, CMS may contact the requestor for additional information.

Grandfathering determination requests may be mailed to:

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: Advisory Opinions
P.O. Box 26505
Baltimore, MD 21207

CMS contractors (for example, intermediaries and carriers) are not authorized to provide guidance on matters relating to the physician self-referral law or the application of the exclusion, civil monetary penalty, or criminal authorities under sections 1128, 1128A, or 1128B of the Social Security Act (including the antikickback statute).

Inquiries regarding the physician self-referral law should be directed to:

Joanne Sinsheimer
Division of Technical Payment Policy, CMS
(410) 786-4620

Inquiries concerning the application of the exclusion, civil monetary penalty, or criminal authorities under sections 1128, 1128A, or 1128B of the Social Security Act (including the anti-kickback statute) should be directed to the:

Office of Counsel to the Inspector General
Industry Guidance Branch
(202) 619-0335

Related Information

If you need further clarification, background, details, or just want to see the original change request implementing the 18-month additional criteria, please refer to the original Change Request 3036. This may be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

Once at that page, scroll down the CR number column to CR 3036 and click on the file for that CR. ❖

Related Change Release (CR) Number: 3036
Related CR Release Date: March 19, 2004
Related CR Transmittal Number: 62
Effective Date: December 8, 2003
Implementation Date: April 2, 2004

Source: CMS Pub 100-20 Transmittal 62, CR 3036

Implementation of Sections 401, 402, 504 and 508(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All Medicare hospitals.

Provider Action Needed

STOP – Impact to You

This article is for informational purposes only.

CAUTION – What You Need to Know

This CR addresses the standardized amount that Medicare pays hospitals for inpatient services, the disproportionate share hospital (DSH) adjustment for rural hospitals, the relative federal/commonwealth blend in Medicare payments in Puerto Rico,

Implementation of Sections 401, 402, 504 and 508(a) of MMA of 2003 (MMA) (continued)

and appeals of hospital wage index classification. This CR:

- Equalizes the national adjusted operating standardized amounts for hospitals in large urban and other areas, increases the large urban and other area national adjusted amounts for Puerto Rico, and equalizes the Puerto Rico-specific urban and other area rates;
- Changes the current blend of Federal and Puerto Rican input in Medicare payments; and increases the DSH adjustment for rural hospitals and urban hospitals with fewer than 100 beds.

GO – What You Need to Do

Make sure that the appropriate hospital staff is aware of these changes.

Background

This one-time notification from the Centers for Medicare & Medicaid Services (CMS) implements sections 401, 402, 504, and 508(a) of the MMA that address the standardized amount that Medicare pays hospitals for inpatient services (Section 401), the disproportionate share hospital (DSH) adjustment for rural hospitals (Section 402), the relative federal/commonwealth blend in Medicare payments in Puerto Rico (Section 504), and appeals of hospital wage index classification (Section 508(a)).

Section 401

MMA Section 401 equalizes the national adjusted operating standardized amounts for hospitals in large urban and other areas. In addition, it increases the large urban and other area national adjusted amounts for Puerto Rico and equalizes the Puerto Rico-specific urban and other area rates.

The Puerto Rico-specific equalization of urban and other areas is retroactive to October 1, 2003, but will not be effective in Medicare systems until April 1, 2004. However, CMS has calculated the payment necessary to make up for the six months that the Puerto Rico "other Areas" did not receive payments equal to the Puerto Rico urban rates.

Therefore, from April 1, 2004, through September 30, 2004, the Puerto Rico-specific other area rate will exceed the Puerto Rico urban rate so that the requirements of the provision can be implemented without reprocessing claims (in accordance with MMA Section 401 (d)(2)).

Section 504

MMA Section 504 changes the current blend of input into Medicare payments, from 50 percent federal and 50 percent Puerto Rico to 62.5 percent federal and 37.5 percent Puerto Rico, effective for discharges from April 1, 2004, through September 30, 2004.

It further adjusts the blend to 75 percent federal and 25 percent Puerto Rico on October 1, 2004. The new national and Puerto Rico rates, based on Sections 401 and 504 of MMA, effective for discharges on or after April 1, 2004, through September 30, 2004, are the following:

	Large Urban		Other Area	
	Labor	**Non-Labor**	**Labor**	**Non-Labor**
National	3,135.49	1,274.49	3,135.49	1,274.49
National PR	3,135.49	1,274.49	3,135.49	1,274.49
PR Specific	1,507.58	606.83	1539.38	619.64

The new budget neutrality factors effective April 1, 2004 are:

Puerto Rico Recalibration Budget Neutrality:	1.001698
Wage Index and DRG Recalibration Budget Neutrality:	1.002628
Geographic Reclassification Budget Neutrality:	0.991798

The new fixed-loss amount used to determine the cost outlier threshold for discharges occurring on or after April 1, 2004 through September 30, 2004, is $30,150. This fixed loss amount is part of the equation used to determine inpatient operating and capital-related costs in both the operating prospective payment system (PPS) and the capital PPS.

For this reason, because the fixed loss amount is being changed for discharges during this period, the resultant new capital PPS rates are $413.48 for national and $202.96 for Puerto Rico.

These rates were determined by an updated national GAF/DRG adjustment factor of 1.0025 with an outlier adjustment of 0.9508 and a Puerto Rico GAF/DRG adjustment factor of 1.0011 with an outlier of 0.9922, also applying to discharges occurring on or after April 1, 2004, through September 30, 2004.

Section 402

Under Section 1886(d)(5)(F) of the Social Security Act, Medicare makes additional DSH payments to acute hospitals that serve a large number of low-income Medicare and Medicaid patients as part of its inpatient PPS. As of April 1, 2001 (as specified in Section 211 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000), all inpatient PPS hospitals that meet the number of beds requirement will be eligible to receive DSH payments when their DSH patient percentage meets or exceeds 15 percent.

Implementation of Sections 401, 402, 504 and 508(a) of MMA of 2003 (MMA) (continued)

MMA Section 402 increases the DSH adjustment for rural hospitals and urban hospitals with fewer than 100 beds, effective for discharges occurring on or after April 1, 2004.

The formulas used to establish a hospital's DSH payment adjustment are based on the hospital's location, number of beds and status as a rural referral center or sole community hospital. These formulas are presented in the following table.

DSH Payment Adjustment Formulas

Urban Hospitals		
0 - 99 Beds	>=15%, <20.2%	2.5% + [.65 x (DSH pct – 15%)]
	>=20.2%	5.88% + [.825 x (DSH pct – 20.2%)]
		Not to Exceed 12%
100 + Beds	>=15%, <20.2%	2.5% + [.65 x (DSH pct – 15%)]
	>=20.2%	5.88% + [.825 x (DSH pct – 20.2%)]
		No Cap
Sole Community Hospitals (SCH)	>=15%, <20.2%	2.5% + [.65 x (DSH pct – 15%)]
	>=20.2%	5.88% + [.825 x (DSH pct – 20.2%)]
		Not to Exceed 12%
Rural Referral Centers (RRC)	>=15%, <20.2%	2.5% + [.65 x (DSH pct – 15%)]
	>=20.2%	5.88% + [.825 x (DSH pct – 20.2%)]
		No Cap
Both SCH and RRC	>=15%, <20.2%	2.5% + [.65 x (DSH pct – 15%)]
	>=20.2%	5.88% + [.825 x (DSH pct – 20.2%)]
		No Cap
Other Rural Hospitals		
0 - 499 Beds	>=15%, <20.2%	2.5% + [.65 x (DSH pct – 15%)]
	>=20.2%	5.88% + [.825 x (DSH pct – 20.2%)]
		Not to Exceed 12%
500 + Beds	>=15%, <20.2 %	2.5% + [.65 x (DSH pct – 15%)]
	>=20.2%	5.88% + [.825 x (DSH pct – 20.2%)]
		No Cap

Section 508(a)

The CR also serves as notice to Medicare fiscal intermediaries (FIs) of forthcoming decisions by the Medicare Geographic Classification Review Board (MGCRB) in accordance with Section 508(a), "One-time Appeals Process for Hospital Wage Index Classification." Under this section, a qualifying hospital may appeal the wage index classification otherwise applicable to the hospital and apply for reclassification to another area of the state in which the hospital is located or at the discretion of the Secretary of HHS, to an area within a contiguous state.

Upon completion of the MGCRB review process, CMS will post a complete listing of the approved Section 508(a) hospital reclassifications on its Web site. Geographic reclassifications approved under Section 508(a) are effective for discharges occurring during the three-year period beginning on April 1, 2004, and ending on March 31, 2007.

Additional Information

To view the actual instruction issued to Medicare (FIs) on these issues, please visit: *http://www.cms.hhs.gov/manuals/pm_trans/R64OTN.pdf*.

Also, if you have any questions, contact your FI at their toll-free number. A list of these numbers may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*. ❖

Related Change Request (CR) Number: 3158
Related CR Release Date: March 26, 2004
Related CR Transmittal Number: 64
Effective Date: April 1, 2004
Implementation Date: April 5, 2004

Source: CMS Pub 100-20 Transmittal 64, CR 3158

Hospital Concerns Regarding Changing of Patient Status Code Due to Discharge/Transfer to Other Facility

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals

Provider Action Needed

STOP – Impact to You

Hospitals will not be out of compliance for changing a patient's status codes due to the common working file (CWF) edit 7272, even if the patient's medical record does not support the change.

CAUTION – What You Need to Know

Hospitals expressed concern over changing the patient status code when they received CWF edit code 7272.

GO – What You Need to Do

Hospitals are advised to change the patient status code in order to receive reimbursement while CMS considers medical necessity issues raised by hospitals for transfers from acute care to post-acute care entities.

Background

Hospitals have expressed concern over changing patient status codes due to CWF edit 7272 when such changes are not supported by the medical record. Hospitals are concerned about being cited for noncompliance in such cases. Hospitals may cite CR 3240 as specific guidance to them in situations where the patient status code must be changed in order to receive reimbursement while CMS considers what can be done when medical necessity issues arise with transfers from acute care to post acute care entities.

Important Dates

This instruction will be implemented on May 23, 2004, and applies to claims for discharges on or after January 1, 2004; however, keep in mind that the CWF edit is searching for related post-acute care claims back to October 1, 2003. Please refer to Medlearn Matters article SE0408 for more information.

Additional Information

The official instruction issued to your fiscal intermediary regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

From that Web page, look for CR 3240 in the CR NUM column on the right, and click on the file for that CR. ❖

Related Change Request (CR) Number:3240
Related CR Release Date: April 16, 2004
Related CR Transmittal Number: 140
Effective Date: January 1, 2004
Implementation Date: May 23, 2004

Source: CMS Pub 100-4 Transmittal 140, CR 32401

CRITICAL ACCESS HOSPITAL SERVICES

Changes to Rules for Receiving Optional Payment Method for Outpatient Services

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Providers Affected

Physicians/practitioners and critical access hospitals (CAH)

Provider Action Needed

STOP – Impact to You

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 has modified the requirements for a CAH to receive payment for outpatient services under the optional payment method.

CAUTION – What You Need to Know

Understand the new requirements and their effective dates. The MMA changes the rules so the law does not require **all** physicians/practitioners to agree to reassign their billing rights to the CAH for outpatient services performed at the CAH in order for the CAH to select the optional payment method. This allows the CAH to receive payment for physician services at 115 percent of the Medicare fee schedule for such services. If a CAH elected the optional payment method before November 1, 2003, the effective date of this change is retroactive to July 1, 2001. If the election was made on or after November 1, 2003, then this rule is effective on July 1, 2004.

GO – What You Need to Do

CAHs need to understand the new rule and decide which payment method to select. (For more information on the optional payment method and the standard payment methods, please see the article MM3051, which can be retrieved at *http://www.cms.hhs.gov/medlearn/matters*. Once at that site, scroll down and select article MM3051.) Once the payment selection is made, the CAH must assure that physicians/practitioners are aware of the selection and act accordingly. In addition, CAHs must ensure that billing staffs are aware of any changes required as a result in any change of the selected payment methodology.

Background

MMA changed the provision that required CAHs to have all of their physician/professional practitioners, who rendered outpatient services at their hospitals, reassign their billing rights to the CAH. Specifically, the MMA prohibits CMS from requiring that all physician/professional practitioners in a CAH reassign their billing rights to the CAH as a condition for electing the optional payment option (Method II).

This provision allows practitioners (**all licensed professionals who otherwise would be entitled to bill the carrier under Part B**) who render outpatient services in a CAH's outpatient department to choose whether they want to reassign their billing rights to the CAH, or file their own claims through their Medicare carrier.

If the CAH elected the optional method before November 1, 2003, the provision is effective beginning on or after July 1, 2001. If the CAH elected the optional method on or after November 1, 2003, the provision is effective July 1, 2004. Whichever method the CAH chose remains in effect for that entire cost reporting period.

Be aware that, with this change, CAHs will receive 115 percent of whatever Medicare would pay of the professional fee schedule for **only** those physicians/professional practitioners who reassign their billing rights to the CAH.

Also, CMS requires that the CAH fully document the fact that a practitioner elects to reassign their billing rights to the hospital. For those practitioners who elect to reassign their billing rights to the CAH, the hospital must have a copy of the 855I, which the individual practitioner must certify. The CAH must also have each practitioner sign an attestation that clearly states that they will not bill the carrier for any services rendered at the CAH once the reassignment has been given to the CAH.

Important Dates to Know

Effective Date: July 1, 2004, for CAHs selecting the optional payment method on or after November 1, 2003; for those CAHs who selected the optional method prior to November 1, the effective date is retroactive to July 1, 2001.

Implementation Date

July 6, 2004

Related Instructions

For more detailed information on the two payment methods available, please refer to CMS Manual System, Publication 100-4, Claim Processing, Chapter 4, sections 250.1 and 250.2. The table of contents for this manual may be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*. Once at that site, scroll down to Chapter 4 and select the version you wish to receive.

The official instruction issued to your carrier or fiscal intermediary regarding this change may be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*. Once at that page, scroll down to look for 3114 in the CR NUM column on the right and click on the file for that CR. ❖

Source: CMS Pub 100-4 Transmittal 103, CR 3114

April 2004 Update to the Medicare Outpatient Code Editor for Non-OPPS Hospitals

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals not paid under the outpatient prospective payment system (OPPS).

Provider Action Needed

STOP – Impact to You

The outpatient code editor (OCE) was updated with new HCPCS coding information recently incorporated into the Healthcare Common Procedure Coding System/Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4). This update affects hospitals not paid under the OPPS.

CAUTION – What You Need to Know

CMS sent detailed information about these changes in separate communications (Program Memorandum AB-03-140, dated September 12, 2003). This OCE is used to process bills from hospitals not paid under the OPPS. Refer to the *Additional Information/Effective Dates* section below for a summary of the code changes.

GO – What You Need to Do

Please be aware of these HCPCS code changes to ensure correct billing.

Additional Information/Effective Dates

The official instruction issued to your [intermediary] regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R120CP.pdf*. Also, the program memorandum issued by CMS on September 12, 2003, may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/AB03140.pdf*.

The following summarizes the OCE updates recently incorporated into the Healthcare Common Procedure Coding System/Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4), version 19.1 R1 of the non-OPPS OCE.

Removed from the list of valid HCPCS codes, **effective January 1, 2003:**

L0474 Q3021 Q3022 Q3023

Added to the list of nonreportable procedures, **effective January 1, 2003:**

92510

Added to the list of noncovered procedures, **effective April 1, 2003:**

G0282

Added to the list of valid HCPCS codes, **effective January 1, 2004:**

C9400	C9402	C9403	C9404	C9405
C9406	C9408	C9410	C9411	C9412
C9413	C9414	C9415	C9416	C9417
C9418	C9419	C9420	C9421	C9422
C9423	C9424	C9425	C9426	C9427
C9428	C9429	C9430	C9431	C9432
C9433	C9434	C9438		

Removed from the list of valid HCPCS codes, **effective January 1, 2004:**

C1088 E2350

Removed the list of noncovered procedures, **effective January 1, 2004:**

93788

Added to the list of nonreportable procedures, **effective January 1, 2004:**

90919	90920	90921	90922	90923
90924	99601	99602	A0800	A4208
A4421	C9400	C9402	C9403	C9404
C9405	C9406	C9408	C9410	C9411
C9412	C9413	C9414	C9415	C9416
C9417	C9418	C9419	C9420	C9421
C9422	C9423	C9424	C9425	C9426
C9427	C9428	C9429	C9430	C9431
C9432	C9433	C9434	C9438	E1150
L3031	L3902	Q4054	Q4055	V2756

Added to the list of noncovered procedures, **effective January 1, 2004:**

A4207

Added to the list of valid HCPCS codes, **effective April 1, 2004:**

A4644	A4645	A4646	G0110	G0111
G0112	G0113	G0114	G0115	G0116
K0627	K0628	K0629	K0630	K0631
K0632	K0633	K0634	K0635	K0636
K0637	K0638	K0639	K0640	K0641
K0642	K0643	K0644	K0645	K0646
K0647	K0648	K0649		

Added to the list of nonreportable procedures, **effective January 1, 2003:**

A5500	A5501	A5503	A5504	A5505
A5506	A5507	A5508	A5509	A5511
A9525	K0627	K0628	K0629	L0476
L0478	L0500	L0510	L0520	L0530
L0540	L0550	L0560	L0561	L0565
L0600	L0610	L0620	L0960	❖

Related Change Request (CR) Number: 3155
Related CR Release Date: March 19, 2004
Related CR Transmittal Number: 120
Effective Date: Various dates as described in the instruction
Implementation Date: April 5, 2004

Source: CMS Pub 100-4 Transmittal 120, CR 3155

ESRD SERVICES

Restoring Composite Rate Exceptions for Pediatric Facilities Under End-Stage Renal Disease Composite Rate System

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Pediatric end-stage renal disease (ESRD) facilities.

Provider Action Needed

STOP

If you meet the definition of a pediatric ESRD facility and do not have an approved exception rate, you may be able to request an exception between April 1, 2004, and September 27, 2004.

CAUTION

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) has revised the definition of a pediatric ESRD facility to mean a renal facility in which at least 50 percent of its patients are under 18 years of age.

GO

If you meet these criteria and do not have an approved exception to the composite payment rate, you can apply for one to your intermediary between April 1, 2004, and September 27, 2004.

Background

A hospital-based or independent pediatric renal dialysis facility may request the Centers for Medicare & Medicaid Services (CMS) to approve an exception to the composite payment rate and set a higher payment rate if:

- Your estimated allowable cost per treatment is higher than your composite rate; and
- If you meet the definition of a pediatric ESRD facility.

In accordance with MMA requirements, CMS has revised section 422(a)(2) of the Benefits Improvement and Protection Act of 2000 to:

(a) Provide that pediatric exception rates in effect on October 1, 2002 will continue in effect so long as the exception rate exceeds the facility's updated composite payment rate; and

(b) Restore the exceptions process for pediatric facilities only.

If you did not have an approved exception rate as of October 1, 2002, MMA Section 623(b)(1)(D) allows you to submit a request for a new exception to your intermediary between April 1, 2004, and September 27, 2004.

The MMA also revises the definition of a pediatric ESRD facility. The statute defines the term "pediatric facility" to mean a renal facility in which at least 50 percent of your patients are individuals under 18 years of age.

If you meet these criteria and project, on the basis of prior years cost and utilization trends, that you will have an allowable cost per treatment higher than your prospective rate, you may request CMS to approve an exception to that rate and set a higher payment rate.

CMS will adjudicate these exception requests in accordance with the exception criteria contained in 42 CFR 413.180 and the Provider Reimbursement Manual, Part I, Chapter 27. However, be aware that your pediatric exception request will be denied if:

- You do not adequately justify the request in accordance with regulations or program instructions; and/or
- Your intermediary does not receive your request before close of business on September 27, 2004.

An exception request is deemed approved unless CMS disapproves it within 60 working days after it is filed with the intermediary. The first day of this 60-working-day deadline is the date that the exception request, containing all of the required documentation, is filed with the intermediary. Therefore, you must send your request to the intermediary through a method that documents the date of receipt. A postmark or other similar date will not serve as documentation of the date of receipt.

Send your request to:

First Coast Service Options, Inc.
Attn: Murry L. McGowan
532 Riverside Avenue, – 16T
Jacksonville, FL 32202

Contact Telephone Number: 1-904-791-8683
Fax Number: 1-904-791-8441

Additional Information

Additional information is contained in the provider Reimbursement Manual Part I, sections 2720.0-2726.2; 42 CFR 413.180 and PRM, Part I, Chapter 27. To access Part I of the PRM, go to: *http://www.cms.hhs.gov/manuals/pub151/PUB_15_1.asp*

Also, to view the actual instruction issued to your intermediary on this change, visit: *http://www.cms.hhs.gov/manuals/pm_trans/R101CP.pdf*. ❖

Related Change Request (CR) Number: 3119
Related CR Release Date: February 20, 2004
Effective Date: March 1, 2004
Implementation Date: April 1, 2004
Related CR Transmittal Number: R101CP

Source: CMS Pub 100-4 Transmittal 101, CR 3119

Frequency Limitations for Darbepoetin Alfa (trade name Aranesp) for Treatment of Anemia in End-Stage Renal Disease Patients on Dialysis

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Renal Dialysis Facilities.

Provider Action Needed
STOP – Impact to You

Medicare is instituting new frequency limitations for treatment of ESRD patients on dialysis with darbepoetin alfa (trade name Aranesp®).

CAUTION – What You Need to Know

Be aware of these frequency limitations to assure correct and timely payment for services supplied to Medicare patients.

GO – What You Need to Do

Make sure you understand the changes effective for services provided on and after April 1, 2004, for the frequency limitations on darbepoetin alfa for ESRD.

Background

Section 1881(b) (11) (B) of the Social Security Act states that payment will be provided for erythropoietin when a patient diagnosis is ESRD. Darbepoetin alfa, a new erythropoietin-like product, differs from epoetin alfa by the addition of two carbohydrate chains, which lengthens the biologic half-life. This change affects how often the biological can be administered and results in a decreased dosing schedule for darbepoetin alfa by comparison to epoetin alfa.

Additional Information

This notice establishes frequency limitations for darbepoetin alfa, and also reiterates the frequency limitations for epoetin alfa (trade name EPO) will remain the same. You can refer back to CR2963 for the payment guidelines on darbepoetin alfa (trade name Aranesp®).

That CR may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R39OTN.pdf*.

Please note that this notice does not apply to physicians' payments for Aranesp or EPO; those payments are established in the drug payment limits pricing file, set by the Medicare Prescription Drug, Modernization, and Improvement Act of 2003.

According to its FDA-approved labeling, darbepoetin alfa is to be given once a week, up to a maximum of five times for a calendar month (30/31 days). Coverage rules for darbepoetin alfa are the same as epoetin alfa for ESRD-related anemia.

To view the actual change request related to this article (CR2984), go to: *http://www.cms.hhs.gov/manuals/pm_trans/R8BP.pdf*. ❖

Related Change Request (CR) Number: 2984
Related CR Release Date: March 5, 2004
Related CR Transmittal Number: 8
Effective Date: April 1, 2004
Implementation Date: April 5, 2004

Source: CMS Pub 100-4 Transmittal 118, CR 2984

New Requirements for End-Stage Renal Disease Drug Payments

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Providers caring for ESRD patients and billing Medicare for drugs in independent dialysis facilities.

Provider Action Needed

Providers should note that drugs not included in the composite rate that are furnished in independent dialysis facilities will be paid at the lower of billed charges or 95 percent average wholesale price (AWP). This went into effect with services provided on or after January 1, 2004.

Billing offices for such facilities should be aware of this and take appropriate steps to incorporate this change. **Please note that hospital based facilities are paid at cost.**

Background

New requirements have been established with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), PL 108-173, signed into law on December 8, 2003, for the payment of drugs furnished in independent dialysis facilities and paid outside of the composite rate.

See the Medicare Benefit Policy Manual, Chapter 11, for a description of drugs that are part of the composite rate and when other drugs may be covered. Section 30 of that chapter provides details on drugs included in the composite rate. To view this information, visit: *http://www.cms.hhs.gov/manuals/102_policy/bp102c11.pdf*.

Effective January 1, 2004, drugs furnished to ESRD patients in independent dialysis facilities and paid outside of the composite rate will be paid at the lower of billed charges or 95 percent AWP for the calendar year 2004.

Implementation

March 29, 2004.

Related Instructions

CMS Manual System, Publication 100-04, Claim Processing, Chapter 8, Section 60, Subsection 60.2/ Drugs Furnished in Dialysis Facilities, has been revised to include this new requirement. You may view this chapter by going to: *http://www.cms.hhs.gov/manuals/104_claims/clm104c08.pdf*

The actual CR released to the Medicare fiscal intermediaries may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R110CP.pdf*. ❖

Related Change Request (CR) #: 3078
Related CR Release Date: February 27, 2004
Effective Date: January 1, 2004
Implementation Date: March 29, 2004
Source: CMS Pub 100-4 Transmittal 110, CR 3078

LOCAL MEDICAL REVIEW POLICIES

In accordance with publications specified by CMS, Medicare contractors no longer distribute full-text local medical review policies (LMRPs)/local coverage determinations (LCDs) to providers in hardcopy format. Providers may obtain full-text LMRPs/LCDs from the provider education Web site *www.floridamedicare.com*. Final LMRPs/LCDs, draft LMRPs/LCDs available for comment, LMRP/LCD statuses, and LMRP/LCD comment/response summaries may be printed from the Part A section under Medical Policy (A).

This section of the *Medicare A Bulletin* features summaries of new and revised medical policies developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the fiscal intermediary's medical policies and review guidelines are consistent with accepted standards of medical practice.

Effective and Notice Dates

Effective dates are provided in each policy, and are based on the date services are furnished unless otherwise noted in the policy. Medicare contractors are required to offer a 45-day notice period for LMRPs/LCDs; the date the LMRP/LCD is posted to the provider education Web site is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new and revised LMRPs/LCDs are posted to the Web site, subscribe to the FCSO *eNews* mailing list. It is very easy to do; simply sign on to the provider education Web site, *http://www.floridamedicare.com*; click on the "Join our electronic mailing list FCSO *eNews*" bar and follow the prompts.

More Information

For more information, or to obtain a hardcopy of a specific LMRP/LCD if you do not have Internet access, contact the Medical Policy department at:

Medical Policy – 19T
First Coast Service Options, Inc.
P.O. Box 2078
Jacksonville, FL 32231-0048
or call 1-904-791-8465

Medical Policy Table of Contents

This Bulletin Should Be Shared with All Health Care Practitioners and Managerial Members of the Provider Staff. Bulletins Are Available at no Cost from Our Provider Education Web Site at *http://www.floridamedicare.com*.

NEW LMRP IMPLEMENTATION

Implementation of Local Coverage Determinations

The Benefit Improvement Protection Act (BIPA) section 522 created local coverage determinations (LCD) that consist only of reasonable and necessary information. LCDs will replace the local medical review policies (LMRP). First Coast Service Options, Inc. (FCSO) will be converting the existing LMRPs to LCDs over the next two years. The LCD format is similar to the LMRP format. The format changes will consist of section title changes and the deletion of some sections. Where deleted sections contain significant information, this will be incorporated into the "Indications and Limitation of Coverage and/or Medical Necessity" section of the LCD.

If there are "Coding or Billing Instructions," these will appear in a companion article entitled with the policy name/LCD title. At the end of the LCD under the section entitled "LCD Attachments," there will be a statement indicating whether or not there is a companion article for this LCD. If there is a companion article, the title will be given. On the provider education Web site, you will be able to click on the title of the companion document to view the corresponding guidelines. Please note that you can only access the coding instructions from the policy with which the guidelines correspond. ❖

Source: CMS Pub. 100-08, Transmittal 63, CR 3010

15822: Upper Eyelid and Brow Procedures—New Policy

The goal of functional or reconstructive surgery is to restore normalcy to a structure that has been altered by trauma, infection, inflammation, degeneration, neoplasia or developmental errors.
The local medical review policy is developed for upper eyelid and brow procedures to define the indications and limitations of coverage and to identify documentation required to support the medical necessity of the services rendered.

This policy is being published in the local coverage determination format.

Effective Date

This policy is effective for services furninshed **on or after July 6, 2004**. ❖

ALEFACEPT—New Policy

Psoriasis is a chronic immune-mediated disease of the skin affecting an estimated two percent of the population. It has been treated with topical, photo and systemic therapies. The topical therapies include tars, salicylic acid, corticosteroids, calcipotriene, tazarotene and anthralin. Phototherapies include UVB, psoralens plus UVA (PUVA), and more recently laser therapy for localized lesions. Systemic therapies include drugs such as methotrexate, cyclosporine, retinoids and an emerging class of biologic drugs including etanercept (Enbrel®) and now alefacept (manufactured by Biogen under the trade name-Amevive). Some of the therapies are used in combination so as to minimize toxicities while maximizing response, or as rotational therapy.

Alefacept is a human fusion protein directed at T-cells expressing the CD2 antigen, preventing lymphocyte activation. These lymphocytes are involved in the inflammatory process in psoriatic lesions. Alefacept is administered as an intramuscular injection of 15mg at weekly intervals, for a total of 12 consecutive weeks. Because alefacept may reduce circulating CD4+ and CD8+ T-lymphocytes, weekly CD4+ tests are required for monitoring while administering the drug. Alefacept has been approved by the FDA for treatment of adult patients with moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy.

Alefacept is billed using HCPCS codes J0215 and C9212 (Injection, alefacept, 0.5 mg). This local coverage determination (LCD) is being developed to allow providers access to this new therapy and to provide indications and limitations for this service.

Effective Date

This policy is effective for services furnished **on or after July 6, 2004**. ❖

BEXXAR: Tositumomab and Iodine I 131 Tositumomab (Bexxar®) Therapy—New Policy

The Bexxar® therapeutic regimen (tositumomab and iodine I 131 tositumomab) is an anti-neoplastic radioimmunotherapeutic monoclonal antibody-based regimen composed of the monoclonal antibody, tositumomab, and the radiolabeled monoclonal antibody, iodine I 131 tositumomab. The regimen is administered in two discrete steps: the dosimetric and therapeutic steps. Each step consists of a sequential infusion of tositumomab followed by iodine I 131 tositumomab. The therapeutic step is administered 7-14 days after the dosimetric step.

The Bexxar® therapeutic regimen is indicated for the treatment of patients with CD20 positive, follicular, non-Hodgkin's lymphoma, with and without transformation, whose disease is refractory to Rituximab and has relapsed following chemotherapy. It is not indicated for the initial treatment of patients with CD20 positive non-Hodgkin's lymphoma.

Full-text for these LMRPs/LCDs is available on the provider education Web site *http://www.floridamedicare.com*.

BEXXAR: Tositumomab and Iodine I 131 Tositumomab (Bexxar®) Therapy (continued)

The Bexxar® therapeutic regimen was FDA approved on June 27, 2003. Because this is a new treatment regimen, there is no utilization data available. This policy was developed to allow providers access to this new therapy, to define the indications and limitations of coverage for this therapy, and to provide appropriate coding guidelines for this therapy.

The following *CPT*/HCPCS codes are included in the LCD:

Dosimetric Step

C1080 G3001 *78804* *77300*

Therapeutic Step

C1081 G3001 *79403*

The following ICD-9-CM codes support medical necessity:

200.00-200.88 202.00-202.08 202.80-202.88

Effective Date

This policy is effective for services furnished **on or after July 6, 2004**. ❖

PULMDIAGSVCS: Pulmonary Diagnostic Services—New Policy

Procedure codes *94240*, *94260*, *94360*, *94370*, *94620*, *94720*, *94725*, and *94750* were chosen for a comprehensive data analysis for fiscal year 2003 based on the January through June 2001 data revealing a carrier to nation ratio of allowed dollars varying from 1.83 (94720 – monoxide diffusing capacity) to 6.12 (*94725 – membrane diffusion capacity*) with a maximum potential savings of $2,734,265.00. Based on the conclusions of the findings, the performance of the services was considered a widespread problem; therefore, a recommendation to perform a widespread probe and possibly develop a local coverage determination (LCD) was made. Two widespread probes were performed, encompassing a total of 201 claims from 37 providers for the time period from January 1, 2001, to June 30, 2001. The purpose of the reviews was to determine if the services billed to Medicare were documented as having been performed and to determine the medical conditions for which the services were being performed.

All of the submitted documentation for the reviews supported some type of pulmonary symptom and/or disease.

The following recommendations were made as a result of the widespread probe reviews:

- Develop a comprehensive LCD to define all pulmonary services, including indications and limitations, components of each test with the expected interpretive results, and the conditions that one would expect services to be repeated.
- Revise and incorporate the current policies related to pulmonary services (*94240*, *94620*, and *94010*, which includes *94360*) in the comprehensive pulmonary policy referenced above.

The following *CPT* codes are included in the LCD:

93720-93722	*94010*	*94060*	*94070*
94150	*94200*	*94240*	*94250*
94260	*94350*	*94360*	*94370*
94375	*94620*	*94621*	*94720*
94725	*94750*		

Effective Date

This policy is effective for services furnished **on or after July 6, 2004**. ❖

ADDITIONS/REVISIONS TO EXISTING LMRPS

43235: Diagnostic and Therapeutic Esophagogastroduodenoscopy—Addition to Policy

This local medical review policy was revised January 1, 2004. Since then, an ICD-9-CM code has been added to the policy.

This revision was based on a provider's request to consider adding ICD-9-CM code V12.71 (Personal history of peptic ulcer disease) as this indication was already stated in the policy. Therefore, ICD-9-CM V12.71 was added to the "ICD-9 Codes that Support Medical Necessity" section of the policy.

This policy has been changed to the local coverage determination (LCD) format.

Effective Date

This addition is effective for services processed **on or after April 1, 2004**. ❖

Full-text for these LMRPs/LCDs is available on the provider education Web site *http://www.floridamedicare.com*.

80100: Qualitative Drug Screen—Revision to Policy

The local medical review policy/local coverage determination for qualitative drug screen was last revised on February 17, 2003. Since that time, a revision to the policy has been made due to an internal request. ICD-9-CM 780.39 (other convulsions) has been added to the policy under "ICD-9 Codes that Support Medical Necessity." The addition of ICD-9-CM code 780.39 appropriately reflects one of the condition "seizures with an undetermined history", which is currently listed under the section "Indications and Limitations of Coverage and/or Medical Necessity."

Effective Date

These revisions are effective for services processed **on or after March 4, 2004**. ❖

92225: Ophthalmoscopy—Revision to Policy

The local medical review policy/local coverage determination for ophthalmoscopy was effective July 17, 2001. This policy has been updated and revised accordingly. Since then, this policy has been updated to include revisions to the following sections of the policy: "LMRP Description," "Coding Guidelines," "Documentation Requirements," and "Utilization Guidelines." "The Indications and Limitations" and "ICD-9 Codes that Support Medical Necessity" sections of the policy were expanded as well. The ICD-9-CM codes added include:

228.03	360.55	364.00-364.05
377.42	871.0-871.9	921.3

Effective Date

This addition is effective for services furnished **on or after May 1, 2004**. ❖

92135: Scanning Computerized Ophthalmic Diagnostic Imaging—Revision to Policy

The original local medical review policy for scanning computerized ophthalmic diagnostic imaging – 92135 was effective September 15, 2000. Since then, this policy has been updated to include revisions to the following sections: "LMRP Description," "Indications and Limitations," "Reasons for Denials," and "Utilization Guidelines." Additional ICD-9-CM codes were added to the "ICD-9 Codes that Support Medical Necessity" section.

Effective Date

The additional ICD-9-CM codes added to the policy are effective for services furnished **on or after April 23, 2003,** and processed **on or after May 1, 2004.** The remainder of the revisions is effective for services furnished **on or after March 29, 2004.** ❖

93501: Cardiac Catheterization—Revision to Policy

This local medical review policy (LMRP) was last revised effective October 1, 2002. Since that time, the indications and documentation requirements have been updated based on Program Memorandum, Transmittal No. A-02-129, dated January 3, 2001, and comments received during the comment period for this policy presented at the November 23, 2003, meeting.

Procedure codes G0275 and G0278 were added to the CPT/HCPCS section of the policy. Language has been added to the indications and documentation requirement section of the policy.

This policy has been changed to the local coverage determination (LCD) format.

Effective Date

These revisions are effective for services furnished **on or after July 6, 2004**. ❖

93724: Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator—Revision to Policy

This local medical review policy was last revised effective October 1, 2002. Since that time, the policy has been revised based on an inquiry from the manufacturer regarding the proper billing for the Web based surveillance of the pacing cardioverter-defibrillator system. It was determined that this service is identical to the face-to-face ICD interrogation without reprogramming service. Therefore, this policy was revised to add additional language and coding guidelines for the Web based modality.

Procedure codes *93741* and *93743* are already included in the policy and must be used rather than an unlisted code.

Effective Date

This revision is effective for services processed **on or after March 4, 2004**. ❖

93925: Duplex Scan of Lower Extremity Arteries—Addition to Policy

This local medical review policy was last revised effective October 1, 2002. Since then, this policy has been revised to include ICD-9-CM code 785.9 (other symptoms involving cardiovascular system) under the "ICD-9 Codes that Support Medical Necessity" section of the policy. This change was based on a request from a provider to add this ICD-9-CM code since it describes an indication that was already listed in the policy.

Effective Date

This addition is effective for services processed **on or after April 8, 2004**. ❖

Full-text for these LMRPs/LCDs is available on the provider education Web site *http://www.floridamedicare.com*.

95805: Sleep Testing—Revision to Policy

The local medical review policy/local coverage determination for sleep testing – 95805 was last updated on April 1, 2002. A revision to the policy was made changing the wording in the policy to clarify that documentation is not required to be submitted with the claim.

Under the "Documentation Requirements" section of the policy, references of "documentation maintained in the clinical record" were added to show that the provider of the service is not required to submit documentation with the claim. However, the documentation maintained in the clinical record must support the medical necessity of this test and support that the procedure billed was actually performed.

Effective Date

This addition is effective for services processed **on or after January 15, 2004**. ❖

97001: Physical Medicine and Rehabilitation—Revision to Policy

The local medical review policy for physical medicine and rehabilitation – 97001 was last revised on January 1, 2004. Since that time, language changes were made to the policy to reflect clarifications per CMS Change Request 2859 and 2779. These changes clarify the time period when a physician must evaluate the patient and corrects omission of nonphysician practitioners. The policy has also been converted to the local coverage decision (LCD) format.

Effective Date

This revision is effective for services processed **on or after February 11, 2004**. ❖

Botulinum Toxins (Formerly J0585 Botulinum Toxin Type A [Botox®] and J0587 Botulinum Toxin Type B [Myobloc®])—Revision to Policy

Botulinum toxins – botulinum toxin type A (Botox®) and botulinum toxin type B (Myobloc®) – are two of seven distinct immunologic serotypes produced by the anaerobic organism clostridium botulinum.

Botulinum toxin type A and botulinum toxin type B injections are used to treat various focal muscle spastic disorders and excessive muscle contractions such as dystonias, spasms, twitches, etc. When administered intramuscularly or subcutaneously, these toxins produce a presynaptic neuromuscular blockade by preventing the release of acetylcholine from the nerve endings. The resulting chemical-denervation of muscle produces local paresis or paralysis and allows individual muscles to be weakened selectively.

Policy has been developed to provide indications and limitations of coverage and clarify the appropriate use of botulinum toxins. The appropriate HCPCS codes used to report botulinum toxins are:

J0585	Botulinum toxin type, A per unit
J0587	Botulinum toxin type B, per 100 units

Effective Date

This revision is effective for services furnished **on or after July 6, 2004**. ❖

EPO: Epoetin alfa—Revision to Policy

The local medical review policy (LMRP) for epoetin alfa was last revised on January 5, 2004. Since then, the LMRP has been converted to the local coverage determination LCD format.

The LCD for epoetin alfa contains an indication for "reduction of allogeneic blood transfusion in surgery patients." Providers have been instructed to bill using ICD-9-CM codes E878.1 and E878.8 for this indication. It has come to our attention that these codes are not appropriate to bill as primary diagnosis codes; therefore, **effective July 6, 2004, providers are instructed to bill ICD-9-CM code V07.8 for this indication.** After this date, ICD-9-CM codes E878.1 and E878.8 will no longer be allowed for this indication.

Effective Date

This LCD revision is effective for services furnished **on or after July 6, 2004**. ❖

G0104: Colorectal Cancer Screening—Revision to Policy

The local medical review policy/local coverage determination for colorectal cancer screening – G0104 was last updated on January 1, 2004. A revision to the policy has been made as a result of CMS Transmittals 3, 5, and 52, Change Request 2996, dated December 19, 2003.

Effective for services furnished on or after January 1, 2004, payment may be made for an immunoassay-based fecal-occult blood test (FOBT, G0328) as an alternative to the guaiac-based FOBT, G0107. Medicare will pay for only one covered FOBT per year (either G0107 or G0328, but not both) for beneficiaries aged 50 and over. Code G0107 is for a guaiac-based test for peroxidase activity, in which the beneficiary takes samples from two different sites of three consecutive stools. Code G0328 is for an immunoassay test that includes the use of a spatula to collect the appropriate number of samples or the use of a special brush for the collection of samples, as determined by the individual manufacturer's instructions. A written order from the beneficiary's attending physician is required for either of these screening tests.

Full-text for this LMRPs/LCDs is available on the provider education Web site *http://www.floridamedicare.com*.

G0104: Colorectal Cancer Screening (continued)

A revision to the LMRP/LCD to reflect this additional coverage was made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy. Also, code G0328 was added under the "CPT/HCPCS Codes" section.

Effective Date

This addition is effective for services furnished **on or after January 1, 2004**. ❖

G0237: Respiratory Therapeutic Services—Revision to Policy

The local medical review policy/local coverage determination for respiratory therapeutic services – G0237 was last updated on January 5, 2004. Since that time, language changes were made to the Indications and Limitations of Coverage and/or Medical Necessity section, Coding Guidelines, and the Documentation Requirements sections of this policy. These language changes clarify the wording for the physician who is treating the patient for the pulmonary disease and to clarify the 30-day re-certification period.

Effective Date

The revision is effective for services furnished **on or after January 5, 2004**. ❖

J0207: Amifostine (Ethyol®)—Revision to Policy

The local medical review policy (LMRP) for amifostine was last revised on October 9, 2003. Since then, this LMRP has been converted to the local coverage determination (LCD) format.

The LCD for Amifostine contains ICD-9-CM code E933.1 to support nephrotoxicity, bone marrow toxicity, and/or neurotoxicity associated with Cisplatin and/or cyclophosphamide regimen. It has come to our attention that this code is not appropriate to bill as a primary code; therefore, **effective July 6, 2004, providers are instructed to bill ICD-9-CM code 995.2 for this indication.** After this date, ICD-9-CM code E933.1 will no longer be allowed for this indication.

Effective Date

This LCD revision is effective for services furnished **on or after July 6, 2004**. ❖

NESP: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])—Revision to Policy

The local medical review policy (LMRP) for darbepoetin alfa was last updated on January 1, 2004. Since then, the LMRP has been converted into the local coverage determination (LCD) format.

The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been updated to include the following:

- An indication for "anemia associated with malignancy." ICD-9-CM range 140.0-239.9 (Neoplasms) has been added to the "ICD-9 Codes that Support Medical Necessity" section of the LCD to support this indication.
- To initiate therapy with darbepoetin alfa, for indications other than ESRD on dialysis, the patient must have a documented anemia as evidenced by symptoms and a hematocrit (HCT) of less than 33 percent or a hemoglobin (HGB) less than 11 g/dL.

Effective Date

This LCD revision is effective for services furnished **on or after February 23, 2004**. ❖

RETIREMENT OF EXISTING LMRPS

93784: Ambulatory Blood Pressure Monitoring (ABPM)—Retired Policy

The local medical review policy/local coverage determination for ambulatory blood pressure monitoring has been retired. Based on instructions received from the Centers for Medicare & Medicaid Services (CMS), all local medical review policies (LMRPs) are to be converted into the local coverage decision (LCD) format. Since a national coverage determination (NCD) has been established for this policy by CMS, it has been determined that this policy does not conform to the LCD format. An NCD is a national policy statement granting, limiting, or excluding Medicare coverage for a specific test/procedure that supercedes any LMRPs/LCDs. Therefore, this policy is being retired accordingly. NCDs can be referenced on the CMS Web site at *http://www.cms.hhs.gov/mcd*.

Effective Date

The retirement of this policy is effective services furnished **on or after April 1, 2004**. ❖

Full-text for this LMRPs/LCDs is available on the provider education Web site *http://www.floridamedicare.com*.

94010: Spirometry—Retired Policy

The local medical review policy (LMRP) for spirometry – 94010 is being retired, effective for services furnished on or after July 5, 2004. This policy has been incorporated into the Pulmonary Diagnostic Services (PULMDIAGSVCS) LMRP/LCD. The full-text for the pulmonary diagnostic services may be found on the provider education Web site *www.floridamedicare.com*.

Effective Date

The retirement of this policy is effective for services furnished **on or after July 5, 2004**. ❖

94240: Functional Residual Capacity or Residual Volume—Retired Policy

The local medical review policy (LMRP) for functional residual capacity of residual volume – 94240 is being retired, effective for services furnished on or after July 5, 2004. This policy has been incorporated into the Pulmonary Diagnostic Services (PULMDIAGSVCS) LMRP/LCD. The full-text for the pulmonary diagnostic services may be found on the provider education Web site *www.floridamedicare.com*.

Effective Date

The retirement of this policy is effective for services furnished **on or after July 5, 2004**. ❖

94620: Pulmonary Stress Testing—Retired Policy

The local medical review policy (LMRP) for pulmonary stress testing – 94240 is being retired, effective for services furnished on or after July 5, 2004. This policy has been incorporated into the Pulmonary Diagnostic Services (PULMDIAGSVCS) LMRP/LCD. The full-text for the pulmonary diagnostic services may be found on the provider education Web site *www.floridamedicare.com*.

Effective Date

The retirement of this policy is effective for services furnished **on or after July 5, 2004**. ❖

ADDITIONAL INFORMATION ON LMRPS

Rho (D) Immune Globulin Intravenous

Rho (D) is an infusible biological used to address Rh incompatibilities in the perinatal period, along with other rare blood problems such as immune thrombocytopenic purpura (ITP). Rho (D) is billed using HCPCS code J2792 (Injection, rho D immune globulin, intravenous, human, solvent detergent, 100 I.U.). Recent data shows extraordinary utilization of IV rho (D) in Florida as 93 percent of the allowed dollars in the nation were paid to Florida providers. This article serves as a reminder of the "Indications and Limitations of Coverage and/or Medical Necessity" criteria identified in local medical review policy (LMRP) J2792 that was published in the June/July 2000 Florida *Medicare A Bulletin*. In addition, the LMRP is available on our provider education Web site, *http://www.floridamedicare.com*.

Specifically of concern is utilization of rho (D) in treatment of immune thrombocytopenic purpura (ITP). As noted in the LMRP (based on FDA approved indications), use of rho (D) may be indicated for treatment of ITP for non-splenectomized rho (D) positive patients in clinical situations requiring an increase platelet count to prevent excessive hemorrhage in children with acute or chronic ITP, adults with chronic ITP, and children or adults with ITP secondary to HIV infection. For the purpose of the policy, ITP is defined based on the following criteria: signs and symptoms of bleeding, a platelet count of less than 30,000/mm^3, rho (D) positive status and non-splenectomized status. The policy also stresses that all patients being treated with rho (D) for ITP should be monitored to determine the clinical response by assessing platelet counts, red blood cells, hemoglobin and reticulocyte counts. The FDA approved package insert was revised in 2000 to state that rho (D) positive ITP patients treated with rho (D) should be monitored for signs and symptoms of intravascular hemolysis, clinically compromising anemia and renal insufficiency based on higher rates of adverse effects in this patient population.

In addition, please note that the descriptor for procedure code J2792 is for 100 I.U. Therefore, if you are giving 300 I.U. of rho (D) then you would bill for three units of procedure code J2792. If you are giving 30,000 I.U. of rho (D) then you would bill for 300 units of procedure code J2792. Actual dosages should fall within the FDA recommended dosages. ❖

92235: Fluorescein Angiography—Correction

An article was published in the Second Quarter 2004 *Medicare A Bulletin* (page 48) indicating revisions to the local medical review policy for fluorescein angiography – 92235. Changes included revisions to the Coding Guidelines, Utilization Guidelines, and ICD-9 Codes that Support Medical Necessity sections of the policy.

The effective date published for these revisions was for services furnished on or after March 15, 2004. The correct effective date is for claims processed **on or after May 1, 2004,** for services furnished **on or after March 15, 2004.** ❖

Full-text for this LMRPs/LCDs is available on the provider education Web site *http://www.floridamedicare.com*.

WIDESPREAD MEDICAL REVIEW PROBES

Posteroanterior and Lateral Chest X-rays—Widespread Probe Review Referral

The Statistical and Medical Data Analysis department conducted an analysis of the Medicare Part A claim data for single-view posteroanterior (PA) and two-view (PA & lateral) chest X-ray services. First Coast Service Options, Inc. (FCSO) has reimbursed its providers approximately $3 million for these specific exams during January to June 2003.

FCSO's local medical review policy (LMRP), *A71010: Chest X-ray*, contains the indication and limitations of coverage as well as an extensive list of covered ICD-9-CM codes. The utilization of single-view (PA) chest X-rays demonstrates the billing of daily services for long periods of time as well as four, six, or eight services per day. Both of these scenarios appear to be in excess of standards of practice/current medical literature. For these reasons, a widespread probe of services will be performed to gain an understanding of this practice pattern. The medical review staff will apply the coverage criteria identified in the LMRP when performing the recommended widespread probe. This service-specific probe review generally will not exceed evaluating a total of 100 claims amassed by requesting three to four records from each billing provider. The purpose of the review is to determine:

- if the services billed to Medicare were documented as having been performed; and
- if the services were reasonable and necessary for the patient's condition.

The information obtained from the widespread probe will be evaluated in terms of the need to enhance the current LMRP. Additionally, opportunities for education may be identified. ❖

Inpatient Psychiatric Facility Services—Widespread Probe Review Referral

The Statistical and Medical Data Analysis department conducted an analysis of inpatient psychiatric facility services. First Coast Service Options, Inc. (FCSO) has reimbursed its thirteen stand-alone psychiatric hospitals and 36 distinct part units (DPUs) $57 million during January to June 2003. This payment exceeds the national average. While FCSO's average length of stay (LOS) per discharge was 11.75 days compared to the nation's 12 days, one-third of our providers have exceeded the national average LOS. In February 2002, the Centers for Medicare & Medicaid Services (CMS) clarified that fiscal intermediaries are responsible for performing medical review functions relative to inpatient rehabilitation services effective April 1, 2002. Based on all these findings, a widespread probe review has been recommended.

The Intermediary Manual, Part 3, Sections 3102-3105, contain CMS' interpretation of the inpatient psychiatric regulation. Effective October 1, 2003, CMS moved this information to the new online Medicare Benefit Policy Manual, Chapter Two, Sections 10-40, and Chapter Four, Sections 10-50. The medical review staff will apply these coverage criteria when performing the recommended widespread probe. This service-specific probe review generally will not exceed evaluating a total of 100 claims amassed by requesting two to three records from each billing provider. The purpose of the review is to determine:

- if the services billed to Medicare were documented as having been performed;
- if the services were reasonable and necessary for the patient's condition; and
- if coverage criteria for active treatment have been met.

The information obtained from the widespread probe will be evaluated in terms of the need to develop local medical review policy to further define national coverage.❖

SKILLED NURSING FACILITY SERVICES

Extend Coverage for Colorectal Cancer Screenings at Skilled Nursing Facilities

The Centers for Medicare & Medicaid Services (CMS) has extended coverage of various colorectal examinations, subject to certain frequency and payment limitations, performed in a skilled nursing facility (SNF). Initially, coverage was limited to hospital outpatient departments and critical access hospitals (CAHs) for test performed on or after January 1, 1998.

The extended coverage applies to the following tests used for colorectal cancer screenings in a SNF, effective for services furnished **on or after July 1, 2004.**

G0107	Fecal-occult blood test, 1-3 simultaneous determinations, (guaiac-based)
G0328	Fecal-occult blood test, 1-3 simultaneous determinations, (immunoassay-based
G0104	Flexible sigmoidoscopy
G0106	Barium enema examination; as an alternative to G0104

Frequency

Fecal-occult blood tests (G0107 and G0328) are covered at a frequency of once every 12 months for beneficiaries who have attained age 50. Medicare will allow either one covered G0328 or one covered G0107, but not both, during a 12-month period.

Flexible sigmoidoscopies (G0104) are covered at a frequency of once every 48 months for beneficiaries who have attained age 50. If during the course of a screening flexible sigmoidoscopy a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal should be billed and paid rather than code G0104.

Barium enema examination (G0106) is covered as an alternative to a screening sigmoidoscopy (code G0104) examination. The same frequency parameters specified in the law for screening flexible sigmoidoscopies apply.

Billing Guidelines

SNF providers should submit claims on Form CMS-1450 using types of bill 22x (SNF inpatient ancillary) or 23x (SNF outpatient). SNFs are reminded that preventative care services (including fecal occult blood tests) must be billed on a type of bill 22x using the coding instructions for Part B beneficiaries.

In addition, the SNF bills revenue codes and HCPCS codes as follows:

HCPCS Code	Screening Test/ Procedure	Revenue Code
G0107, G0328	Occult blood test	030x
G0106	Barium enema	032x
G0104	Flexible sigmoidoscopy	075x

Reimbursement Medthodology

Screening flexible sigmoidoscopy (code G0104) and screening barium enema (code G0106) will be reimbursed based on the Medicare physician fee schedule.

Screening fecal-occult blood tests (codes G0107 and G0328) will be reimbursed based on the clinical diagnostic laboratory fee schedule. ❖

Source: CMS Pub 100-4 Transmittal 80, CR 287

April 2004 Update to the Skilled Nursing Facility Consolidated Billing Provision

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the skilled nursing facility prospective payment system (SNF PPS). Services appearing on this list submitted on claims to both Medicare fiscal intermediaries (FIs) and carriers, including durable medical equipment regional carriers (DMERCs), will not be paid by Medicare to providers, other than a SNF, when **included** in SNF CB provision.

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical, occupational or speech language therapy services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay.

Services **excluded** from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB. This notification provides a list of the exclusions, and some inclusions, to SNF CB and is effective for services furnished **on or after April 1, 2004.**

The codes below are listed as being added or removed from the codes identified in the January 2004 annual update. (See Second Quarter 2004 *Medicare A Bulletin,* pages 27-31.)

April 2004 Update to the Skilled Nursing Facility Consolidated Billing Provision (continued)

Major Category I

Exclusion of Services Beyond the Scope of a SNF
Magnetic Resonance Imaging (MRI)

- Added *CPT* code *72198*

While this code can be submitted by critical access hospitals and hospitals not subject to OPPS, OPPS hospitals submit C8918 – C8920 instead. These alternate codes are already edited for SNF CB.

Angiography, Lymphatic, Venous and Related Procedures

- Added G0269
- Added G0275

Major Category V

Part B Services Included in SNF CB
Therapy services billed using revenues codes 42x (physical therapy), 43x (occupational therapy), 44x (speech-language pathology)

- Removed *CPT* code *92613**
- Removed *CPT* code *92615**
- Added *CPT* code *92597*
- Added *CPT 0020T*
- Added HCPCS G0295

* Editing of these codes as consolidated billing inclusions will end effective with this instruction since they are physician procedures.

Correct Revenue Codes for Epoetin Alfa and Darbepoetin Alfa

Epoetin alfa (Epogen®) and darbepoetin alfa (Aranesp®) are Medicare approved for use by end stage renal disease (ESRD) beneficiaries. Epoetin alfa claims for ESRD beneficiaries are identified with the following revenue codes when services are provided in a renal dialysis facility (RDF):

- 634 – (EPO with less than 10,000 units
- 635 – EPO with 10,000 or greater units.

Do not use revenue code 636 to bill epoetin alfa on RDF claims.

The newly covered drug darbepoetin alfa is always billed in revenue code 636 exclusively using HCPCS code Q4054. ❖

Source: CMS Pub 100-4 Transmittal 92, CR 3070

Additional Information in Medicare Summary Notices to Beneficiaries about Skilled Nursing Facility Benefits

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article..

Provider Types Affected

Skilled nursing facilities

Provider Action Needed

Providers should note that Medicare summary notices (MSNs) sent to Medicare beneficiaries on a monthly basis will now include the number of days remaining under the beneficiaries Part A benefit for a skilled nursing facility (SNF).

This is informational only and CMS is announcing this to providers in the event they receive questions from their patients regarding the addition of this information to the MSN.

Background

The Medicare summary notice (MSN) is mailed on a monthly basis to Medicare beneficiaries when a claim is processed. For a given spell of illness, beneficiaries do not currently receive information on their MSNs regarding the number of days remaining under their Part A benefit for a skilled nursing facility (SNF).

However, the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires MSNs to report on the number of days remaining in a Part A spell of illness for SNF beneficiaries. Therefore, new MSN messages sent to beneficiaries on or after July 6, 2004, will report the number of days remaining of the 100 days available under their SNF Part A benefit for a given spell of illness.

Also, information reported on MSNs is only as accurate as claims received and processed as of the date the MSN is generated. Therefore, if a SNF does not bill timely, or there is a delay in processing claims, information on days remaining in the spell may not be completely up to date.

Implementation

July 6, 2004.

Additional Information

The following Medicare Web site includes an example of a MSN: *http://www.medicare.gov/basics/summarynotice_howtoread.asp*

Related Change Request (CR) Number: 3098
Medlearn Matters Number: MM3098
Related CR Release Date: February 6, 2004
Related CR Transmittal Number: R94CP
Effective Date: July 1, 2004 for MSNs generated on or after that date.
Implementation Date: July 6, 2004. ❖

Source: CMS Pub 100-4 Transmittal 94, CR 3098

Skilled Nursing Facility Prospective Payment System Non-Payable Services

As part of the implementing legislation for skilled nursing facility (SNF) prospective payment system (PPS), the Balanced Budget Act of 1997 requires that all Part B services provided to SNF residents be paid on any existing fee schedule. Additionally, there are certain medical and other health services for which payment may not be made to SNFs. The Centers for Medicare & Medicaid Services (CMS) provides the fiscal intermediaries annually with a HCPCS code file for services not payable in a SNF. Quarterly updates are issued as necessary.

CMS has releasing a corrected file for services furnished on or April 1, 2004.

Skilled Nursing Facility No Pay Services

0001F	00174	00630	00914	01400	01782	11044	20526	38204
0002F	00176	00632	00916	01402	01810	11055	20551	38207
0003F	00190	00634	00918	01404	01820	11056	20552	38208
0004F	00192	00635	00920	01420	01830	11057	20553	38209
0005F	00210	00670	00922	01430	01832	11200	20974	38210
0006F	00212	00700	00924	01432	01840	11201	21084	38211
0007F	00214	00702	00926	01440	01842	11300	21085	38212
0008F	00215	00730	00928	01442	01844	11305	21497	38213
0009F	00216	00740	00930	01444	01850	11400	26010	38214
0010F	00218	00750	00932	01462	01852	11719	29058	38215
0011F	00220	00752	00934	01464	01860	11720	29355	44500
0001T	00222	00754	00936	01470	01904	11721	29358	47133
0002T	00300	00756	00938	01472	01905	11730	29425	48160
0003T	00320	00770	00940	01474	01906	11740	29435	48550
0005T	00322	00790	00942	01480	01908	11900	29440	48554
0006T	00350	00792	00944	01482	01910	11901	29450	50300
0007T	00352	00794	00946	01484	01912	11920	29700	51725
0008T	00400	00796	00948	01486	01914	11921	29705	51726
0009T	00402	00797	00950	01490	01916	11922	29710	51736
0010T	00404	00800	00952	01500	01918	11950	29715	51741
0012T	00406	00802	00955	01502	01920	11951	29720	51772
0013T	00410	00810	01112	01520	01921	11952	29730	51784
0014T	00450	00820	01120	01522	01922	11954	29740	51785
0016T	00452	00830	01130	01610	01924	11975	29750	51792
0017T	00454	00832	01140	01620	01925	11976	29799	51795
0018T	00470	00840	01150	01622	01926	11977	30300	51797
0019T	00472	00842	01160	01630	01930	12001	30901	53600
0021T	00474	00844	01170	01632	01931	12004	31720	53660
0023T	00500	00846	01173	01634	01932	12005	31725	53670
0024T	00520	00848	01180	01636	01933	15780	31730	53675
0025T	00522	00850	01190	01638	01951	15781	32850	54150
0026T	00524	00851	01200	01650	01952	15783	33930	54235
0029T	00528	00855	01202	01652	01953	15786	33940	54240
0030T	00529	00857	01210	01654	01960	15787	36000	54250
0031T	00530	00860	01212	01656	01961	15788	36002	55870
00100	00532	00862	01214	01670	01962	15789	36140	55970
00102	00534	00864	01215	01680	01963	15792	36400	55980
00103	00537	00865	01220	01682	01964	15793	36405	57160
00104	00540	00866	01230	01710	01967	15810	36406	57170
00120	00542	00868	01232	01712	01968	15811	36415	58300
00124	00544	00869	01234	01714	01969	16000	36430	58301
00126	00546	00870	01250	01716	01990	16020	36440	58321
00140	00548	00872	01260	01730	01995	17000	36450	58323
00142	00550	00873	01270	01732	01996	17003	36455	59020
00144	00560	00880	01272	01740	01999	17004	36468	59025
00145	00562	00882	01274	01742	10040	17110	36469	59425
00147	00563	00884	01320	01744	10060	17111	36470	59426
00148	00566	00902	01340	01756	10080	17250	36471	59430
00160	00580	00904	01360	01758	10120	17340	36597	62367
00162	00600	00906	01380	01760	11040	17360	36600	62368
00164	00604	00908	01382	01770	11041	17380	36620	63043
00170	00620	00910	01390	01772	11042	17999	36680	63044
00172	00622	00912	01392	01780	11043	20000	36800	65205

Skilled Nursing Facility No Pay Services (continued)

65760	89105	90875	92355	93018	95170	99080	99281	99387
65765	89130	90876	92358	93025	95180	99082	99282	99391
65771	89132	90880	92370	93040	95199	99090	99283	99392
69000	89135	90882	92371	93042	95830	99091	99284	99393
69090	89136	90885	92390	93224	95857	99100	99285	99394
69210	89140	90887	92391	93227	95857	99116	99288	99395
69710	89141	90889	92392	93230	95970	99135	99289	99396
72159	90283	90899	92393	93233	95971	99140	99290	99397
73225	90287	90918	92395	93235	95972	99141	99291	99401
75556	90288	90919	92396	93237	95973	99142	99292	99402
75953	90291	90920	92502	93268	95974	99170	99295	99403
76006	90379	90921	92504	93272	95975	99172	99296	99404
76070	90384	90922	92510	93313	95991	99173	99297	99411
76140	90386	90923	92511	93316	96004	99183	99298	99412
76390	90389	90924	92512	93536	96100	99190	99299	99420
76393	90399	90925	92516	93607	96117	99191	99301	99429
78351	90471	90935	92520	93650	96150	99192	99302	99431
78459	90472	90937	92525	93651	96151	99199	99303	99432
78491	90474	90939	92531	93652	96152	99201	99311	99433
78492	90669	90940	92532	93668	96153	99202	99312	99435
78608	90723	90945	92533	93720	96154	99203	99313	99436
78609	90799	90947	92534	93722	96155	99204	99315	99440
78810	90801	90989	92551	93727	96400	99205	99316	99450
78990	90802	90993	92559	93740	96549	99211	99321	99455
80103	90804	90997	92560	93760	96570	99212	99322	99456
80500	90805	90999	92590	93762	96571	99213	99323	99499
80502	90806	91100	92591	93770	96902	99214	99331	99500
85060	90807	91105	92592	93784	96999	99215	99332	99501
85095	90808	92002	92593	93790	97005	99217	99333	99502
85097	90809	92004	92594	93797	97006	99218	99341	99503
85102	90810	92012	92613	93798	97010	99219	99342	99504
86077	90811	92014	92615	94014	97770	99220	99343	99505
86078	90812	92015	92595	94016	97780	99221	99344	99506
86079	90813	92018	92950	94150	97781	99222	99345	99507
86485	90814	92019	92953	94640	97802	99223	99347	99508
86586	90815	92020	92960	94656	97803	99231	99348	99509
86910	90816	92070	92961	94657	97804	99232	99349	99510
86911	90817	92100	92970	94660	98925	99233	99350	99511
88000	90818	92120	92971	94662	98926	99234	99354	99512
88005	90819	92130	92973	94664	98927	99235	99355	99539
88007	90821	92140	92974	94667	98928	99236	99356	99551
88012	90822	92225	92975	94668	98929	99238	99357	99552
88014	90823	92226	92977	94760	98940	99239	99358	99553
88016	90824	92230	92980	94761	98941	99241	99359	99554
88020	90826	92260	92981	95010	98942	99242	99360	99555
88025	90827	92287	92982	95015	98943	99243	99361	99556
88027	90828	92310	92984	95075	99000	99244	99362	99557
88028	90829	92311	92986	95120	99001	99245	99371	99558
88029	90842	92312	92987	95125	99002	99251	99372	99559
88036	90843	92314	92990	95130	99024	99252	99373	99560
88037	90844	92315	92992	95131	99025	99253	99374	99561
88040	90845	92316	92993	95132	99026	99254	99377	99562
88045	90846	92317	92995	95133	99050	99255	99378	99563
88099	90847	92330	92996	95134	99052	99261	99379	99564
88141	90849	92335	92997	95144	99054	99262	99380	99565
88291	90853	92340	92998	95145	99056	99263	99381	99566
88299	90857	92341	93000	95146	99058	99271	99382	99567
88321	90862	92342	93010	95147	99070	99272	99383	99568
88325	90865	92352	93014	95148	99071	99273	99384	99569
88329	90870	92353	93015	95149	99075	99274	99385	99600
89100	90871	92354	93016	95165	99078	99275	99386	99601

Skilled Nursing Facility No Pay Services (continued)

99602	A4557	A4721	A7004	B4220	C9103	E0169	E0273	E0562
A0420	A4558	A4722	A7005	B4222	C9105	E0175	E0274	E0565
A0422	A4570	A4723	A7006	B4224	C9109	E0176	E0275	E0570
A0424	A4575	A4724	A7007	B5000	C9111	E0177	E0276	E0571
A0888	A4580	A4725	A7008	B5100	C9112	E0178	E0277	E0572
A0999	A4590	A4726	A7009	B5200	C9113	E0179	E0280	E0574
A4206	A4595	A4728	A7010	B9000	C9116	E0180	E0290	E0575
A4207	A4608	A4730	A7011	B9002	C9119	E0181	E0291	E0580
A4208	A4611	A4735	A7012	B9004	C9120	E0182	E0292	E0585
A4209	A4612	A4736	A7013	B9006	C9121	E0184	E0293	E0590
A4210	A4613	A4737	A7014	B9098	C9123	E0185	E0294	E0600
A4211	A4614	A4740	A7015	B9099	C9200	E0186	E0295	E0601
A4213	A4615	A4750	A7016	B9998	C9201	E0187	E0296	E0602
A4215	A4616	A4755	A7017	B9999	C9202	E0188	E0297	E0603
A4216	A4617	A4760	A7018	C1010	C9203	E0189	E0298	E0604
A4217	A4618	A4765	A7019	C1011	C9204	E0191	E0300	E0605
A4220	A4619	A4766	A7020	C1015	C9205	E0192	E0301	E0606
A4221	A4620	A4770	A7046	C1016	C9208	E0193	E0302	E0607
A4222	A4621	A4771	A7501	C1017	C9209	E0194	E0303	E0608
A4230	A4622	A4772	A9280	C1018	C9503	E0196	E0304	E0609
A4231	A4624	A4773	A9150	C1020	C9701	E0197	E0305	E0610
A4232	A4625	A4774	A9160	C1021	C0703	E0198	E0310	E0615
A4244	A4626	A4780	A9170	C1022	C9708	E0199	E0315	E0616
A4245	A4627	A4790	A9190	C1079	C9711	E0200	E0316	E0617
A4246	A4628	A4800	A9270	C1088	E0100	E0202	E0325	E0620
A4247	A4630	A4801	A9280	C1091	E0105	E0205	E0326	E0621
A4248	A4631	A4802	A9300	C1092	E0110	E0210	E0350	E0625
A4250	A4632	A4820	A9999	C1122	E0111	E0215	E0352	E0627
A4253	A4635	A4850	A9517	C1166	E0112	E0217	E0370	E0628
A4254	A4636	A4860	A9518	C1167	E0113	E0218	E0371	E0629
A4255	A4637	A4870	A9900	C1178	E0114	E0220	E0372	E0630
A4256	A4638	A4880	A9901	C1200	E0116	E0221	E0373	E0635
A4257	A4640	A4890	B4034	C1201	E0118	E0225	E0424	E0637
A4258	A4647	A4900	B4035	C1207	E0130	E0230	E0425	E0638
A4259	A4649	A4901	B4036	C1300	E0135	E0231	E0430	E0650
A4260	A4650	A4905	B4081	C1305	E0140	E0232	E0431	E0651
A4261	A4651	A4910	B4082	C1716	E0141	E0235	E0434	E0652
A4262	A4652	A4911	B4083	C1718	E0142	E0236	E0435	E0655
A4265	A4653	A4912	B4084	C1719	E0143	E0238	E0439	E0660
A4270	A4655	A4913	B4085	C1720	E0144	E0239	E0440	E0665
A4301	A4656	A4914	B4086	C1765	E0145	E0240	E0441	E0666
A4305	A4657	A4918	B4150	C1774	E0146	E0241	E0442	E0667
A4306	A4660	A4919	B4151	C1775	E0147	E0242	E0443	E0668
A4335	A4663	A4920	B4152	C1783	E0148	E0243	E0444	E0669
A4360	A4670	A4921	B4153	C1814	E0149	E0244	E0450	E0671
A4370	A4671	A4927	B4154	C1818	E0153	E0245	E0455	E0672
A4380	A4672	A4928	B4155	C1884	E0154	E0246	E0457	E0673
A4390	A4673	A4929	B4156	C1888	E0155	E0247	E0459	E0675
A4421	A4674	A4930	B4164	C1900	E0156	E0248	E0460	E0690
A4464	A4680	A4931	B4168	C2614	E0157	E0249	E0462	E0700
A4465	A4690	A5064	B4172	C2616	E0158	E0250	E0470	E0710
A4470	A4700	A5074	B4176	C2618	E0159	E0251	E0471	E0720
A4480	A4705	A5075	B4178	C2632	E0160	E0255	E0472	E0730
A4490	A4706	A5508	B4180	C9000	E0161	E0256	E0480	E0731
A4495	A4707	A6000	B4184	C9003	E0162	E0260	E0481	E0740
A4500	A4708	A6025	B4186	C9007	E0163	E0261	E0482	E0744
A4510	A4709	A6260	B4189	C9008	E0164	E0265	E0500	E0745
A4538	A4712	A7000	B4193	C9009	E0165	E0266	E0550	E0746
A4550	A4714	A7001	B4197	C9010	E0166	E0270	E0555	E0747
A4554	A4719	A7002	B4199	C9013	E0167	E0271	E0560	E0748
A4556	A4720	A7003	B4216	C9102	E0168	E0272	E0561	E0749

Skilled Nursing Facility No Pay Services (continued)

E0752	E0972	E1110	E1575	E2331	G0174	G0315	J0510	J1060
E0753	E0973	E1130	E1580	E2340	G0175	G0316	J0515	J1070
E0754	E0974	E1140	E1590	E2341	G0176	G0317	J0520	J1080
E0755	E0975	E1150	E1592	E2342	G0177	G0318	J0530	J1090
E0759	E0976	E1160	E1594	E2343	G0178	G0319	J0540	J1095
E0760	E0977	E1170	E1600	E2351	G0179	G0320	J0550	J1100
E0765	E0978	E1171	E1610	E2360	G0180	G0321	J0560	J1110
E0776	E0979	E1172	E1615	E2361	G0181	G0322	J0570	J1120
E0779	E0980	E1180	E1620	E2362	G0182	G0323	J0580	J1160
E0780	E0981	E1190	E1625	E2363	G0184	G0324	J0583	J1165
E0781	E0982	E1195	E1630	E2364	G0185	G0325	J0585	J1170
E0782	E0983	E1200	E1632	E2365	G0186	G0326	J0587	J1180
E0783	E0984	E1210	E1634	E2366	G0187	G0327	J0590	J1190
E0784	E0985	E1211	E1635	E2367	G0192	G9001	J0595	J1200
E0785	E0986	E1212	E1636	E2399	G0236	G9002	J0600	J1205
E0786	E0990	E1213	E1637	E2402	G0237	G9003	J0610	J1212
E0791	E0991	E1220	E1638	E2500	G0238	G9004	J0620	J1230
E0830	E0992	E1221	E1639	E2502	G0239	G9005	J0630	J1240
E0840	E0993	E1222	E1640	E2504	G0240	G9006	J0635	J1250
E0850	E0994	E1223	E1699	E2506	G0241	G9007	J0640	J1260
E0855	E0995	E1224	E1700	E2508	G0244	G9008	J0670	J1270
E0860	E0996	E1225	E1701	E2510	G0247	G9009	J0690	J1320
E0870	E0997	E1226	E1702	E2511	G0248	G9010	J0692	J1325
E0880	E0998	E1227	E1800	E2512	G0249	G9011	J0694	J1327
E0890	E0999	E1228	E1801	E2599	G0250	G9012	J0695	J1330
E0900	E1000	E1230	E1805	G0002	G0251	G9016	J0696	J1335
E0910	E1001	E1240	E1806	G0004	G0252	J0120	J0697	J1362
E0920	E1002	E1250	E1810	G0007	G0253	J0130	J0698	J1364
E0930	E1003	E1260	E1811	G0016	G0254	J0151	J0702	J1380
E0935	E1004	E1270	E1815	G0026	G0255	J0152	J0704	J1390
E0940	E1005	E1280	E1816	G0027	G0256	J0170	J0706	J1410
E0941	E1006	E1285	E1820	G0104	G0257	J0190	J0710	J1435
E0942	E1007	E1290	E1821	G0105	G0258	J0200	J0713	J1436
E0943	E1008	E1295	E1825	G0108	G0259	J0205	J0715	J1438
E0944	E1009	E1296	E1830	G0109	G0260	J0207	J0720	J1440
E0945	E1010	E1297	E1840	G0110	G0261	J0210	J0725	J1441
E0946	E1019	E1298	E1900	G0111	G0270	J0215	J0730	J1450
E0947	E1021	E1300	E1902	G0112	G0271	J0256	J0735	J1452
E0948	E1028	E1310	E2000	G0113	G0278	J0270	J0740	J1455
E0950	E1029	E1340	E2001	G0114	G0282	J0275	J0743	J1460
E0951	E1030	E1353	E2101	G0115	G0289	J0280	J0744	J1470
E0952	E1031	E1355	E2120	G0116	G0290	J0282	J0745	J1480
E0953	E1035	E1372	E2201	G0121	G0291	J0285	J0760	J1490
E0954	E1050	E1390	E2202	G0122	G0292	J0286	J0770	J1500
E0955	E1060	E1391	E2203	G0126	G0293	J0290	J0780	J1510
E0956	E1065	E1399	E2204	G0127	G0294	J0295	J0800	J1520
E0957	E1066	E1400	E2300	G0128	G0297	J0300	J0810	J1530
E0958	E1069	E1401	E2301	G0129	G0298	J0330	J0835	J1540
E0959	E1070	E1402	E2310	G0141	G0299	J0340	J0850	J1550
E0960	E1083	E1403	E2311	G0151	G0300	J0350	J0880	J1560
E0961	E1084	E1404	E2320	G0152	G0302	J0360	J0895	J1561
E0962	E1085	E1405	E2321	G0153	G0303	J0380	J0900	J1563
E0963	E1086	E1406	E2322	G0154	G0304	J0390	J0945	J1565
E0964	E1087	E1500	E2323	G0155	G0305	J0395	J0970	J1570
E0965	E1088	E1510	E2324	G0156	G0308	J0400	J1000	J1580
E0966	E1089	E1520	E2325	G0163	G0309	J0456	J1020	J1590
E0967	E1090	E1530	E2326	G0164	G0310	J0460	J1030	J1595
E0968	E1091	E1540	E2327	G0165	G0311	J0470	J1040	J1600
E0969	E1092	E1550	E2328	G0166	G0312	J0475	J1050	J1610
E0970	E1093	E1560	E2329	G0167	G0313	J0476	J1055	J1620
E0971	E1100	E1570	E2330	G0168	G0314	J0500	J1056	J1626

Skilled Nursing Facility No Pay Services (continued)

J1630	J2280	J2940	J7060	K0007	K0068	K0179	K0546	L3213
J1631	J2300	J2941	J7070	K0008	K0069	K0180	K0547	L3214
J1642	J2310	J2950	J7100	K0009	K0070	K0181	K0548	L3215
J1644	J2320	J2970	J7110	K0010	K0071	K0183	K0549	L3216
J1645	J2321	J2993	J7120	K0011	K0072	K0184	K0550	L3217
J1650	J2322	J2995	J7130	K0012	K0073	K0185	K0551	L3218
J1655	J2330	J2997	J7140	K0013	K0074	K0186	K0552	L3219
J1670	J2350	J3000	J7150	K0014	K0075	K0187	K0560	L3221
J1690	J2352	J3010	J7300	K0015	K0076	K0188	K0600	L3222
J1700	J2355	J3030	J7302	K0016	K0077	K0189	K0601	L3223
J1710	J2353	J3070	J7303	K0017	K0078	K0190	K0602	L3230
J1720	J2354	J3080	J7308	K0018	K0079	K0191	K0603	L3250
J1730	J2360	J3100	J7310	K0019	K0080	K0192	K0604	L3251
J1739	J2370	J3105	J7315	K0020	K0081	K0195	K0605	L3252
J1741	J2400	J3120	J7316	K0021	K0082	K0268	K0606	L3253
J1742	J2405	J3130	J7320	K0022	K0083	K0277	K0607	L3254
J1745	J2410	J3140	J7330	K0023	K0084	K0284	K0608	L3255
J1750	J2430	J3150	J7515	K0024	K0085	K0401	K0609	L3257
J1755	J2440	J3230	J7516	K0025	K0086	K0417	K0610	L3260
J1760	J2460	J3240	J7520	K0026	K0087	K0452	K0611	L3265
J1770	J2480	J3245	J7526	K0027	K0088	K0455	K0612	L3300
J1780	J2500	J3250	J7599	K0028	K0089	K0460	K0613	L3310
J1785	J2505	J3260	J7608	K0029	K0090	K0461	K0614	L3320
J1790	J2510	J3265	J7618	K0030	K0091	K0462	K0615	L3330
J1800	J2512	J3270	J7619	K0031	K0092	K0503	K0616	L3332
J1810	J2515	J3280	J7621	K0032	K0093	K0504	K0617	L3334
J1820	J2540	J3301	J7622	K0033	K0094	K0505	K0618	L3340
J1825	J2543	J3302	J7624	K0034	K0095	K0506	K0619	L3350
J1830	J2545	J3303	J7628	K0035	K0096	K0507	L2102	L3360
J1835	J2550	J3305	J7629	K0036	K0097	K0508	L2104	L3370
J1840	J2560	J3310	J7631	K0037	K0098	K0509	L2122	L3380
J1850	J2590	J3320	J7635	K0038	K0099	K0511	L2124	L3390
J1885	J2597	J3350	J7636	K0039	K0100	K0512	L3000	L3400
J1890	J2640	J3360	J7637	K0040	K0101	K0513	L3001	L3410
J1910	J2650	J3364	J7638	K0041	K0102	K0514	L3002	L3420
J1930	J2670	J3365	J7639	K0042	K0103	K0515	L3003	L3430
J1940	J2675	J3370	J7641	K0043	K0104	K0516	L3010	L3440
J1950	J2680	J3390	J7642	K0044	K0105	K0518	L3020	L3450
J1955	J2690	J3400	J7643	K0045	K0106	K0519	L3030	L3455
J1956	J2700	J3410	J7644	K0046	K0107	K0520	L3031	L3460
J1960	J2710	J3411	J7648	K0047	K0108	K0521	L3040	L3465
J1970	J2720	J3415	J7649	K0048	K0112	K0522	L3050	L3470
J1980	J2725	J3420	J7658	K0049	K0113	K0523	L3060	L3480
J1990	J2730	J3430	J7659	K0050	K0114	K0524	L3070	L3485
J2000	J2760	J3450	J7668	K0051	K0115	K0525	L3080	L3500
J2001	J2765	J3465	J7669	K0052	K0116	K0526	L3090	L3510
J2010	J2770	J3470	J7680	K0053	K0119	K0527	L3100	L3520
J2020	J2780	J3475	J7681	K0054	K0120	K0528	L3140	L3530
J2050	J2783	J3480	J7682	K0055	K0121	K0530	L3150	L3540
J2060	J2790	J3485	J7683	K0056	K0122	K0531	L3160	L5400
J2150	J2792	J3486	J7684	K0057	K0168	K0532	L3170	L5410
J2175	J2795	J3490	J7699	K0058	K0169	K0533	L3201	L5420
J2180	J2800	J3520	J7799	K0059	K0170	K0534	L3202	L5430
J2185	J2810	J3530	J8499	K0060	K0171	K0538	L3203	L5450
J2210	J2820	J3535	J9098	K0061	K0172	K0539	L3204	L5460
J2240	J2860	J3570	K0001	K0062	K0173	K0540	L3206	L7499
J2250	J2910	J7030	K0002	K0063	K0174	K0541	L3207	L8100
J2260	J2912	J7040	K0003	K0064	K0175	K0542	L3208	L8130
J2270	J2915	J7042	K0004	K0065	K0176	K0543	L3209	L8140
J2271	J2920	J7050	K0005	K0066	K0177	K0544	L3211	L8150
J2275	J2930	J7051	K0006	K0067	K0178	K0545	L3212	L8160

Skilled Nursing Facility No Pay Services (continued)

L8170	Q0132	Q2015	Q3022	Q9934	V2555	V2615	V5110
L8180	Q0144	Q2016	Q3023	Q9935	V2556	V2629	V5120
L8190	Q0183	Q2017	Q4052	Q9936	V2557	V2630	V5130
L8195	Q0184	Q2018	Q4053	Q9937	V2558	V2631	V5140
L8200	Q0185	Q2019	Q4054	Q9938	V2559	V2632	V5150
L8210	Q1001	Q2020	Q4055	Q9939	V2560	V2756	V5160
L8220	Q1002	Q2021	Q4075	Q9940	V2561	V2781	V5170
L8230	Q1003	Q3001	Q4076	R0076	V2562	V2785	V5180
M0064	Q1004	Q3002	Q4077	V2020	V2563	V2790	V5190
M0075	Q1005	Q3003	Q4078	V2025	V2564	V2797	V5200
M0076	Q2001	Q3004	Q9920	V2541	V2565	V2799	V5210
M0100	Q2002	Q3005	Q9921	V2542	V2566	V5008	V5220
M0300	Q2003	Q3006	Q9922	V2543	V2567	V5010	V5230
M0301	Q2004	Q3007	Q9923	V2544	V2568	V5011	V5240
M0302	Q2005	Q3008	Q9924	V2545	V2569	V5014	V5336
P2028	Q2006	Q3009	Q9925	V2546	V2570	V5020	C0001 – C9999
P2029	Q2007	Q3010	Q9926	V2547	V2571	V5030	D0001 – D9999
P2031	Q2008	Q3011	Q9927	V2548	V2572	V5040	I0001 – I9999
P2033	Q2009	Q3012	Q9928	V2549	V2573	V5050	S0001 – S9999 ❖
P2038	Q2010	Q3013	Q9929	V2550	V2574	V5060	
P3001	Q2011	Q3014	Q9930	V2551	V2575	V5070	
P7001	Q2012	Q3015	Q9931	V2552	V2599	V5080	
P9612	Q2013	Q3016	Q9932	V2553	V2600	V5090	
Q0081	Q2014	Q3021	Q9933	V2554	V2610	V5100	

Source: CMS Pub. 100-4 Transmittal 143, CR 3238

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

April 2004 Outpatient Code Editor Specifications Version 5.1 Used in OPPS

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals and other providers paid under the outpatient prospective payment system (OPPS).

Provider Action Needed

Affected hospitals and providers should note that instructions and specifications have been issued for the January 2004 revision of the outpatient code editor (OCE) version 5.0 as well as changes incorporated in the April 2004 OCE version 5.1. This OCE is used in the OPPS claims payment processes.

Background

This CR, released by the Centers for Medicare & Medicaid Services (CMS), provides revised OCE instructions and specifications that will be utilized under the for:

- Hospital outpatient departments
- Community mental health centers (CMHCs)
- Limited services as defined in CR 3170, when provided:
  - In a comprehensive outpatient rehabilitation facility (CORF);
  - In a home health agency (HHA) not under home health PPS; or
  - To a hospice patient for the treatment of a non-terminal illness.

This revised version of the OCE represents a significant change because it will process claims consisting of multiple days of services. The April 2004 OCE specifications version 5.1 also contains additional significant technical information not repeated in this article. This information is contained in the actual CR 3170 released by CMS, which may be found at:
http://www.cms.hhs.gov/manuals/pm_trans/R123CP.pdf

Implementation

The implementation date for this instruction is April 5, 2004.

Additional Information

If you have any questions, please contact your intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*. ❖

Related Change Request (CR) Number: 3170
Related CR Release Date: March 19, 2004
Related CR Transmittal Number: 123
Effective Date: April 1, 2004
Implementation Date: April 5, 2004

Source: CMS Pub 100-4 Transmittal 123, CR 3170

April 2004 Changes to the Hospital Outpatient Prospective Payment System: Payment for Drugs, Biologicals and Radiopharmaceuticals, Generic versus Brand Name

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals subject to the OPPS

Provider Action Needed

STOP

This article describes changes to the OPPS for payment of drugs, biologicals, and radiopharmaceuticals, brand name versus generic.

CAUTION

This instruction addresses coding and payment for innovator multiple-source drugs (brand name drugs) and non-innovator multiple-source drugs (generic drugs), and it implements codes and payment amounts for brand name drugs that were not implemented in the January 1, 2004 OPPS update. The new codes implemented in the April 1, 2004 release are required to enable differentiation between the payment amount required under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) for a brand name drug and the payment amount required under the MMA for its generic form.

GO

Affected providers should be aware of the information in this article and take appropriate steps to assure correct billing to Medicare.

Background

This instruction reflects changes resulting from enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) on December 8, 2003, especially Section 621(a) of the Act. Also, it describes changes to the OPPS to be implemented on April 2004.

Payment for Drugs, Biologicals and Radiopharmaceuticals, Generic versus Brand Name (continued)

Three categories of drugs are mandated by the MMA (Section 621(a)) as the basis for payment of radiopharmaceuticals, drugs, and biologicals that had pass-through status on or before December 31, 2002, ("specified covered drugs"). These three categories of drugs are:

- Single source drugs (drugs for which there are no generic alternatives available on the market) are to be paid between 88 and 95 percent of the average wholesale price (AWP) published in the *Red Book* on May 1, 2003.
- Innovator multiple-source drugs (drugs that have FDA new drug application approval and for which there exists generic alternatives on the market) are to be paid an amount not to exceed 68 percent of the May 1, 2003, AWP.
- Non-innovator multiple-source drugs (drugs that do not have FDA new drug application approval and are, in effect, generic drugs) are to be paid an amount not to exceed 46 percent of the May 1, 2003, AWP.

To describe and set payment amounts for the brand name form of specified covered drugs affected by the MMA requirements, new HCPCS alphanumeric C-codes and new APCs are being implemented by this instruction. The descriptors for the new alphanumeric C-codes include "brand name" to distinguish the new C-codes from existing HCPCS codes, which generally describe the chemical designation of the product without identifying whether the drug is a brand name or generic drug.

The specified covered drugs for which there exists both a generic and a brand name form are identified in Table 1. Also, for each multiple-source specified covered drug, biological, or radiopharmaceutical whose payment is affected by MMA, Table 1 includes the HCPCS code, APC (ambulatory payment classification), descriptor, status indicator (SI), and payment rate for both the generic and the brand name forms.

Table 1 – Specified Covered Drugs for Which There Exists Both a Generic and Brand Name Form

Codes and Payment Rates for Generic Products						Codes and Payment Rates for Brand Name Products					
Codes	**SI**	**APC**	**Description**	**Payment Rate**	**Copay**	**Codes**	**SI**	**APC**	**Description**	**Payment Rate**	**Copay**
A9505	K	1603	Thallous chloride TL 201/mci	$18.29	$3.66	C9400	K	9400	Thallous chloride, brand	$19.89	$3.98
A9517	K	1064	Th I131 so iodide cap millic	$5.48	$1.10	C9402	K	9402	Th I131 so iodide cap, brand	$5.48	$1.10
A9528	K	1064	Dx I131 so iodide cap millic	$5.48	$1.10	C9403	K	9403	Dx I131 so iodide cap, brand	$5.48	$1.10
A9529	K	1065	Dx I131 so iodide sol millic	$6.49	$1.30	C9404	K	9404	Dx I131 so iodide sol, brand	$6.49	$1.30
A9530	K	1065	Th I131 so iodide sol millic	$6.49	$1.30	C9405	K	9405	Th I131 so iodide sol, brand	$6.49	$1.30
C1775	K	1775	FDG, per Dose (4-40 mCi/ml)	$324.48	$64.90	C9408	K	9408	FDG, brand, per dose	$324.48	$64.90
J1190	K	0726	Dexrazoxane HCl injection	$112.48	$22.50	C9410	K	9410	Dexrazoxane HCl inj, brand	$112.48	$22.50
J2430	K	0730	Pamidronate disodium /30 MG	$128.74	$25.75	C9411	K	9411	Pamidronate disodium, brand	$174.32	$34.86
J7310	K	0913	Ganciclovir long act implant	$86.54	$17.31	C9412	K	9412	Ganciclovir implant, brand	$86.54	$17.31
J7317	K	7316	Sodium hyaluronate injection	$67.16	$13.43	C9413	K	9413	Sodium hyaluronate inj, brand	$99.29	$19.86
J7502	K	0888	Cyclosporine oral 100 mg	$2.41	$0.48	C9438	K	9438	Cyclosporin e oral, brand	$2.56	$0.51
J8560	K	0802	Etoposide oral 50 MG	$21.91	$4.38	C9414	K	9414	Etoposide oral, brand	$27.37	$5.47
J9000	K	0847	Doxorubic hcl 10 MG vl chemo	$4.69	$0.94	C9415	K	9415	Doxorubic hcl chemo, brand	$6.61	$1.32
J9031	K	0809	Bcg live intravesical vac	$77.54	$15.51	C9416	K	9416	Bcg live intravesical, brand	$103.75	$20.75

Payment for Drugs, Biologicals and Radiopharmaceuticals, Generic versus Brand Name (continued)

Codes and Payment Rates for Generic Products						Codes and Payment Rates for Brand Name Products					
Codes	**SI**	**APC**	**Description**	**Payment Rate**	**Copay**	**Codes**	**SI**	**APC**	**Description**	**Payment Rate**	**Copay**
J9040	K	0857	Bleomycin sulfate injection	$88.32	$17.66	C9417	K	9417	Bleomycin sulfate inj, brand	$130.56	$26.11
J9060	K	0813	Cisplatin 10 MG injection	$7.73	$1.55	C9418	K	9418	Cisplatin inj, brand	$11.42	$2.28
J9065	K	0858	Inj cladribine per 1 MG	$24.84	$4.97	C9419	K	9419	Inj cladribine, brand	$36.72	$7.34
J9070	K	0815	Cyclophosphamide 100 MG inj	$2.77	$0.55	C9420	K	9420	Cyclophosphamide inj, brand	$4.10	$0.82
J9093	K	0816	Cyclophosphamide lyophilized	$2.36	$0.47	C9421	K	9421	Cyclophosphamide lyo, brand	$3.50	$0.70
J9100	K	0817	Cytarabine hcl 100 MG inj	$1.55	$0.31	C9422	K	9422	Cytarabine hcl inj, brand	$2.28	$0.46
J9130	K	0819	Dacarbazine 100 mg inj	$5.31	$1.06	C9423	K	9423	Dacarbazine inj, brand	$5.31	$1.06
J9150	K	0820	Daunorubicin	$35.94	$7.19	C9424	K	9424	Daunorubicin, brand	$53.14	$10.63
J9181	K	0824	Etoposide 10 MG inj	$0.83	$0.17	C9425	K	9425	Etoposide inj, brand	$1.22	$0.24
J9200	K	0827	Floxuridine injection	$66.24	$13.25	C9426	K	9426	Floxuridine inj, brand	$97.92	$19.58
J9208	K	0831	Ifosfomide injection	$72.81	$14.56	C9427	K	9427	Ifosfomide inj, brand	$106.04	$21.21
J9209	K	0732	Mesna injection	$17.66	$3.53	C9428	K	9428	Mesna injection, brand	$26.11	$5.22
J9211	K	0832	Idarubicin hcl injection	$178.21	$35.64	C9429	K	9429	Idarubicin hcl inj, brand	$178.21	$35.64
J9218	K	0861	Leuprolide acetate injection	$14.48	$2.90	C9430	K	9430	Leuprolide acetate inj, brand	$21.41	$4.28
J9265	K	0863	Paclitaxel injection	$79.04	$15.81	C9431	K	9431	Paclitaxel inj, brand	$112.14	$22.43
J9280	K	0862	Mitomycin 5 MG inj	$30.91	$6.18	C9432	K	9432	Mitomycin inj, brand	$45.70	$9.14
J9340	K	0851	Thiotepa injection	$45.31	$9.06	C9433	K	9433	Thiotepa inj, brand	$59.93	$11.99
Q3002	K	1619	Gallium ga 67	$11.22	$2.24	C9434	K	9434	Gallium ga 67, brand	$11.22	$2.24

For specified covered drugs (brand name and generic), biologicals, and radiopharmaceuticals **furnished on or after January 1, 2004 through March 31, 2004**, the following **applies before April 1, 2004**:

- For billing, hospitals shall report the existing HCPCS code for the drug, biological, or radiopharmaceutical, regardless of whether a brand name or a generic product was administered.
- Claims for services during this period reporting the new C-codes for brand name drugs cannot be processed for payment and will be returned to the provider.
- Payment of claims for services during this period will be based on the amount required by the MMA for the generic product reflected in CMS' prices in the January 1, 2004, PRICER.

For specified covered brand name and generic drugs, biologicals, and radiopharmaceuticals **furnished on or after April 1, 2004**, the following **applies as of April 1, 2004**:

- For billing, hospitals shall report the appropriate existing HCPCS code listed in Table 1 when the generic form of a product is furnished and hospitals shall report the appropriate new C-code listed in Table 1 when the brand name form of a product is furnished.

Payment for Drugs, Biologicals and Radiopharmaceuticals, Generic versus Brand Name (continued)

- The payment amount for innovator multiple-source products (brand name products) are paid an amount not to exceed 68 percent of the May 1, 2003, AWP and non-innovator multiple-source products (generic products) are paid an amount not to exceed 46 percent of the May 1, 2003, AWP.

As of April 5, 2004, to receive appropriate payment for specified covered brand name drugs, hospitals may submit an adjustment bill utilizing the new C-code for a brand name drug (administered on or after January 1, 2004, through March 31, 2004) that was processed to payment prior to April 5.

The C-codes and payment amounts implemented by this instruction apply ONLY to payments under the OPPS. Hospitals that are not paid under the OPPS should continue to bill and be paid for the drugs, and biologicals and radiopharmaceuticals using existing billing and payment methods.

Coding and payment for sole source drugs under the OPPS is addressed in the January 6, 2004, interim final rule with comment period and in a separate notification issuance.

Implementation

The implementation date is April 5, 2004.

Related Instructions

The Centers for Medicare & Medicaid Services Hospital Outpatient Prospective Payment System Web site for CY 2004 can be found at: *http://www.cms.hhs.gov/regulations/hopps/2004f/default.asp*

For more information about the HCPCS, visit the CMS Website at: *http://cms.hhs.gov/medicare/hcpcs*

The official instruction issued to your carrier regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

From that web page, look for CR 3144 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*. ❖

Related Change Request (CR) Number: 3144
Related CR Release Date: February 27, 2004
Related CR Transmittal Number: R112CP
Effective Date: January 1, 2004
Implementation Date: April 5, 2004

Source: CMS Pub 100-4 Transmittal 112, CR 3144

Claims Requiring Adjustment as a Result of April 2004 Changes to the Outpatient Prospective Payment System

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals reimbursed under the outpatient prospective payment system (OPPS).

Provider Action Needed

STOP

This change applies to you only if you are an OPPS hospital. The changes required by MMA do not apply to payments to non-OPPS hospitals. Also, the related CR makes a correction to the relative weight, payment rate, and co-payment amount for APC 0384.

CAUTION

The correct amounts for APC (ambulatory payment classification) 0384, for services that you provide on and after January 1, 2004, appear in the ***Background*** section below. In addition, payment rates for a number of HCPCS code related to drugs, biologicals, and radiopharmaceuticals, in the Interim Final Rule (CMS-1371-IFC) published in the *Federal Register* on January 6, 2004, were also incorrect.

The correct payment rates for these codes and the services related to the codes that are provided on and after January 1, 2004, appear in ***Background*** below.

GO

Make sure that your billing offices are aware of these corrections. Note that the fiscal intermediaries will automatically adjust the payment for claims you submitted for the services you provided between January 1, 2004, and March 31, 2004. You don't need to send an adjustment for these claims. Lastly, you should expect to see these adjusted payments on or before June 5, 2004.

Background

This One-Time Notification describes changes to the hospital OPPS. The information it provides reflects changes resulting from enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) on December 8, 2003, and corrects payment rates for APC 0384.

Claims Requiring Adjustment as a Result of April 2004 Changes to the Outpatient PPS (continued)

The December 31, 2003, Correction Notice (68 FR 75442) incorrectly stated the relative weight, payment rate, and co-payment amounts for APC 0384.

Table 1 below displays the correct relative weight, payment rate, and co-payment amounts for APC 0384, effective for services furnished on and after January 1, 2004. These changes apply to CPT codes 43219, 43256, 43268, 43269, 44370, 44379, 44383, 45345, 44397, 45327, and 45387, all of which map to APC 0384.

Table 1 – Payment Rates for APC 0384

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Co-payment	Minimum Unadjusted Co-payment
0384	GI Procedures with Stents	T	28.9631	$1,580.26	$343.22	$316.05

In addition, the Interim Final Rule (CMS-1371-IFC), published in the *Federal Register* on January 6, 2004 (69 FR 820), incorrectly stated the payment rates for certain HCPCS codes related to drugs, biologicals, and radio-pharmaceuticals. In some cases, the drug codes were misclassified as multiple-source instead of sole-source drugs, and in other cases, the payment rates were based on an inaccurate average wholesale price (AWP).

Table 2 displays the affected HCPCS codes and the payment rates that are in effect for services furnished on and after January 1, 2004.

Table 2 - Payment Rate Changes Effective January 1, 2004

HCPCS Codes	SI	Description	APC	IFC Payment	Corrected Payment	Corrected Co-payment
A9502	K	Technetium TC99M tetrofosmin	0705	$665.28	$110.88	$22.18
A9511	K	Technetium TC 99m depreotide	1095	$704.00	$37.87	$7.57
A9605	K	Samarium sm153 lexidronamm	0702	$493.89	$944.84	$188.97
C1091	K	IN111 oxyquinoline,per 0.5mCi	1091	$224.52	$396.00	$79.20
C9008	K	Baclofen Refill Kit-500 mcg	9008	$73.92	$10.82	$2.16
C9105	K	Hep B imm glob, per 1 ml	9105	$65.58	$125.45	$25.09
J0288	K	Ampho b cholesteryl sulfate	0735	$20.86	$15.20	$3.04
J0289	K	Amphotericin b liposome inj	0736	$20.86	$33.16	$6.63
J1563	K	Immune globulin, 1 g	0905	$37.95	$72.60	$14.52
J1564	K	Immune globulin 10 mg	9021	$0.41	$0.79	$0.16
J1745	K	Infliximab injection	7043	$31.81	$60.86	$12.17
J7190	K	Factor viii	0925	$0.42	$0.81	$0.16
J7192	K	Factor viii recombinant	0927	$0.61	$1.17	$0.23
J7193	K	Factor IX non-recombinant	0931	$0.51	$1.04	$0.21
J7194	K	Factor ix complex	0928	$0.18	$0.37	$0.07
J7198	K	Anti-inhibitor	0929	$0.69	$1.32	$0.26
J7517	K	Mycophenolate mofetil oral	9015	$1.36	$2.60	$0.52
J9395	G	Injection, Fulvestrant	9120	$78.36	$78.36	$13.09
Q0166	K	Granisetron HCl 1 mg oral	0765	$171.78	$41.40	$8.28
Q0180	K	Dolasetron mesylate oral	0763	$152.38	$67.09	$13.42
Q2006	K	Digoxin immune fab (ovine)	7025	$1.79	$352.00	$70.40
Q2022	K	VonWillebrandFactrCmplxperIU	1618	$0.46	$0.95	$0.19
Q3005	K	Technetium tc99m mertiatide	1622	$1,650.00	$33.00	$6.60
Q3007	K	Sodium phosphate p32	1624	$66.44	$100.70	$20.14
Q3011	K	Chromic phosphate p32	1628	$81.27	$155.47	$31.09
Q3025	K	IM inj interferon beta 1-a	9022	$13.36	$78.93	$15.79
A9508	K	Iobenguane sulfate I-131, per 0.5 mCiI	1045	$165.82	$1,056.00	$211.20
Q3012	K	Cyanocobalamin cobalt co57	1089	$47.38	$90.64	$18.13

The corrected payment rates in Table 2 are in effect for services furnished **on or after January 1, 2004.**

Your Medicare intermediaries will adjust the payment for claims that were incorrectly paid for services furnished January 1, 2004, through March 31, 2004.

Please note that the corrected payment for J9395 is the same as the payment listed in the IFC payment column. The IFC payment amount of $78.36 was determined to be correct.

Hospitals need take no action to make these adjustments. The adjustments should be paid on or before June 5, 2004.

Claims Requiring Adjustment as a Result of April 2004 Changes to the Outpatient PPS (continued)

Additional Information

To view the actual CR 3145, which contains the instructions to your intermediary, go to: *http://www.cms.gov/manuals/pm_trans/R113CP.pdf*.

If you have additional questions, please feel free to contact your intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

Note: The pricing information for HCPCS code J9395 for fulvestrant injection was reported incorrectly in the original CR 3145. The above table contains the correct pricing information based on CMS Joint Signature Memorandum – 189, dated March 26, 2004. ❖

Related Change Request (CR) Number: 3145
Related CR Release Date: February 27, 2004
Effective Date: January 1, 2004
Implementation Date: April 5, 2004
Transmittal Number: 113

Source: CMS Pub 100-4 Transmittal 113, CR 3145

April 2004 Update of the Hospital Outpatient Prospective Payment System

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals and other providers paid under the outpatient prospective payment system (OPPS).

Provider Action Needed

This article describes changes to the Medicare claim processing systems for OPPS claims. Medicare fiscal intermediaries implemented these changes on April 5, 2004.

Background

This article outlines changes in the OPPS for the April 1, 2004, quarterly update of Medicare's claim processing systems. Unless otherwise noted, all changes in this instruction are effective for services furnished on or after April 1, 2004. The changes in this instruction are implemented through revisions to the outpatient code editor (OCE) and the OPPS PRICER.

Changes in payment for certain drugs, biologicals, and radiopharmaceuticals mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) that were implemented in the April 1, 2004, quarterly OPPS update are addressed in CR 3144 and CR 3145, which have been issued separately. Medlearn Matters articles MM3144 and MM3145 cover the changes conveyed by those earlier CRs.

Also, providers should remember that the provision of a HCPCS code and a payment rate under the OPPS for a drug, device, procedure, or service does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid *if* covered by the program.

Intermediaries must determine whether a drug, device, procedure, or service meets all program requirements for coverage; for example, that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Revised Addenda A and B

Beginning April 1, 2004, the Centers for Medicare & Medicaid Services (CMS) will post revised Addenda A and B on the hospital OPPS Web site (*http://www.cms.hhs.gov/providers/hopps/*) to reflect quarterly changes in the OPPS.

The revised Addenda will represent a "snapshot" of the codes and payment rates in effect at the beginning of each quarter. Mid-quarter changes, or changes that are retroactive to an earlier quarter, will not necessarily be captured in the quarterly revised Addenda, nor will CMS update Addenda that are posted for prior quarters.

For example, a HCPCS code listed in the January update of the OPPS, which is deleted effective April 1, will appear in the January Addendum B as "Deleted with Grace Period (DG)." However, the code will **not** reappear in the April quarterly update of Addendum B because, effective April 1, the code is deleted from the OPPS.

The deleted code will be listed as a deleted code in the Summary of Data Changes that is attached to the April quarterly update, but will not otherwise be flagged in the updated Addendum B. Condition codes will not be included in the quarterly updates of Addenda A and B. (See the *Additional Information* section below for a listing and definitions of condition codes.)

CMS will post updates to Addenda A and B for the April 1, July 1, and October 1 quarterly releases, in addition to the Addenda that are issued each year as part of the January 1 annual update of the OPPS following publication of the final rule.

Summary of Current Changes

Billing for Intensity Modulated Radiation Therapy

The following language (*italicized*) replaces section I.B.5, included in Transmittal 32, issued December 19, 2003, that notified contractors of changes in the OPPS resulting from the annual update of the OPPS effective January 1, 2004. Changes are ***bolded and italicized***.

April 2004 Update of the Hospital Outpatient Prospective Payment System (continued)

Intensity modulated radiation therapy (IMRT), also known as conformal radiation, delivers radiation with adjusted intensity to preserve adjoining normal tissue. IMRT has the ability to deliver a higher dose of radiation within the tumor and a lower dose of radiation to surrounding healthy tissue. Two types of IMRT are multi-leaf collimator-based IMRT and compensator-based IMRT. IMRT is provided in two treatment phases, planning and delivery. Effective January 1, 2004, when IMRT is furnished to beneficiaries in a hospital outpatient department that is paid under the OPPS, hospitals are to bill according to the following guidelines:

A. If using CPT code 77301 to report IMRT planning services, do not report CPT 77301 with the same line item date of service reported for CPT codes 77280-77295, 77305-77321, or 77336 if these codes are also billed during a patient course of therapy.

B. Hospitals are not prohibited from using existing IMRT CPT codes 77301 and 77418 to bill for compensator-based IMRT technology in the hospital outpatient setting.

C. Payment for IMRT planning does not include payment for CPT codes 77332 - 77334 when furnished on the same day. When provided, these services are to be billed in addition to the IMRT planning code 77301.

D. Providers billing for both CPT codes 77301 (IMRT treatment planning) and 77334 (design and construction of complex treatment devices) on the same day should append a modifier 59.

Billing and Payment for Brachytherapy Sources

A. Report charges related to supervision, handling, and loading of radiation sources, including brachytherapy sources, in one of two ways:

1. Report separately using *CPT* code *77790*, in addition to reporting the associated HCPCS procedure code(s) for application of the radiation source;

   OR

2. Include the charge as part of the charge reported with the HCPCS procedure code(s) for application of the radiation source.

3. Do not bill a separate charge for brachytherapy source storage costs. These costs are treated as part of the department's overhead costs.

B. The **MMA (Section 621(b))** establishes separate payment for devices of brachytherapy consisting of a seed or seeds (or radioactive source), based on the hospital's charges for the source(s), adjusted to cost, effective January 1, 2004, through December 31, 2006. The following codes are to be reported **only for payment of brachytherapy sources under the OPPS.**

Codes for Brachytherapy Sources

HCPCS	Descriptor	APC	APC title	New Status Indicator
C1716	Brachytx source, Gold 198	1716	Brachytx source, Gold 198	H
C1717	Brachytx source, HDR Ir-192	1717	Brachytx source, HDR Ir-192	H
C1718	Brachytx source, Iodine 125	1718	Brachytx source, Iodine 125	H
C1719	Brachytx sour, Non-HDR Ir-192	1719	Brachytx source, Non-HDR Ir-192	H
C1720	Brachytx source, Paladium 103	1720	Brachytx source, Paladium 103	H
C2616	Brachytx source, Yttrium-90	2616	Brachytx source, Yttrium-90	H
C2633	Brachytx source, Cesium-131	2633	Brachytx source, Cesium-131	H
C2632*	Brachytx sol, I-125, per mCi*	2632*	Brachytx sol, I-125, per mCi	H

*APC 2632 has pass-through status.

Payment for Ammonia N-13

HCPCS A9526 and Q4078 were incorrectly assigned **status indicator 'N'** in the December 31, 2003 Correction Notice (68FR75442). Effective January 1, 2004, the correct **status indicator for these HCPCS codes is 'K'**. See the *Additional Information* section below for a listing and explanation of payment status indicators for the hospital OPPS.

As soon as the April 2004 OPPS OCE release is installed, hospitals may submit an adjustment bill to receive appropriate payment for HCPCS codes A9526 or Q4078 furnished on or after January 1, 2004, through March 31, 2004, that were processed to payment prior to installation of the April 1, 2004, release.

Ammonia N-13 Rates

HCPCS	SI	Cond	APC	Description	Payment Rate	Minimum Unadjusted Copayment
A9526	K	NI	0737	Ammonia N-13, per dose	$162.63	$32.53
Q4078	K	DG	0737	Ammonia N-13, per dose	$162.63	$32.53

April 2004 Update of the Hospital Outpatient Prospective Payment System (continued)

Payment for HCPCS Code C9207, Injection, Bortezomib, per 3.5 mg ("Velcade®")

CMS inadvertently installed an incorrect effective date in PRICER for APC 9207. CMS has corrected the effective date to October 1, 2003. Hospitals that billed HCPCS C9207 for services furnished on or after October 1, 2003, through December 31, 2003, and which did not receive payment, may resubmit claims following installation of the April 2004 PRICER.

PRICER Logic Changes Resulting from Section 621 of the MMA Effective January 1, 2004

A. Co-payment amounts are calculated for the following APCs:

1716 1717 1718 1719 1720 2616 2633

B. Co-payment amounts are not calculated for the following APC: 2632

C. Outlier payments are not calculated for APCs with status indicator "K," **except** for the following APCs:

0701 0702 0704 0705 0737 1045 1064 1065 1079 1080 1081 1089
1091 1092 1095 1096 1122 1200 1201 1600 1603 1604 1619 1620
1622 1624 1625 1628 1775 9013 9025 9100 9117 9118 9400 9402
9403 9404 9405 9408 9434

Reminder Regarding Reporting of Implantable Devices

Hospitals are strongly encouraged to separately bill devices using a device category "C" code or other appropriate HCPCS code for implantable devices along with the charge for the device. Complete and accurate reporting of the codes and the charges for the devices is critical to ensuring that the relative weights for the services are accurate and thus, for ensuring proper payment to hospitals for the procedures that use implanted devices. All device category "C" codes for both current pass-through devices as well as packaged devices can be found in Addendum B on the CMS OPPS Web site: *http://www.cms.hhs.gov/regulations/hopps/2004f/.*

Devices, whether packaged or paid as pass-through devices, are reported using revenue codes:

272 275 276 278 279 280 289 or 624.

Newly-Approved Drugs and Biologicals Eligible for Pass-Through Payment

The following drugs have been designated as eligible for pass-through payment under the OPPS effective April 1, 2004:

Codes	Effective Date for Pass-Through Status	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment	Effective Date for Payment Rate
C9124	April 1, 2004	G	9124	Injection, daptomycin	Injection, daptomycin, per 1 mg	$0.31	$0.05	January 1, 2004
C9125	April 1, 1, 2004	G	9125	Injection, risperidone	Injection, risperidone, per 12.5 mg	$131.86	$19.71	January 1, 2004
J2783	April 1, 2004	G	0738	Rasburicase	Injection, rasburicase, 0.5 mg	$105.54	$17.63	April 1, 2004

Note that the effective date for pass-through status for C9124 and C9125 coincides with the date of assignment of HCPCS codes for each of these drugs. Pass-through payment for C9124 and C9125 equals 95 percent of average wholesale price (AWP).

Beginning in 2004, the MMA requires payment at 95 percent of AWP for a drug before it receives a HCPCS code. Therefore, C9124 and C9125 will be paid at 95 percent of AWP for the period prior to assignment of a HCPCS code and for the duration of their pass-through status.

The code for rasburicase (J2783) was assigned effective January 1, 2004. Therefore, the MMA provision governing payment for drugs without HCPCS does not apply to J2783 and the payment will be at 85 percent of AWP for the duration of its pass-through status.

In addition, effective January 1, 2004, as mentioned in Medlearn Matters article MM3145, the correct payment rate for HCPCS code J9395, Injection, fulvestrant, 25 mg, is $78.36 and the correct co-payment for that HCPCS code is $13.09.

Services Added to New Technology APCs

The following services are assigned for payment in new technology service APCs under the OPPS OCE, version 5.1, effective April 1, 2004:

April 2004 Update of the Hospital Outpatient Prospective Payment System (continued)

Services Added to New Technology APCs

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
C9712*	April 1, 2004	S	1506	Insert pH capsule, GERD	Insertion of a pH capsule for measurement and monitoring of gastroesophageal reflux disease, includes data collection and interpretation	$450.00	$90.00
C9713	April 1, 2004	S	1525	Non-contact laser vap prosta	Non-contact laser vaporization of prostate, including coagulation control of intraoperative and post-operative bleeding	$3,750.00	$750.00
C9714	April 1, 2004	S	1523	Breast inters rad tx, immed	Placement of balloon catheter into the breast for interstitial radiation therapy following a partial mastectomy; concurrent/immediate (add-on) $2,750.00	$550.00	
C9715	April 1, 2004	S	1524	Breast inters rad tx, delay	Placement of balloon catheter into the breast for interstitial radiation therapy following a partial mastectomy; delayed	$3,250.00	$650.00

***C9712** may involve a single endoscopy. If an endoscopy is used with this procedure, report the endoscopic procedure separately. Only one endoscopy procedure/encounter may be associated with insertion of this device.

Summary of April 2004 Modifications

The OPPS OCE Final Summary of Data Changes Effective April 1, 2004, can be found in Attachment A of CR3154 at the following Web site: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

Once at that site, scroll down the CR NUM column on the right to CR3154 and click on the file for that number. Attachment A of CR 3154 summarizes all of the modifications made to APCs, HCPCS/CPT procedure codes, APC assignments, status indicators, modifiers, revenue codes, and edits, to update the OPPS for the April 1, 2004, quarterly release.

Implementation

The implementation date for this instruction is April 5, 2004.

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR3154 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The CMS hospital outpatient prospective payment system Web site can be found at: *http://www.cms.hhs.gov/providers/hopps/*.

The payment status indicators for the hospital outpatient prospective payment system for fiscal year 2004 was published by CMS as Addendum D in the *Federal Register*: January 6, 2004 (Volume 69, Number 3)].

It can be found at the CMS Web site (Proposed CY 2004 Hospital Outpatient Prospective Payment System for Proposed Changes to the Hospital Outpatient Prospective Payment System (OPPS) and Calendar Year 2004 Payment Rates) located at: *http://www.cms.hhs.gov/regulations/hopps/2004p/changecy2004.asp*. ❖

Related Change Request (CR) Number: 3154
Related CR Release Date: March 30, 2004
Related CR Transmittal Number: 132
Effective Date: April 1, 2004, except as otherwise noted
Implementation Date: April 5, 2004

Source: CMS Pub 100-4 Transmittal 132, CR 3154

Payment Rate Correction for Fulvestrant (Faslodex)

The Centers for Medicare & Medicaid Services (CMS) has corrected the payment rate for HCPCS code J9395, injection, fulvestrant, 25 mg, under the hospital outpatient payment system.

Section I of Transmittal 113, "Claims Requiring Adjustment As a Result of April 2004 Changes to the Outpatient Prospective Payment System," (Change Request 3145, dated February 27, 2004) states the changes in payment rate and copayment for fulvestrant (Faslodex) – HCPCS code J9395, effective January 1, 2004, incorrectly as $156.72 and the copayment as $26.18.

The **correct payment rate** for HCPCS code J9395, injection, fulvestrant, 25 mg, is **$78.36**. The **correct copayment** for HCPCS code J9395, injection, fulvestrant, 25 mg, is **$13.09**. The corrected payment rate and copayment have already been installed in the PRICER software.

CMS has incorporated this correction in the Medlearn Matters article related to CR 3145. ❖

Source: CMS JSM 189, Dated March 26, 2004

PROVIDER AUDIT ISSUES

Inpatient Rehabilitation Facility Outlier Payments—Cost-to-Charge Ratios

The Centers for Medicare & Medicaid Services (CMS) has revised instructions for applying the cost-to-charge ratio (CCR) for an inpatient rehabilitation facility (IRF) subject to the IRF prospective payment system (PPS). The implementation date for these instructions is March 8, 2004.

Under the existing IRF PPS outlier methodology, the CCR from an IRF's latest settled cost report is used in determining whether a case qualifies for payment as an outlier and the amount of any such payment. Based on the final rule published in the *Federal Register* on August 1, 2003, this notification provides instructions for applying CCRs for IRFs, including: the use of an alternative CCR when directed by CMS or at the request of the facility and the use of a CCR based on the tentative settlement of the cost report for discharges on or after October 1, 2003.

For discharges beginning on or after October 1, 2003, fiscal intermediaries will use a CCR from the most recent tentative settled cost report or the most recent settled cost report (whichever is the later period). Effective October 1, 2003, an IRF will be assigned the appropriate national average CCR when the IRF has a CCR that falls above three standard deviations from the national mean (upper threshold). The upper threshold is 1.461. However, Medicare will not use a lower threshold and an IRF will receive the actual CCR, no matter how low their ratio falls.

For discharges occurring in cost reporting periods beginning on or after October 1, 2003, FI s are to reconcile IRF PPS outlier payments at the time of cost report final settlement if:

1. Actual CCR is found to be plus or minus ten percentage points from the CCR used during that time period to make outlier payments, and
2. Outlier payments exceed $500,000 in that cost reporting period. ❖

Source: CMS Pub 100-4 Transmittal 77, CR 2998

Implementation of Section 508(f) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

The Centers for Medicare & Medicaid Services (CMS) has issued a one-time notification (OTN) implementing Section 508(f) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Public Law 108-173). Under Section 508(f), any reclassification of a county or other area resulting from an act of Congress that expired on September 30, 2003, shall be deemed to be in effect during the period beginning on January 1, 2004, and ending on September 30, 2004.

Implementation of Section 508 (f) does not affect providers served by First Coast Service Options, Inc. Information about this transmittal is available at *http://www.cms.hhs.gov/manuals/pm_trans/R65OTN.pdf*. ❖

Source: CMS Pub 100-20 Transmittal 65, CR 3084

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Modification of CMS' Medicare Contingency Plan for HIPAA Implementation

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Providers Affected

All Medicare physicians, providers, and suppliers who submit electronic claims to Medicare.

Provider Action Needed

STOP – Impact to You

Effective July 1, 2004, Medicare is modifying its Health Insurance Portability and Accountability Act (HIPAA) contingency plan. The modification continues to allow submission of non-compliant electronic claims. However, the payment of electronic claims that are not HIPAA compliant will take thirteen additional days.

CAUTION – What You Need to Know

While the contingency plan remains in place, the submission of non-HIPAA electronic claims to Medicare after July 6, 2004, means that Medicare will take longer to pay such claims.

GO – What You Need to Do

Submit HIPAA compliant claims. If you are already submitting HIPAA-compliant claims, or will do so on or before July 6, 2004, then this change does not apply to you.

Background

Currently, Medicare pays electronic media claims (EMC) no earlier than the 14th day after the date of receipt (13-day waiting period). Non-electronic claims cannot be paid earlier than the 27th day after the date of receipt (26-day waiting period).

HIPAA requires that claims submitted electronically, effective October 16, 2003, be in a format that complies with the appropriate standard adopted for national use.

The Administrative Simplification and Compliance Act (ASCA) requires claims to be submitted to Medicare electronically, with some exceptions, effective October 16, 2003.

Based on guidance issued by the Department of Health and Human Services to maintain cash flow in the healthcare industry beyond October 16, 2003, and the fact that only 33 percent of Medicare's electronic claims were in HIPAA formats as of that date, Medicare implemented a contingency plan to temporarily allow electronic claims to continue to be submitted in a pre-HIPAA format. This was done to provide those members of the healthcare community, who demonstrate a good faith effort to comply, additional time to become HIPAA compliant.

Under the subject modification to the October 16, 2003, contingency plan, those claims submitted electronically and in a HIPAA-compliant format will continue to be considered as eligible for Medicare payment on the 14th day after the date of receipt. Claims submitted electronically in a pre-HIPAA format under a Medicare contingency plan, will be considered as eligible for Medicare payment on the 27th day after the date of receipt. As an example, HIPAA compliant claims received on July 1, 2004, can be paid as early as July 15, while a claim that is not HIPAA compliant and is received electronically on July 1, 2004, can be paid no earlier than July 28.

Medicare is continuing to allow claims to be submitted in a pre-HIPAA format for a limited time to maintain provider payments, but this modification of the contingency plan should provide an incentive for moving to HIPAA formats quickly. This is a measured step toward ending the contingency plan for all incoming claims.

Important Dates

Medicare has instructed its carriers and intermediaries to begin enforcing these rules on July 6, 2004, and the rules will apply to claims received on or after July 1, 2004.

Additional Information

CMS has instructed its Medicare carriers and intermediaries to make available free/low cost software that will enable submission of HIPAA compliant claims electronically. Contact your carrier or intermediary in order to obtain this software at their special EDI number. For those billing Medicare Part A (including hospital outpatient services), a list of these numbers by state is available at: *http://www.cms.hhs.gov/providers/edi/anum.asp*.

For those billing Medicare Part B, you may find those numbers listed by state at: *http://www.cms.hhs.gov/providers/edi/bnum.asp*.

For additional information on HIPAA, visit the CMS Web site at: *http://www.cms.hhs.gov/hipaa/hipaa2/default.asp*.

To view the revised manual chapter for the claims receipt rules, see Chapter 1, Section 80.2.1.2, which can be found in Pub 100-04, the Medicare Claims Processing Manual. This can be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

To view the actual instruction issued by CMS to your carrier or intermediary, visit: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

Once at that site, scroll down the CR NUM column to 2981 and click on that file. ❖

Related Change Request (CR) Number: 2981
Related CR Release Date: February 27, 2004
Related CR Transmittal Number: 114
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 114, CR 2981

Health Insurance Portability and Accountability Act X12N 837 Health Care Claim Implementation Guide Editing Additional Instruction

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article..

Provider Types Affected

All Medicare providers who bill Medicare fiscal intermediaries (FIs).

Provider Action Needed

STOP – Impact to You

Effective July 1, 2004, Medicare systems are enforcing additional HIPAA edit instructions related to X12N 837 Institutional Claims. These changes are required by the HIPAA Implementation Guides for the 837 transaction.

CAUTION – What You Need to Know

It is important for you to become familiar with the changes outlined in this article. Failure to comply with these changes will result in claim rejects and accompanying payment delays.

GO – What You Need to Do

Be sure your billing processes comply with these changes to continue correct and timely payments. Refer to the Background section for an itemized list of the required changes.

Background

When preparing for HIPAA implementation, CMS focused first on inbound claims. As CMS tested with providers, we worked through changes that needed to be made. Once the inbound claim process was in order, CMS began to work on the coordination of benefits (COB) transaction. Medicare sends almost 80 percent of all claims out to trading partners as a COB record. Many new issues have arisen since the trading partners treat these COB records, also known as crossover claims, as inbound claims. Issues surfaced where Medicare's business rules were different from other payers. The changes that will take effect in July fall into three primary categories:

- First, Medicare will now require certain data elements that are not needed for Medicare claims adjudication, but are required by HIPAA.
- Second, data that Medicare previously allowed, but is not permitted by HIPAA, will result in claims rejections.
- Third, certain data that Medicare now edits only for syntax will be edited for content and will cause claim rejections if the data is not valid.

One source of confusion between CMS and COB trading partners is the distinction between inpatient and outpatient bill types. This instruction specifies how Medicare categorizes each bill type. In general, Medicare considers the following bill types as outpatient:

13x, 14x	Outpatient hospital
23x, 24x	Skilled nursing facility (SNF)
32x, 33x, 34x	Home health agency (HHA)
71x	Rural health clinic (RHC)
72x	Renal dialysis facility (RDF)
73x	Federally qualified health center (FQHC)
74x	Outpatient rehabilitation facility (ORF)
75x	Comprehensive outpatient rehabilitation facility (CORF)
76x	Community mental health center (CMHC)
81x, 82x	Hospice
83x	Hospice – hospital outpatient surgery subject to ambulatory surgery center (ASC) payment limits
85x	Critical access hospital (CAH)

In general, the following bill types are considered as inpatient:

11x	Hospital
12x	Inpatient Part B hospital
18x	Swing bed
21x	Skilled nursing facility (SNF)
22x	Inpatient Part B SNF
41x	Religious non-medical facility (RNHCI)

Following is a summary of the itemized changes that Medicare systems will now implement, but you should also look at the CR for all technical details:

1. For all outpatient claims, all line items must contain a date or dates of service for each revenue code or it will be rejected.
2. Any outpatient claims containing Covered Days (QTY Segment) will be rejected.
3. All claims will be edited to ensure all Health Insurance Prospective Payment System (HIPPS) Rate Codes used with a "ZZ" modifier are accepted (not just HIPPS SNF rate codes). A complete list of valid HIPPS codes may be found at *http://www.cms.hhs.gov/providers/hippscodes/*.
4. All claims containing a NPP000 UPIN will be rejected.
5. All claims containing an invalid E-code (an E-code not listed in the external code source referenced by the HIPAA 837 institutional implementation guide) will be rejected. Note that Medicare does not require or use E codes, but if they are sent, they must be valid.
6. All claims that contain healthcare provider taxonomy codes (HPTCs) must have HTPCs that comply with the implementation guides or they will be rejected. Note that Medicare does not require or use taxonomy codes, but if they are sent, they must be valid.
7. All HIPAA X12N 837 claims that contain revenue code 045X, 0516, or 0526 must also contain an HI02-1 code of "ZZ" along with a HIPAA-compliant "Patient Reason for Visit" diagnosis code or it will be rejected.
8. All inpatient claims must contain the admission date, admitting diagnosis, admission type code, patient status code, and admission source code or the claim will be rejected. Medicare previously did not require these elements on 12x or 22x bill types, but now they will be required.

Providers and their submitters should carefully review these requirements to ensure that claims are not unnecessarily rejected effective July 6, 2004.

HIPAA X12N 837 Health Care Claim Implementation Guide Editing Additional Instruction (continued)

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

From that web page, look for CR 3031 in the CR NUM column on the right, and click on the file for that CR.

For additional information on HIPAA, please visit: *http://www.cms.hhs.gov/hipaa/hipaa2/links/default.asp*

For additional information on the implementation guides, please visit: *http://www.wpc-edi.com/hipaa/HIPAA_40.asp*. ❖

Source: CMS Pub 100-4 Transmittal 107, CR 3031

HIPAA/Medicare Contingency Plan—Medicare Providers, Their Vendors, Clearinghouses, or Other Third-Party Billers

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All Medicare physicians, providers, and suppliers who use a vendor, clearinghouse, or other third-party billing agent to submit Medicare claims.

Provider Action Needed

Understand the requirements of HIPAA, the Medicare HIPAA contingency plan, its impact, and the need to verify HIPAA compliance by those who bill Medicare on your behalf.

Background

In a recent *Medlearn Matters* article (see MM2981, which may be found at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM2981.pdf*), the Centers for Medicare & Medicaid Services (CMS) announced a modification of the HIPAA contingency plan implemented by Medicare on October 16, 2003. Specifically, CMS announced on February 27, 2004, that Medicare would continue to accept claims electronically in a pre-HIPAA format on or after July 1, 2004, but such claims would not be eligible for Medicare payment until the 27th day after receipt, at the earliest. All electronic claims today are eligible for payment at 14 days after receipt.

This modification of the HIPAA contingency plan was intended to give providers additional time to become HIPAA compliant, but **was also a measured step toward ending the contingency plan for all incoming Medicare claims.**

CMS understands that many physicians, providers, and suppliers do not submit claims directly to Medicare, but submit their claims through a third party, such as a billing vendor, clearinghouse or other third-party billing agent. CMS recognizes the importance of these third parties to many providers and the extent to which providers rely on those entities to meet HIPAA requirements in a cost-effective manner with minimal impact on the provider's most important mission, i.e., delivering high quality medical care to those who need such care.

Each provider has made a business decision to use these agents and is therefore best positioned to assess the value of that decision.

CMS urges Medicare providers to understand the following issues, to assess their impact on the provider's business and determine what, if any, steps need to be taken.

Issue 1 Understand where your vendor, clearinghouse, or other third party biller stands in terms of HIPAA compliance.

Providers are required by statute to achieve compliance and to bill Medicare electronically in a HIPAA compliant manner. Thus, it is crucial for providers to assure themselves of their third-party partner's readiness. It is especially important to remember that, at the time Medicare's contingency plan is terminated, providers who remain non-compliant will face significant problems.

So, what steps might providers take to assure that they AND their partners are ready?

- Check with your clearinghouse, vendor, or other third party biller.
- Ask them about their readiness.
- Ask them how they have certified their readiness.
- Make sure they are aware of the Medicare contingency plan and the modification announced on February 27, 2004.
- Ask them if your claims will continue to be eligible for payment on the 14th day after receipt, as of July 1, 2004. Or, will your claims not qualify for such prompt payment from Medicare?
- If your agent indicates that the Medicare contingency plan will affect your claims, ask them when they will correct the problem so your claims are eligible for prompt payment and ask when that will happen.

As stated earlier, CMS's business relationship is with providers and we look to the provider to meet requirements for correct submission of claims in HIPAA compliant formats. We also know that every piece of the process, and every entity involved, must be ready. That is why it is important for providers to question their agents, obtain assurances, and keep abreast of HIPAA developments. Ultimately, the benefits of compliance or the consequences of non-compliance will fall on the provider. Remember that continued timely payment of Medicare claims is closely linked to HIPAA readiness.

HIPAA/Medicare Contingency Plan—Providers, Their Vendors, Clearinghouses, or Other Third-Party Billers (continued)

Issue 2 Make sure your agent builds on the HIPAA compliance you have achieved.

There have been instances where some third-party billers are taking claims submitted to them by Medicare providers that are HIPAA compliant and then converting them to a non-compliant format before sending them to a Medicare claims processing contractor. Such vendors and agents may be doing this because some of their providers are still not HIPAA compliant and the vendor has chosen to submit non-compliant formats for all their provider customers until all customers are compliant.

These decisions may make good business sense to the vendor, clearinghouse or other third party biller, but their decision may adversely affect providers who are compliant. That will certainly be the case for such claims submitted to Medicare on or after July 1, 2004, when Medicare deems such claims do not qualify for the prompt payment afforded to electronic claims that are HIPAA compliant. At the time Medicare ends its contingency plan, the consequences for non-compliant claims could be even more severe, e.g., a complete stoppage of payments for such claims.

What can providers do? The answer is similar to the one presented for the first issue, i.e., talk with your vendor, clearinghouse, or other third party biller. Ask them about their readiness. Ask them if they are altering your HIPAA compliant input to them into a non-compliant format before sending to Medicare. Ask them to assure you that your claims will remain eligible for payment on the 14th day after receipt on and after July 1, 2004.

As mentioned before, it is the provider's ultimate responsibility to assure they are HIPAA compliant and that means assuring that your claims meet the transaction code set and format standards.

Issue 3 Understand when your vendor, clearinghouse, or other third party biller will stop accepting non-compliant transactions.

While CMS implemented a contingency plan on October 16, 2003, which allows Medicare providers, suppliers, and other electronic billers to continue sending pre-HIPAA formats, that plan is not binding on other entities. At any time, vendors, clearinghouses, and other third party billers could decide to limit or discontinue supporting pre-HIPAA formats.

We encourage providers and suppliers using a third party entity for sending their electronic claims to work closely with that entity to understand the HIPAA electronic claims requirements. Verify that you are submitting the data required under HIPAA and that your claims are being transmitted in the standard HIPAA format.

In conclusion, the bottom line is that; in order to protect your interests and ensure **uninterrupted cash flow**, begin immediately to work toward meeting the HIPAA standard requirements.

Additional Information

For additional information on HIPAA, visit the CMS Web site at:
http://www.cms.hhs.gov/hipaa/hipaa2/default.asp. ❖

Related Change Request (CR) Number: N/A
Effective Date: N/A – Informational Only

Source: CMS Medlearn Matters Article SE0414

ELECTRONIC DATA INTERCHANGE

Transmittal 49 Implementation Date Extension

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals and other providers who bill Medicare fiscal intermediaries.

Provider Action Needed

Affected providers should note that fiscal intermediaries (FIs) were instructed in Transmittal 49, CR 2879 to implement the Arkansas Part A Standard System (APASS) Health Insurance Portability and Accountability Act (HIPAA) Implementation Guide (IG) module in the Fiscal Intermediary Shared System (FISS). This CR was to be effective April 1, 2004, and had an implementation date of April 5, 2004.

Based on FI feedback, the Centers for Medicare & Medicaid Services (CMS) is **extending the Implementation Date for Transmittal 49, CR 2879 from April 5, 2004, to July 6, 2004.** Providers need take no additional action other than to be aware of the delayed implementation of these additional edits.

Transmittal 49 Implementation Date Extension (continued)

Also, due to the delay in implementing these IG edits, claims are still being edited under the rules in existence prior to those specified in CR2879.

Background

CMS developed requirements for FIs who use the Fiscal Intermediary Shared System (FISS) to ensure that they are consistently rejecting X12N 837 claims at the claim level when certain levels of errors are detected.

Intermediaries who return the entire batch of claims as a result of errors that occur at the claim level must make the necessary IG editing changes to their front-end system and/or translator to:

- Accept HIPAA complaint claims; and
- Reject only those claims with IG errors.

Intermediaries must implement the APASS IG module in the FISS and the requirements for the APASS IG module that were to go into effect on April 1, 2004 with an implementation date of April 5, 2004 (Transmittal 49, Change Request 2879, dated Dec. 19, 2003).

Many FIs have already implemented or have begun the process of implementing the APASS IG module, and based on FI feedback, this instruction is extending the implementation date for Transmittal 49, CR 2879, from April 5, 2004, to July 6, 2004.

Implementation

The implementation date of this instruction is July 6, 2004.

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR3197 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

Also, Transmittal 49, Change Request 2879, dated Dec. 19, 2003, can be found at the following CMS Web site: *http://www.cms.hhs.gov/manuals/pm_trans/R49CP.pdf*. ❖

Related Change Request (CR) Number: 3197
Related CR Release Date: April 2, 2004
Related CR Transmittal Number: 68
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Source: CMS Pub 100-20 Transmittal 68, CR 3197

Changes to ANSI 4010A1 Implementation Guide Edits

Effective July 1, 2004, Implementation Guide (IG) edits for ANSI 837 version 4010A1 will be performed at the claim level.

Your Entire File Will No Longer Reject When Only One Claim Has An IG Error!

Implementation Guide edits were developed to review the format and data contents within the electronic claim transaction before the claims are sent to be processed. Data content includes both Medicare business edits, which are outlined within our Companion Document. The Companion Document, available at *http://www.floridamedicare.com*, contains information outlining what data must be included in your Medicare Part A ANSI 4010A1 transactions.

What is Changing? What Remains the Same?

When you send your ANSI 834 4010A1 file to us, the first level of file editing, the 997, will still be returned to you on the same day.

The new process will be at the Implementation Guide level. The IG claim level reports will now be generated and ready for pickup in your electronic mailbox on the business day following the day the file was transmitted. For example, if a file is sent on Monday and passes standard level edits with a positive 997 report, the IG claim level reports will be available on Tuesday. IG claim level reports will be retrieved via normal mailbox procedures.

New 'Obtain' Script Needed to Retrieve IG Edit Reports

To receive the new *Implementation Guide* reports you must create a second 'OBTAIN' command. The DATATYPE for these reports is 'REJ', not 'EDI' that is currently used for implementation guide reporting. Your obtain command for the 997 standard report will stay the same.

Examples:
For the 997 report your obtain command should be:
$BCBSF$ OBTAIN EDI $BCBSF$

For the IG reports your obtain command should be:
$BCBSF$ OBTAIN REJ ALL $BCBSF$

IF the word 'ALL' is sent in the command above, all available REJ reports will be sent back to you within the same transmission. This can include rejection files for other lines of business. If the word 'ALL' is removed – multiple obtains might need to be sent. Please refer to the *Guide to Gateway* available at *http://www.floridamedicare.com* for further details. These commands may need to be changed by your vendor.

When Can I Retrieve My Reports?

The first obtain, for the 997 report, can be sent immediately after the file is sent. The second obtain REJ should be sent the next business day. The reject report will not be available the same day in which the claim file is sent.

Details of the changes to the Implementation Guide level editing are available at the provider education Web site *http://www.floridamedicare.com*.

All electronic Part A senders have received a flyer in the mail in the beginning of April 1, 2004. ❖

Source: CMS Pub 100-4 Transmittal 49, CR 2879

April 2004 Remittance Advice Remark and Reason Code Update

The Centers for Medicare & Medicaid Services (CMS) is the national maintainer of the remittance advice remark code list that is one of the code lists mentioned in ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010 Implementation Guide (IG). Under the Insurance Portability and Accountability Act (HIPAA), all payers, including Medicare, have to use reason and remark codes approved by X12-recognized maintainers instead of proprietary codes to explain any adjustment in the payment. CMS received a significant number of requests for new remark codes and modifications in existing remark codes from non-Medicare entities. These additions and modifications may not impact Medicare. Traditionally, Medicare staff request remark code changes in conjunction with policy changes that impact the Medicare program. Contractors are notified of those new/modified codes in the corresponding implementation instructions or manual instructions implementing the policy change.

The complete list of remark codes is available at:

http://www.wpc-edi.com/codes/Codes.asp and *http://www.cms.hhs.gov/providers/edi/hipaadoc.asp*

The list is updated each March, July, and November. The following list summarizes changes made from July 1, 2003 to October 31, 2003, and was effective **April 1, 2004.**

Code	Current Narrative
N212	Changes processed under a Point of Service benefit.

Modified Remark Codes

Code	Current Modified Narrative
M39	The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.
M68	Missing/incomplete/invalid attending, ordering, rendering, supervising or referring physician identification.
M80	Not covered when performed during the same session/date as a previously processed service for the patient.
M81	You are required to code to the highest level of specificity. See M76 for rest of the previous text.
M84	Medical code sets used must be the codes in effect at the time of service
M116	Paid under the Competitive Bidding Demonstration project. Project is ending, and future services may not be paid under this project.
MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.
MA121	Missing/incomplete/invalid date the x-ray was performed.
N40	Missing/incomplete/invalid X-ray.
N157	Transportation to/from this destination is not covered.
N160	The patient must choose an option before a payment can be made for this procedure/equipment/supply/service.

Deactivated Remark Codes

Code	Current Modified Narrative
M33	Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.
M34	Claim lacks the CLIA certification number.
M88	We cannot pay for laboratory tests unless billed by the laboratory that did the work.
M92	Services subjected to review under the Home Health Medical Review Initiative.
MA06	Missing/incomplete/invalid beginning and/or ending date(s).
MA49	Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services.
MA85	Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.
MA86	Missing/incomplete/invalid group or policy number of the insured for the primary coverage.
MA87	Missing/incomplete/invalid insured's name for the primary payer.
MA102	Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider.
N17	Per admission deductible.

X12 N 835 Health Care Claim Adjustment Reason Codes

The Health Care Code Maintenance Committee maintains the health care claim adjustment reason codes. The Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year after each X12 trimester meeting at:

http://www.wpc-edi.com/codes/Codes.asp.

Select 'Claim Adjustment Reason Codes' from the pull down menu on this Web site. All reason code changes approved in September 2003 are listed here.

The request for a reason code change may come from non-Medicare entities. If Medicare requests a change, it may be included in a Medicare instruction in addition to the regular code update notification. The regular code update notification will be issued on a periodic basis to provide a summary of changes in the reason and remark codes introduced since the last update notification, and will

Remittance Advice Remark and Reason Code Update—April 2004 Update (continued)

establish the deadline for Medicare contractors to implement the reason and remark code changes that may not already have been implemented as part of a previous Medicare policy change instruction.

A reason code may be retired if it is no longer applicable or a similar code exists. Retirements are effective for a specified future and succeeding versions, but contractors also can discontinue use of retired codes in prior versions. The committee approved the following reason code changes in September 2003.

Reason Code Changes (as of October 31, 2003)

Code	Current Narrative
156	Flexible spending account payments.
157	Payment denied/reduced because service/procedure was provided as a result of an act of war.
158	Payment denied/reduced because service/procedure was provided outside of the United States.
159	Payment denied/reduced because service/procedure was provided as a result of terrorism.
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion.
113	Payment denied/reduced because service/procedure was provided outside the United States or as a result of war.
A2	Contractual Adjustment. ❖

Source: CMS Pub 100-4 Transmittal 93, CR 3122

Third-party Web sites. *This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.*

FRAUD AND ABUSE

Hospital Discounts Offered To Patients Who Cannot Afford To Pay Their Hospital Bills

This document addresses the views of the Office of Inspector General ("OIG") on the following topics: (1) discounts provided by hospitals for uninsured patients who cannot afford to pay their hospital bills and (2) reductions or waivers of Medicare cost-sharing amounts by hospitals for patients experiencing financial hardship. For the following reasons, the OIG believes that – hospitals have the ability to provide relief to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost- sharing amounts. The OIG fully supports hospitals' efforts in this area.

Discounts for Uninsured Patients Who Cannot Afford to Pay Their Hospital Bills

No OIG authority prohibits or restricts hospitals from offering discounts to uninsured patients who are unable to pay their hospital bills. It has been suggested that two laws enforced by the OIG may prevent hospitals from offering discounted prices to uninsured patients. We disagree and address each law in turn.

- **The Federal Anti-Kickback Statute.**[1] The federal anti-kickback statute prohibits a hospital from giving or receiving anything of value in exchange for referrals of business payable by a federal health care program, such as Medicare or Medicaid. *The federal anti-kickback statute does not prohibit discounts to uninsured patients who are unable to pay their hospital bills.* However, the discounts may not be linked in any manner to the generation of business payable by a federal health care program. Discounts offered to *underinsured* patients potentially raise a more significant concern under the anti-kickback statute, and hospitals should exercise care to ensure that such discounts are not tied directly or indirectly to the furnishing of items or services payable by a federal health care program. As discussed below, the statute and regulations offer means to reduce or waive coinsurance and deductible amounts to provide assistance to underinsured patients with reasonably verified financial need.
- **Section 1128(b)(6)(A) of the Social Security Act.**[2] This law permits–but does not require–the OIG to exclude from participation in the federal health care programs any provider or supplier that submits bills or requests for payment to Medicare or Medicaid for amounts that are substantially more than the provider's or supplier's usual charges. The statute contains an exception for any situation in which the Secretary finds "good cause" for the substantial difference. The statute is intended to protect the Medicare and Medicaid programs–and taxpayers–from providers and suppliers that routinely charge the programs substantially more than their other customers.

  The OIG has never excluded or attempted to exclude any provider or supplier for offering discounts to uninsured or underinsured patients. However, to provide additional assurance to the industry, the OIG recently proposed regulations that would define key terms in the statute.[3] Among other things, the proposed regulations would make clear that free or substantially reduced charges to uninsured persons would not affect the calculation of a provider's or supplier's "usual" charges, as the term "usual charges" is used in the exclusion provision. The OIG is currently reviewing the public comments to the proposed regulations. *Until such time as a final regulation is promulgated or the OIG indicates its intention not to promulgate a final rule, it will continue to be the OIG's enforcement policy that, when calculating their "usual charges" for purposes of section 1128(b)(6)(A), individuals and entities do not need to consider free or substantially reduced charges to (i) uninsured patients or (ii) underinsured patients who are self-paying patients for the items or services furnished.*

  As noted in the preamble to the proposed regulations, the exclusion provision does not require a hospital to charge everyone the same price; nor does it require a hospital to offer Medicare or Medicaid its "best price." However, hospitals cannot routinely charge Medicare or Medicaid substantially more than they usually charge others.

In addition to the two laws discussed above, it has been suggested that hospitals are reluctant to give discounts to uninsured patients because the OIG requires hospitals to engage in vigorous collection efforts against uninsured patients. This misperception may be based on some limited OIG audits of specific hospitals' compliance with Medicare's bad debt rules. The bad debt rules and regulations, including the scope of required collection efforts, are established by the Centers for Medicare & Medicaid Services ("CMS"). No OIG rule or regulation requires a hospital to engage in any particular collection practices.

Reductions or Waivers of Cost-Sharing Amounts for Medicare Beneficiaries Experiencing Financial Hardship

The fraud and abuse laws clearly permit the waiver of all or a portion of a Medicare cost-sharing amount for a financially needy beneficiary.[4] Importantly, under the fraud and abuse laws, the "financial need" criterion is *not* limited to "indigence," but can include any reasonable measures of financial hardship.

Like many private insurance plans, the Medicare program includes a cost-sharing requirement. Cost-sharing is an important control on overutilization of items and

Hospital Discounts Offered To Patients Who Cannot Afford To Pay Their Hospital Bills (continued)

services. If beneficiaries are required to pay for a portion of their care, they will be better health care consumers. selecting items or services because they are medically needed.

The routine waiver of Medicare coinsurance and deductibles can violate the federal anti- kickback statute (discussed above) if one purpose of the waiver is to generate business payable by a federal health care program.[5] In addition, a separate statutory provision prohibits offering inducements–including cost-sharing waivers–to a *Medicare* or *Medicaid* beneficiary that the offer or knows or should know are likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier.[6] (This prohibition against inducements offered to Medicare and Medicaid beneficiaries does not apply to uninsured patients.)

However, there are two important exceptions to the general prohibition against waiving Medicare coinsurance and deductibles applicable to hospitals, one for financial hardship situations, and one for inpatient hospital services.

First, providers, practitioners, and suppliers may forgive a Medicare coinsurance or deductible amount in consideration of a particular patient's financial hardship. Specifically, under the fraud and abuse laws, Medicare cost-sharing amounts may be waived so long as:

- the waiver is not offered as part of any advertisement or solicitation;
- the party offering the waiver does not routinely waive coinsurance or deductible amounts; and
- the party waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need or reasonable collection efforts have failed.[7]

The OIG recognizes that what constitutes a good faith determination of "financial need" may vary depending on the individual patient's circumstances and that hospitals should have flexibility to take into account relevant variables. These factors may include, for example:

- the local cost of living;
- a patient's income, assets, and expenses;
- a patient's family size; and
- the scope and extent of a patient's medical bills.

Hospitals should use a reasonable set of financial need guidelines that are based on objective criteria and appropriate for the applicable locality. The guidelines should be applied uniformly in all cases. While hospitals have flexibility in making the determination of financial need, we do not believe it is appropriate to apply inflated income guidelines that result in waivers for beneficiaries who are not in genuine financial need. Hospitals should consider that the financial status of a patient may change over time and should recheck a patient's eligibility at reasonable intervals sufficient to ensure that the patient remains in financial need. For example, a patient who obtains outpatient hospital services several times a week would not need to be re-checked every visit. Hospitals should take reasonable measures to document their determinations of Medicare beneficiaries' financial need. We are aware that in some situations patients may be reluctant or unable to provide documentation of their financial status. In those cases, hospitals may be able to use other reasonable methods for determining financial need, including, for example, documented patient interviews or questionnaires.

Second, another exception to the general prohibition against Medicare cost-sharing waivers is contained in an OIG "safe harbor" regulation related to patient hospital services.[8] Compliance with a safe harbor regulation is voluntary, and failure to comply does not necessarily mean an arrangement is illegal. However, a hospital that complies fully with a safe harbor is assured that it will not be prosecuted under the federal anti-kickback statute.[9]

The safe harbor for waivers of coinsurance and deductibles provides that a hospital may waive coinsurance and deductible amounts for inpatient hospital services for which Medicare pays under the prospective payment system if the hospital meets three conditions:

- the hospital cannot claim the waived amount as bad debt or otherwise shift the burden to the Medicare or Medicaid programs, other payers, or individuals;
- the waiver must be made without regard to the reason for admission, length of stay, or diagnostic related group; and
- the waiver may not be part of a price reduction agreement between the hospital and a third-party payer (other than a Medicare SELECT plan).

While the OIG is not concerned about *bona fide* cost-sharing waivers for beneficiaries with genuine financial need, we have a long-standing concern about providers and suppliers that use "insurance only billing" and similar schemes to entice federal health care program beneficiaries to obtain items or services that may be medically unnecessary, overpriced, or of poor quality.

OIG Advisory Opinion Process

The OIG has an advisory opinion process that is available to hospitals or others that want assurance that they will not run afoul of the fraud and abuse laws.[10] DIG advisory opinions are written opinions that are legally binding on the OIG, the Department of Health and Human Services, and the party that requests the opinion. To obtain an opinion, the requesting party must submit a detailed, written description of its existing or proposed business arrangement. The length of time that it takes for the DIG to issue an opinion varies based upon a number of factors, including the complexity of the arrangement, the completeness of the submission, and how promptly the requestor responds to requests for additional information. Further information about the process, including frequently asked questions, can be found on the OIG Web page at *http://oig.hhs.gov/fraud/advisoryopinions.html*.

Conclusion

Hospitals have the ability to provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations. Nothing in the OIG rules or regulations prohibits such discounts, and the OIG fully supports the hospital industry's efforts to lower health care costs for those unable to afford care.

Hospital Discounts Offered To Patients Who Cannot Afford To Pay Their Hospital Bills (continued)

While every case must be evaluated on its own merits, it is important to note that the OIG has never brought a case based on a hospital's *bona fide* discounting of its bill for an uninsured or underinsured patient of limited means.

Guidance about the anti-kickback statute and other fraud and abuse authorities is available on the OIG's Web page at *http://oig.hhs.gov/*. This guidance includes the Special Fraud Alert on Routine Waivers of Copayments and Deductibles under Medicare Part B; safe harbor regulations (and the "preamble" discussions that include explanatory information), the compliance program guidance for hospitals, and OIG advisory opinions. ❖

[1] 42 U.S.C. § 1320a-7b(b).
[2] 42 U.S.C. § 1320a-7(b)(6)(A).
[3] 68 *Federal Register* 53939 (Sept. 15, 2003)
[4] Hospitals still need to ensure that they comply with all relevant Medicare program rules.
[5] In certain circumstances, the *routine* waiver of coinsurance and deductible amounts can implicate the False Claims Act, 31 U.S.C. § 3729. *See* Special Fraud Alert: Routine Waiver of Copayments or Deductibles Under Medicare Part B, 59 *Federal Register*. 65372, 65374 (Dec. 19, 1994), available on the OIG Web page at *http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html*.
[6] 42 U.S.C. § 1320a-7a(a)(5). The statute includes several other exceptions. One exception permits the waiver of cost-sharing amounts for certain preventive care services without any requirement to determine financial need. 42 U.S.C. § 1320a-7a(i)(6)(D); 42 C.F.R. § 1003.101; *see also* 65 *Federal Register*. 24400, 24409 (April 26, 2000).
[7] 42 U.S.C. § 1320a-7a(i)(6)(A); Special Fraud Alert, *supra* note 5.
[8] 42 C.F.R. § 1001.952(k).
[9] Furthermore, 42 U.S.C. § 1 320a-7a(i)(6)(B) provides that any waiver that fits in a safe harbor to the anti-kickback statute is similarly protected under the beneficiary inducements statute (discussed above).
[10] Section 1128D(b) of the Social Security Act; 42 C.F.R. part 1008.

Source: Office of Inspector General Web page at *http://oig.hhs.gov/fraud/docs/alertsandbulletins/*
Submitted by TriCenturion, Inc., CMS Division of Benefit Integrity

Medicare Discount Drug Program Scam

A Medicare beneficiary reported that supposed representatives from Medicare were going door-to-door discussing the Medicare Discount Drug Program. According to the information reported, these individuals are fraudulently impersonating or misrepresenting Medicare by telephone and by door-to-door visits to Medicare beneficiary homes to discuss the Medicare Discount Drug Program and to obtain personal identifying information from the beneficiaries. In one particular case, the impersonator had the beneficiary's personal identifying information and asked for "the color of her house" to make sure he/she went to the correct address. The impersonator did not leave a name, telephone number, or any business cards.

Medicare beneficiaries should not be releasing their personal identifying information to individuals representing themselves as Medicare officials. The Medicare program has not yet begun its enrollment, marketing, or outreach efforts for the Prescription Discount Drug Program.

The Medicare program is asking for assistance from individuals who may be aware of this activity occurring in their areas by reporting it to the Medicare contractor. ❖

Source: CMS Division of Benefit Integrity, submitted by TriCenturion, Inc.

Questions on Charges for The Uninsured

Q1 Can a hospital waive collection of charges to an indigent, uninsured individual?

A1 Yes. Nothing in the Centers for Medicare & Medicaid Services' (CMS) regulations, Provider Reimbursement Manual, or Program Instructions prohibit a hospital from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the hospital's indigency policy. By "indigency policy" we mean a policy developed and utilized by a hospital to determine patients' financial ability to pay for services. By "medically indigent," we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses. In addition to CMS' policy, the Office of Inspector General (OIG) advises that nothing in that agency's rules or regulations under the Federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a Federal health care program – a highly unlikely circumstance.

Q2 What if a hospital wants to discount charges to patients with large medical bills?

A2 In the same way that a hospital can waive collection of charges for individuals under its indigency policy, a hospital may also offer discounts to those who have large medical bills. Hospitals have flexibility in establishing their own indigency policies. The separate issue of how Medicare reimburses for the uncollectible deductibles and coinsurance of Medicare beneficiaries will be discussed in answers below.

Questions On Charges For The Uninsured (continued)

The OIG advises that discounts to underinsured patients can raise concerns under the Federal anti-kickback statute, but only where the discounts are linked in any way to business payable by Medicare or other Federal health care programs. In addition, depending on the circumstances, discounts to underinsured patients may trigger liability under the provision of the civil monetary penalties statute that prohibits inducements offered to Medicare or Medicaid beneficiaries. But again, if no inducement is being offered, neither statute is implicated. The OIG's views on the related issue of reducing or waiving Medicare cost-sharing amounts on the basis of financial hardship is addressed in answers to questions below. Further information on these fraud and abuse issues is available on the OIG webpage.

Q3 Does a hospital need to get prior approval from either CMS or its fiscal intermediary before offering discounts? How should discounted charges be reflected on a Medicare cost report?

A3 No, a hospital does not need permission before offering discounts. However, the Medicare cost report should reflect full uniform charges rather than the discounted amounts. The hospital should also make the intermediary aware that it has reported its full charges on its cost report.

Q4 Does offering discounts to the uninsured/ underinsured affect a hospital's cost to charge ratio or Medicare cost apportionment?

A4 No, as long as the provider properly reports full charges on the Medicare cost report. This is important because a hospital's cost-to-charge ratio is used to set reimbursement in certain areas of the Medicare program, such as some features of the outpatient prospective payment system.

Q5 How is the above any different than a hospital giving a discount to Blue Cross or any other insurer?

A5 For apportionment purposes, discounting charges to uninsured or underinsured patients is no different than giving an allowance to Blue Cross or other commercial insurers for non-Medicare patients. The Provider Reimbursement Manual directs a provider to report its full uniform charges for courtesy, charity, and third-party payer allowances. The Medicare program sees no complications where a provider offers discounts or allowances to uninsured or underinsured patients versus allowing discounts or allowances to third-party payers.

Q6 Does the Medicare program's lesser of costs or charges (LCC) principle alter any of the above advice or prohibit hospitals from offering discounts to the uninsured or the underinsured?

A6 The LCC principle is a feature of the prior cost method of reimbursing hospitals, before the current payment rules were enacted in the 1980s and 1990s. Under these old rules, Medicare paid hospitals the lesser of the hospital's costs or charges. If that system were still in effect for most services, the LCC principle could be implicated by discounting charges for the uninsured, because if a hospital discounted its charges below its costs or failed to collect from a substantial percentage of charge-paying patients, Medicare reimbursement to the hospital may be reduced. The reality is that this LCC principle has limited applicability today. For example, the LCC principle might apply in the first year of reimbursement for pediatric or certain cancer hospitals. But the vast majority of services provided in hospitals in America today are not subject to the LCC principle.

In the cases where LCC is applicable, however, the Provider Reimbursement Manual provides that if a hospital offers free care or care at a reduced charge to patients determined to be financially indigent, and meets the provisions in the manual, the reduced charges do not result in adjustment to charges under LCC. And since charges are not adjusted, Medicare reimbursement to the hospital is not affected either.

Q7 Will Medicare pay a hospital's bad debts for non-Medicare patients who don't pay their bills?

A7 No. Medicare does not pay the bad debts of non-Medicare patients.

Q8 Does Medicare provide any special compensation to hospitals that treat a large number of uninsured patients – especially those hospitals that have to write off a large number of bills for the uninsured?

A8 Yes. CMS makes payments – significant payments – to hospitals that treat a large number of low-income and uninsured patients. For example, the Medicare and Medicaid disproportionate share provisions paid $22 billion to hospitals last year. And under the rules we explain in Question 9, Medicare pays over $1 billion per year to hospitals for the bad debts of Medicare patients.

Q9 Can a hospital be reimbursed by Medicare for a Medicare patient's unpaid deductibles or coinsurance? Are there special rules for this "bad debt" if the patient meets the hospital's indigency guidelines?

A9 Yes. In the case of Medicare patients generally, the program reimburses a hospital for a percentage of the "bad debt" of a Medicare beneficiary (i.e., unpaid deductibles or coinsurance) as long as the hospital sends a bill to a patient and engages in reasonable, consistent collection efforts. However, if a hospital, using its customary methods, can document that a Medicare patient is indigent or medically indigent (as we used that term in question 1), the hospital can then forgo any collection effort aimed at the patient. And, if the hospital also determines that no source other than the patient is legally responsible for the unpaid deductibles and coinsurance, the hospital may claim the amounts as Medicare bad debts. Hospitals may,

Questions On Charges For The Uninsured (continued)

but are not required to, determine a patient's indigency using a sliding scale. In this type of arrangement, the provider would agree to deem the patient indigent with respect to a portion of the patient's account (e.g., a flat percentage of the debt based on the patient's income, assets, or the size of the patient's liability relative to their income). In the case of a Medicare patient that is determined to be indigent using this method, the amount the hospital decides, pursuant to its policy, not to collect from the patient can be claimed by the provider as Medicare bad debt. The provider must, however, engage in a reasonable collection effort to collect the remaining balance.

Q10 Can a hospital determine its own individual indigency criteria?

A10 Yes. It must, however, apply the criteria to Medicare and non-Medicare patients uniformly.

Q11 Does CMS have any requirements as to what documentation a hospital must secure in order to make an indigency determination? If so, what are those requirements?

A11 For indigent patients who are not Medicare patients, the Medicare program does not prescribe any specific rules for providers to make indigence determinations; rather, the hospital is permitted to use its own business judgment in determining whether or not a non-Medicare patient is indigent and therefore entitled to a discount pursuant to its own indigency policy. For Medicare patients, however, if a provider wants to claim Medicare bad debt reimbursement CMS does require documentation to support the indigency determination. To claim Medicare bad debt reimbursement, the provider must follow the guidance stated in the Provider Reimbursement Manual. A hospital should examine a patient's total resources, which could include, but are not limited to, an analysis of assets, liabilities, income and expenses and any extenuating circumstances that would affect the determination. The provider should document the method by which it determined the indigency and include all backup information to substantiate the determination. Medicare also requires documentation where a collection effort is made. The effort should be documented in the patient's file with copies of the bill(s), follow-up letters, and reports of telephone and personal contacts. In the case of a dually-eligible patient (i.e., a patient entitled to both Medicare and Medicaid), the hospital must include a denial of payment from the State with the bad debt claim.

Q12 Are hospitals required to take low-income patients to court, or seize their homes, or send claims out to a collection agency when those patients don't pay their hospital bills?

A12 No. Nothing in the Medicare instructions requires the hospital to seize a patient's home, take them to court, or use a collection agency. Hospitals aren't required under federal law to engage in any specific level of collection effort for Medicare or non-Medicare patients. However, as we noted and explained more fully above in question 9, the Medicare program does contain a special feature that allows a hospital to be paid for its Medicare bad debts. If a hospital wants this special reimbursement adjustment, it must, at the very least, send the Medicare patient a bill for the debt and must make the same reasonable effort to collect from Medicare patients as it does for its non-Medicare patients. In other words, if the hospital sends non-Medicare patients' bills to a collection agency but does not do so for Medicare patients, the hospital has not engaged in uniform collection efforts and cannot ask Medicare to reimburse it for Medicare patients' bad debt.

Q13 Can a hospital write off a Medicare patient's bill but take aggressive collection action against a non-Medicare patient who doesn't pay his/her bill?

A13 Again, this is a decision to be made by the hospital. If a hospital decides that it wants the special Medicare reimbursement allowing for payment of Medicare bad debts, however, then it must engage in uniform collection efforts for all patients, both Medicare and non-Medicare.

Q14 Can a hospital be subject to criminal sanctions or penalties if it writes off a patient's bill?

A14 As explained more fully on its webpage, the OIG advises that offering a discount to an uninsured patient will not implicate the Federal anti-kickback statute, so long as the discount is not linked in any way to referrals of Federal health care program business.

Q15 What if the hospital wants to write off a Medicare patient's deductible and coinsurance regardless of their income level? Is that permissible?

A15 Yes. If a hospital does not want to collect, but wants to write off the uncollected debt regardless of income level, as "charity care" or as a "courtesy allowance," Medicare rules don't prohibit that, but Medicare will also not reimburse these amounts. Furthermore, a hospital may also forgo collection of deductible and coinsurance amounts using its customary methods for determining indigency, according to the bad debt policy stated in the Provider Reimbursement Manual. Bad debt reimbursement policies are governed by Medicare, but, as we note in the answers to Questions 12 and 13, these apply only where a hospital which has unpaid Medicare coinsurance and deductibles wants Medicare reimbursement for them. Moreover, as explained in detail on its webpage, the OIG advises that under the Federal anti-kickback statute, there is an available safe harbor for waivers of Part A deductible and coinsurance amounts without regard to financial need. In addition, hospitals have the ability to provide relief to Medicare beneficiaries who cannot afford to pay their hospital bills by waiving all or part of a Medicare cost-sharing amount, so long as the waiver is not advertised, not routine, and made

Questions On Charges For The Uninsured (continued)

after there has been a good faith, individualized determination of financial need or failure of reasonable collection efforts. Advertised cost-sharing waivers, routine waivers, or waivers not based on good faith, individualized determinations of financial need or failed collection efforts potentially implicate both the anti-kickback statute and the civil monetary penalties provision barring the offering of inducements to Medicare and Medicaid beneficiaries.

Q16 What steps can hospitals take to assist the uninsured? The underinsured?

A16 The Department of Health and Human Services notes with interest the many steps that state hospital associations such as the Hospital Association of New York State and the Florida Hospital Association, and community hospitals across the country, have taken recently to address the issue of charges to the indigent and medically indigent. As these hospitals have already discovered, they can take several steps to assist patients with payment for hospital care. For example, hospitals can ensure that all written policies for assisting low-income patients are applied consistently. In addition, hospitals can review their current charge structures and ensure that they are reasonably related to both the cost of the service and to meeting all of the community's health care needs. Finally, hospitals could also implement written policies about when and under whose authority patient debt is advanced for collection. For example, a hospital could decide that only the CEO of the hospital can authorize collection action for a patient debt. As we have noted, this is a decision to be made by the hospital; the only Medicare requirement is that whatever decision the hospital makes, it must be consistently applied if the hospital wishes to seek Medicare reimbursement for Medicare bad debts. ❖

Source: CMS Division of Benefit Integrity, submitted by TriCenturion, Inc.

EDUCATIONAL RESOURCES

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CMS Web Page Update for Provider/Supplier Audience

The Centers for Medicare & Medicaid Services (CMS) has updated the new Web page URL addresses and the valuable provider Web tools on the CMS Web site *http://www.cms.hhs.gov*. CMS wants to ensure providers and health care practitioners have quick access to accurate Medicare program information. In keeping with this goal, the specific Web pages listed below are a one-stop resource focused on the informational needs and interests of Medicare providers, including physicians and other practitioners.

Provider/supplier-specific Web pages can be accessed from *http://www.cms.hhs.gov/provider* or *http://www.cms.hhs.gov/suppliers*. From the CMS home page, click on *Providers* from the left navigation bar under *Topics* or search under the *Professionals* tab or drop-down menu.

Specialized information on these one-stop resource pages includes links to federal regulations and notices, transmittals/change requests, and frequently asked questions. General information includes links for coverage, coding, program integrity/medical review and a wealth of subjects of interest to all audiences. Each page also has a highlight section to emphasize important and timely information such as pertinent regulations, instructions, or conferences. Providers, physicians, and suppliers can now go to *http://www.cms.hhs.gov/mailinglists* to subscribe to listservs for various Medicare audiences or categories.

New Provider/ Supplier Web Pages

New provider/supplier Web pages include:

Emergency Medical Treatment & Labor Act (EMTALA) – Content includes policy, regulations, manuals, frequently asked questions and more.

http://www.cms.hhs.gov/providers/emtala

End-Stage Renal Disease (ESRD) Information Resource – Content includes regulations, coverage, billing, demonstrations, CROWN, forms, network organizations, public use files, publications, dialysis facility compare, and more.

http://www.cms.hhs.gov/providers/esrd.asp

Practice Administration Information Resource for Medicare – Content includes up-to-date information and tools as they relate to administrators, Coders, billing personnel, and others outside the traditional provider role.

http://www.cms.hhs.gov/providers/pair

Ambulatory Surgical Centers (ASC) – Content includes information on enrollment/ participation, payment rates, regulations, and more.

http://www.cms.hhs.gov/suppliers/asc

Federally Qualified Health Centers (FQHC) – Content includes regulations, HIPAA, enrollment, frequently asked questions, forms, manuals, publications and more.

http://www.cms.hhs.gov/providers/fqhc

Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) – Content includes billing instructions, coding, payment, medical review information and more.

http://www.cms.hhs.gov/suppliers/dmepos

Home Health Agencies (HHA) – Content includes regulations, coding, billing, outcome and assessment information set (OASIS) and outcome-based quality improvement (OBQI), and more.

http://www.cms.hhs.gov/providers/hha

Hospice – Content includes certification, educational articles, frequently asked questions, research and statistics information and more.

http://www.cms.hhs.gov/providers/hospiceps

Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS) – Content includes useful information related to the development of a PPS for Medicare inpatient psychiatric services, including background and coding information, the proposed regulation and assessment tool and more.

http://www.cms.hhs.gov/providers/ipfpps

Mammography Services – Content includes coding, policies/regulations, helpful resources and more.

http://www.cms.hhs.gov/suppliers/mammography

Rural Health Clinics – Content includes regulations, enrollment, coverage, publications, forms, manuals, and more.

http://www.cms.hhs.gov/providers/rh

Skilled Nursing Facilities (SNF) PPS – Content includes regulations, publications, rates and indices, MDS, swing bed, frequently asked questions and more.

http://www.cms.hhs.gov/providers/snfpps

New Provider/ Supplier Web Pages

New provider Web tools include:

Medicare Physician Fee Schedule Lookup – View physician service information, geographic practice cost indices and payment policy.

http://www.cms.hhs.gov/physicians/mpfsapp

National Correct Coding Initiative (NCCI) Edits – The NCCI promotes uniformity among the contractors that process Medicare claims in interpreting Medicare payment policies. The edits are pairs of services that normally should not be billed by the same provider for the same patient on the same day.

NCCI edits for physicians
http://www.cms.hhs.gov/physicians/cciedits

NCCI edits for hospital outpatient departments
http://www.cms.hhs.gov/providers/hopps/cciedits

Medlearn Matters…Information for Medicare Providers – This page includes links to educational articles and related change requests, in order to present consistent information to providers.

http://www.cms.hhs.gov/medlearn/matters

Additional pages are currently under development for anesthesiologists, surgeons and the Indian Health Service. As the new pages are developed, you will be notified through future publications. The goal is to improve both functionality and formatting to make the pages more user-friendly. ❖

Source: CMS JSM 115, February 20, 2004

Distribution of the *Medicare A Bulletin*

Use of the Internet has become an accepted standard of communication throughout the world. Publications produced by First Coast Service Options, Inc. (FCSO) for our Medicare Florida Part A customers are available on our provider education Web site *http://www.floridamedicare.com*. Our Medicare publications are posted to the Web sites in PDF (portable document format) and may be viewed, printed, or downloaded free of charge.

Hardcopy publications, by contrast, nationally cost Medicare a substantial amount of money for printing and postage. Reducing the number of hardcopies produced is one way Medicare contractors can reduce costs that may be better utilized elsewhere. In addition, enhancements to online publications can be made that are not possible in print.

Providers Must Qualify and Register to Receive the *Medicare A Bulletin* in Hardcopy or CD-ROM Format

Hardcopy or CD-ROM distribution of the *Medicare A Bulletin* is limited to individual providers and medical facilities billed at least one Part A claim to Florida Medicare fiscal intermediary for processing during the twelve months prior to the release of each issue. **Medicare providers who meet these criteria have to register with us to receive the *Bulletin* in hardcopy or CD-ROM format.** Qualifying providers will be eligible to receive one hardcopy or CD-ROM of that issue, *if* a valid reason can be shown why the electronic publication available on the Internet cannot be utilized. "I just prefer hardcopy" is an invalid reason – a valid reason might be lack of a personal computer with Internet access, lack of a CD-ROM drive, or another technical or other barrier.

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Note: If you have a paid subscription, you will receive hardcopies or CD-ROMs of the *Medicare A Bulletin* through your subscription period.

Features of the Electronic Publication

There are advantages to accessing the *Bulletin* online: the electronic version is posted to the Web before print copies are distributed, and you can view, print, or download only those articles important to your business.

In addition, we will be enhancing the format of electronic and CD-ROM newsletters to provide helpful features that do not appear in the current hardcopy format, including hyperlinks. A hyperlink is an element in an electronic document that links the user to another place in the same document, to an entirely different document, or to a Web site. This feature will provide users instant access to the following items:

- *Articles of Interest* – The publication table of contents will include hyperlinks to each article, therefore a provider can choose an article(s) of particular interest to his/her medical practice.
- *Third-Party Web sites* – All third-party Web sites referenced within articles will include hyperlinks to the applicable information on that Web site. (*Online publications only*.)
- *References within the Contractor Web sites* – All additional resources or reference materials mentioned in the newsletter will include hyperlinks to that information within the FCSO Medicare Web sites (e.g., full-text versions of local medical review policies, prior publications, forms, online registration, etc.). Additionally, links to unique Web pages will allow access to information applicable to the user's specialty classification. (*Online publications only*.)

The enhanced electronic publications are available at no charge through the FCSO Medicare Web sites and on CD-ROM at a minimal cost. In addition, you may sign up for the *FCSO eNews*, our free electronic mailing list. Subscribers receive an email notice when new publications are posted to our Web sites, plus frequent notification of other items of interest. Anyone with an email address may sign up for *eNews*; you don't have to be at the office. ❖

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To receive the *Medicare A Bulletin* in hardcopy or CD-ROM format, you must complete this registration form. Please complete and fax or mail it to the number or address listed at the bottom of this form. To receive a hardcopy or CD-ROM of the Fourth Quarter 2004 *Bulletin* your form must be faxed or postmarked on or before June 15, 2004.

Please note that you are not obligated to complete this form to obtain information published in the *Medicare A Bulletin* – issues published beginning in 1997 are available free of charge on our provider education Web site *http://www.floridamedicare.com*.

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A

B

C

C (continued)

D

E

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G

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H (continued)

I

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L (continued)

M

N

O

O (continued)

P

R

S

S (continued)

T

T (continued)

V

W

Addresses

CLAIMS STATUS

Coverage Guidelines
Billing Issues Regarding
Outpatient Services, CORF, ORF, PHP
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

APPEAL RECONSIDERATIONS

Claim Denials (outpatient services only)
Medicare Fair Hearings (Part A)
P. O. Box 45203
Jacksonville, FL 32232-5203

MEDICARE SECONDARY PAYER (MSP)

Information on Hospital Protocols
Admission Questionnaires
Audits
Medicare Secondary Payer
Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

General MSP Information
Completion of UB-92 (MSP Related)
Conditional Payment
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Automobile Accident Cases
Settlements/Lawsuits
Other Liabilities
Medicare Secondary Payer Subrogation
P. O. Box 44179
Jacksonville, FL 32231-4179

PROVIDER EDUCATION

Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Seminar Registration Hotline
1-904-791-8103

ELECTRONIC CLAIM FILING

"DDE Startup"
Direct Data Entry (DDE)
P. O. Box 44071
Jacksonville, FL 32231-4071

FRAUD AND ABUSE

Medicare Fraud and Abuse
P. O. Box 45087
Jacksonville, FL 32232-5087

REVIEW REQUEST

Denied claims that may have been payable under the Medicare Part A program
Medicare Part A Reconsiderations
P. O. Box 45053
Jacksonville, FL 32232-5053

OVERPAYMENT COLLECTIONS

Repayment Plans for Part A Participating Providers
Cost Reports (original and amended)
Receipts and Acceptances
Tentative Settlement Determinations
Provider Statistical and Reimbursement (PS&R) Reports
Cost Report Settlement (payments due to provider or Program)
Interim Rate Determinations
TEFRA Target Limit and Skilled Nursing Facility Routine Cost Limit Exceptions
Freedom of Information Act Requests (relative to cost reports and audits)
Provider Audit and Reimbursement Department (PARD)
P.O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

MEDICARE REGISTRATION

American Diabetes Association Certificates
Medicare Registration – ADA
P. O. Box 2078
Jacksonville, FL 32231-2078

Phone Numbers

PROVIDERS

Customer Service Representatives
Toll-Free
1-877-602-8816

BENEFICIARY

Toll-Free
1-800-333-7586
Hearing Impaired
1-800-754-7820

ELECTRONIC MEDIA CLAIMS

EMC Start-Up
1-904-791-8767, option 4

Electronic Eligibility
1-904-791-8131

Electronic Remittance Advice
1-904-791-6865

Direct Data Entry (DDE) Support
1-904-791-8131

PC-ACE Support
1-904-355-0313

Testing
1-904-791-6865

Help Desk (Confirmation/Transmission)
1-904-905-8880

Medicare Web Sites

PROVIDERS

Florida Medicare Contractor
www.floridamedicare.com
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

BENEFICIARIES

Florida Medicare Contractor
www.medicarefla.com
Centers for Medicare & Medicaid Services
www.medicare.gov

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY

Home Health Agency Claims
Hospice Claims
Palmetto Goverment Benefit Administrators – Gulf Coast
34650 US Highway 19 North, Suite 202
Palm Harbour, FL 34684-2156

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)

Durable Medical Equipment Claims
Orthotic and Prosthetic Device Claims
Take Home Supplies
Oral Anti-Cancer Drugs
Palmetto Goverment Benefit Administrators
P. O. Box 100141
Columbia, SC 29202-3141

RAILROAD MEDICARE

Railroad Retiree Medical Claims
Palmetto Goverment Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

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