Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

Features

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
- ☐ _____
- ☐ _____
- ☐ _____

CMS Centers for Medicare & Medicaid Services

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

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The *Medicare A Bulletin* is published quarterly by the Medicare Publications Department, to provide timely and useful information to Medicare Part A providers in Florida.

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

Medicare Part A Publications
P.O. Box 45270 11T
Jacksonville, FL
32232-5270

A PHYSICIAN'S FOCUS

Investigational Device Exemption vs. Routine Cost of Deemed Qualifying Clinical Trial

A frequent area of provider concern is billing for services associated with clinical research. As the nation's largest health insurer, the Medicare Program is limited by statute to coverage of, and payment for, that which is "reasonable and necessary" for the diagnosis or treatment of an illness or injury. Medicare is not a program for the subsidy of pure clinical research. Investigational services are generally not covered except in relation to Category B Investigational Device Exemption (IDE – effective date November 1995). Also, routine costs associated with deemed qualifying clinical trials are covered – not the item under investigation (effective date September 2000).

Brief Background

Medicare coverage of a category B investigational device is subject to the same process and criteria used by Medicare contractors when making coverage decisions for approved devices. Coverage of the device is dependent on all Medicare coverage requirements contained in the statute, regulations, and instructions issued by the Centers for Medicare & Medicaid Services (CMS). The Food and Drug Administration-approved IDE study protocols restrict investigational device shipment to a limited number of investigational sites for testing on a specific number of patients. Medicare coverage of a category B device is limited to beneficiaries who meet the protocol requirements. For example, coverage of an investigational device may be limited to Medicare beneficiaries participating in approved clinical trials conducted by certain health care practitioners. Coverage under Medicare for a category B device will be based on information provided in the IDE submission. Hospitals and physicians participating in a clinical trial of a category B device should contact the Medicare contractor responsible for processing their claims and understand the types of information contractors need to make a coverage decision on a category B device. First Coast Service Option's process has been published and is coordinated by Medical Policy (email: medical.policy@fcso.com).

As of September 19, 2000, Medicare covers "routine costs" of "qualifying" clinical trials, as well as reasonable and necessary items and services used to diagnose and treat complications arising from participation in such trials. Excluded from coverage are the following: investigational item or service itself, items and services provided solely to satisfy data collection and analysis needs, and items and services customarily provided by research sponsors free of charge for enrollees in the trial. Routine costs specifically include conventional care items and services typically provided absent a clinical trial, items and services provided solely for provision of the investigational item or service, and those items and services needed for reasonable and necessary care arising from provision of an investigational item or service (i.e., diagnosis and treatment of complications). Medicare's clinical trials coverage policy is applicable only to items and services provided to a patient who is officially enrolled in a **qualifying clinical trial**. Currently, Medicare coverage policy only applies to trials **deemed** to be automatically qualified as defined in the national coverage decision on clinical trials (*www.cms.hhs.gov/coverage/8d.asp*). Treatments performed by providers outside of a qualifying clinical trial are subject to normal Medicare coverage rules.

Billing

Requirements for billing category B investigational devices and the routine costs of qualifying clinical trials have been published on the provider educational Web site at *www.floridamedicare.com*. In general, the Category B IDE requires local contractor verification of the clinical study before claims can be submitted for possible coverage. On the other hand, Medicare's coverage of the routine costs of qualifying clinical trials requires no local contractor review of clinical study information. It is recommended that providers have mechanisms for determining, on a current and updated basis, whether devices furnished to Medicare beneficiaries are eligible for coverage in accordance with requirements and whether or not routine costs associated with clinical trials are part of qualifying clinical trials.

James J. Corcoran, M.D., M.P.H.
Medicare Medical Director

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 notification parameters, the approximate delivery dates are:

Publication Name	Publication Date	Effective Date of Changes
First Quarter 2003	Mid-November 2002	January 1, 2003
Second Quarter 2003	Mid-February 2003	April 1, 2003
Third Quarter 2003	Mid-May 2003	July 1, 2003
Fourth Quarter 2003	Mid August 2003	October 1, 2003

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 *www.floridamedicare.com*. In some cases, additional unscheduled special issues will also be published.

Who Receives the *Bulletin*?

Distribution of the Medicare Part A *Bulletin*, is limited to one copy per medical facility that is actively billing Medicare claims to the fiscal intermediary in Florida. FCSO, the Medicare Part A fiscal intermediary, uses the same mailing address for **all** Medicare correspondence. No issue of the *Bulletin* may be sent to a specific person/department within an office. To ensure continued receipt of all Medicare correspondence, providers must keep their mailing addresses current. For additional copies, providers may purchase a separate annual subscription for $75.00. A subscription order form may be found in the Education Resources section in each issue. Issues published since January 1997 may be downloaded from the provider Web site free of charge.

What Is in the *Bulletin*?

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

The publication always 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.) Also, 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, effective with the First Quarter 2003, this section may contain information on wide spread probe review 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 Web site information, and reproducible forms. An index and important addresses and phone numbers are on the back.

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. Medicare Part A (FCSO) maintains the mailing lists for each issue; inclusion on these mailing lists implies that the issue was received by the provider in the event there is a dispute over whether a provider received advance notice regarding coverage of a specific service and the financial liability for it.

Do You Have Comments?

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

Medicare Communication & Education
Editor, *Medicare A Bulletin*
P.O. Box 45270 – 11T
Jacksonville, FL 32232-5270

GENERAL INFORMATION

Claim Processing Requirements for Clinical Diagnostic Laboratory Services Based on the Negotiated Rulemaking

Section 4554(b)(1) of the Balanced Budget Act (BBA), Public Law 105-33 mandated the use of a negotiated rulemaking committee to develop national coverage and administrative policies for clinical diagnostic laboratory services payable under Part B of Medicare. The BBA required that these national policies be designed to promote program integrity and national uniformity and simplify administrative requirements with respect to clinical diagnostic laboratory services payable under Part B.

A national coverage determination (NCD) for a diagnostic laboratory test is a national policy statement granting, limiting or excluding Medicare coverage for that test. It states the Centers for Medicare & Medicaid Services policy with respect to the circumstances under which the test(s) will be considered reasonable and necessary, and not screening or otherwise not covered, for Medicare purposes. Such a policy applies nationwide. An NCD is neither a practice parameter nor a statement of the accepted standards of medical practice. Words such as "may be indicated" or "may be considered medically necessary" are used for this reason. Where a policy gives a general description and then lists examples, the list of examples is not meant to be inclusive, but merely to provide guidance.

An article published in the Third Quarter 2002 *Medicare A Bulletin* (pages 9-10) provided guidelines for the implementation of some administrative provisions of the rule that become effective February 21, 2002. The implementation of the remaining administrative policies specified in the final regulation are effective for services furnished **on or after November 25, 2002.**

Policy Guidelines

Changes effective for services furnished **on or after November 25, 2002** apply to every diagnostic clinical laboratory service that is payable under Medicare Part B. Neither the place where the service was performed, nor the type of contractor that will process the request for payment, has any effect on the applicability of these policies. A clinical laboratory service done in a hospital laboratory, independent laboratory, physician/practitioner office laboratory or other type of CLIA (Clinical Laboratory Improvement Amendment) approved laboratory service is subject to these administrative policies.

The final rule did not supercede the requirement that all physician claims must have a diagnosis. If a physician submits a claim for a service performed in a physician office laboratory, that claim is considered a physician claim and must meet the requirements for physician claims.

Implementation Guidelines

Date of Service

- Date of service must be reported as the **date of specimen collection.**
- The person obtaining the specimen must furnish the date of collection for the specimen to the entity billing Medicare.
- For specimen collections that span more than a 24-hour period, the date of service must be reported as the date the collection began.
- For laboratory tests that require a specimen from stored collections, the date of service must be defined as the date the specimen was obtained from the archives.

Grace Period

For the date of service guideline described above, Medicare will consider granting a grace period of up to 12 months from November 25, 2002 for claims with dates of service on or after November 25, 2002, to accommodate any provider system changes required by the policy changes or clarifications resulting from the provisions of this rule.

Entities that want to request a grace period to permit additional time to implement computerized system changes must send a request in writing on or before November 25, 2002 to the following address:

Customer Service Dept.
Attn: CDL Approval – 6T
P. O. Box 2078
Jacksonville, FL 32231-0048

The request for a grace period must include:

1. A description of the nature of the system changes not able to be implemented timely.
2. A description of the actions the entity has taken to implement timely.
3. A work plan with a timeline providing a detailed description of the tasks that the entity shall undertake to accomplish full implementation.
4. The dates when tasks shall be performed.
5. The date that the entity will be able to implement fully.

Medicare will review the information submitted and respond to the requester advising the revised implementation date. Revised implementation dates will always be on or before November 25, 2003.

If an entity does not meet the deadline for submitting a request for the grace period, a limited additional time for the submittal may be granted based on the Medicare contractor's discretion.

If an entity requested and was granted a grace period and then does not meet the requirements of these instructions by the revised implementation date, the claims submitted by the entity will be returned to the provider.

Note: ***The grace period applies to the date of service requirement, not the NCD.***

Matching of Diagnosis to Procedure

If there is a local medical review policy (LMRP) or national coverage determination (NCD) for one or more of the services included on the claim, the claim is reviewed based on all the diagnosis codes for making a determination regarding medical necessity of the service.

Claim Processing Requirements for Clinical Diagnostic Laboratory Services... (continued)

Even though a claim matches diagnosis to procedure in accordance with an NCD, other rules of adjudication may apply, which could result in denial.

Diagnoses are not required on claims for laboratory services from hospitals or independent laboratories unless there is an NCD or an LMRP for the service; or the provider has been notified of the need for diagnoses on the claims due to a medical review.

Physicians who submit claims for tests done in a physician office laboratory are still subject to the requirement for an ICD-9-CM diagnosis on a claim.

Clarification of the Use of the Term "Screening" or "Screen"

The final rule clarifies that effective, February 21, 2002, the use of the term "screening" or "screen" in *CPT* code descriptor does not necessarily describe a test performed in the absence of signs and symptoms of illness, disease or condition.

Tests that are performed in the absence of signs, symptoms, complaints, personal history of disease, or injury are not covered except when there is a statutory provision that explicitly covers a tests for screening as described.

If a person is tested to rule out or to confirm a suspected diagnosis because the patient has a sign and/or symptoms, this is considered a diagnostic test, not a screening test. The Medicare contractor has discretionary authority to make reasonable and necessary scope of benefit determinations. ❖

Source: CMS Transmittal AB-02-129, CR 2169

List of Policies for Clinical Diagnostic Laboratory Services

The following lists the 23 national coverage determination (NCD) policies for clinical diagnostic laboratory services established under the negotiated rulemaking. The full-text for these national policies is available on the CMS Web site at *http://cms.hhs.gov/manuals/memos/comm_date_dsc.asp*.

- Culture, Bacterial, Urine
- Human Immunodeficiency Virus Testing (Prognosis including monitoring)
- Human Immunodeficiency Virus Testing (Diagnosis)
- Blood Counts
- Partial Thromboplastin Time
- Prothrombin Time
- Serum Iron Studies
- Collagen Crosslinks, Any Method
- Blood Glucose Testing
- Glycated Hemoglobin/ Glycated Protein
- Thyroid Testing
- Lipids
- Digoxin Therapeutic Drug Assay
- Alpha-fetoprotein
- Carcinoembryonic Antigen
- Human Chorionic Gonadotropin
- Tumor Antigen by Immunoassay – CA125
- Tumor Antigen by Immunoassay CA 15-3/CA 27.29
- Tumor Antigen by Immunoassay CA 19-9
- Prostate Specific Antigen
- Gamma Glutamyl Transferase
- Hepatitis Panel/Acute Hepatitis Panel
- Fecal Occult Blood. ❖

Source: CMS Transmittal AB-02-110, CR 2130

Questions and Answers Related to Implementation of National Coverage Determinations for Clinical Diagnostic Laboratory Services

The Centers for Medicare & Medicaid Services (CMS) recently issued guidelines (PM AB-02-087 and AB-02-110) to provide instructions related to the implementation of 23 national coverage determination (NCD) policies for clinical diagnostic laboratory services established under negotiated rulemaking published in the *Federal Register* on November 23, 2001 (66 FR 58788). These PMs are available on the CMS Web site at *http://cms.hhs.gov/manuals/memos/comm_date_dsc.asp*.

CMS awarded a contract to Computer Sciences Corporation to develop diagnosis-to-procedure edit tables to be used nationwide by Medicare contractors to process claims for outpatient clinical diagnostic laboratory services covered under the NCDs.

Since publication of these PMs, CMS has received numerous questions related to implementation of the NCDs. The questions and answers below are to clarify information in the PMs:

Q The NCDs become effective on November 25, 2002. How is this applied?

A The effective date of the NCDs is for services furnished on or after November 25, 2002. The NCDs will be applied on a date of service basis.

***Q Since implementation of the system edits to apply the NCDs will be delayed until January 1, 2003,* should a laboratory hold claims with dates of service on or after November 25, 2002 until then?**

A No, it is not necessary for laboratories to hold claims until January 1, 2003. Medicare claim processing contractors have been instructed to review their local medical review policies (LMRP) to ensure that they do not conflict with the NCDs by November 25, 2002. If there is no conflicting LMRP for the test in your area, the claim should not be edited, and in most cases, will be paid. Laboratories should identify claims that are not appropriate for payment under the new NCDs by using the GA, GZ, and GY modifiers, as appropriate (see next Q & A). Contractors may conduct postpayment review of laboratory claims that are subject to the NCDs to ensure appropriate payment. As a result, erroneously paid claims may be adjusted and erroneous payments may be recovered.

Q PM AB-02-110 states that laboratories should use the GZ modifier for claims where the diagnosis is in list 2, ICD-9-CM codes denied. The GZ modifier is for services that are not medically necessary. Is this the correct modifier?

Questions and Answers Related to Implementation of National Coverage Determinations... (continued)

A Most of the items in list 2 are not covered for statutory reasons other than medical necessity. Labs should use the GY modifier for items that are not covered for reasons other than medical necessity. For items in list 3, ICD-9-CM codes that do not support medical necessity, use the GA modifier for cases where an advance beneficiary notice (i.e., a waiver of liability statement) is on file or the GZ modifier when there is not an advance beneficiary notice on file.

Q The NCD for urine culture includes in the list of CPT codes tests that can be performed to identify bacteria for urine and other purposes. Specifically, CPT codes 87184 and 87186 are for sensitivity studies and are not specific to urine. Concern was raised with editing these CPT codes generally with the diagnoses listed in the covered list.

A It is true that *CPT* codes for sensitivity testing are not specific to urine. Editing of these *CPT* codes with the list of covered diagnoses is likely to result in inappropriate denial of these services when they are performed on specimens other than urine. The edit module will not edit for these *CPT* codes. Rather, they will return a "not applicable" response from the edit module. Contractors are free to edit these codes locally either on a prepayment or postpayment basis.

Q What happens to those codes not included in one of the three lists?

A Every single ICD-9-CM code falls into one of the three lists. Each of the 23 NCD policies has a section that states the codes covered for that policy, the codes denied for that policy, and the codes that (generally) do not support medical necessity. Two of the lists will list specific codes while the third list consists of a default category consisting of any ICD-9-CM codes not listed in the other two.

Q How will the edit module treat claims where the diagnosis is in list 3, ICD-9-CM codes that do not support medical necessity?

A Some contractors have the ability to use an electronic indicator on the claims to show that there is documentation submitted with the claim. Where the indicator is not present, a deny response will be issued, unless the claim is accompanied by an override code. Where the indicator is present on the claim, the edit module will send back a suspend response. Contractors may not deny these suspend claims unless they have reviewed the documentation and made a determination that the documentation does not support medical necessity of the service. Contractors may pay suspend response claims without review of the documentation. In cases where the contractor does not currently have the capability to use an electronic documentation indicator, contractors should either instruct laboratories to submit claims hard copy or develop some other mechanism for the laboratories to notify the contractor that documentation should be associated with the claim. Contractors will then make a decision to either pay the claim without review of the documentation or review the documentation and make a decision based on the evidence supplied. If the decision is to pay the claim, the contractor should use the override code to indicate such so that the edit module will send a pass response. Claims sent to the edit module without the override indicator or the documentation indicator will receive a deny response. See the specifications for the edit module for additional information regarding the record layout for transmitting this information to the edit module and appropriate values.

Q How should contractors correct any claims that were denied in error due to failure to override the edit module?

A Contractors should reopen claims as authorized by the regulations.

Q What MSN messages should be used for denial of claims under the NCDs?

A The edit module will produce two different deny responses. For those services where the response is based on the diagnosis being included on list 2, ICD-9-CM codes that are not covered by Medicare, use MSN message 21.11, service not covered by Medicare. For those services where the denial response is based on the diagnosis being included on list 3, ICD-9-CM codes that do not support medical necessity, use MSN message 15.4, services not medically necessary.

Q How will the edit module handle multiple services with a date code that spans the effective date of the NCDs?

A If the through date of the claim is on or after the effective date, all services on the claim will be edited. In order to avoid claims being edited by the module inappropriately, a provider may split the bill into two bills—one for services prior to the effective date and one for services on or after the effective date. Carriers may also allow providers to split the services onto individual claim lines as well, if their systems allow the claims to be appropriately processed this way.

Q The laboratory final rule makes an exception to the date of service for specimens that have been stored. The date of service for stored specimens is the date the specimen is removed from archives. Sometimes, a laboratory may store a specimen for a day or two before testing. How long does a specimen need to be stored in order to qualify for this exception?

A The final rule did not define the period of time a specimen needs to be stored in order to qualify for this exception. In the absence of national instructions, contractors have the discretion to further clarify the criterion for this exception. The intent of the exception was to recognize long storage periods that occurred prior to testing. Contractors can address the exact length of time on an individual basis.

Q What are the allowable bill types for clinical diagnostic laboratory services?

A The allowable bill types are 12x, 13x, 14x, 22x, 23x, 72x, 74x, 75x, 76x, 83x, and 85x. Clinical diagnostic laboratory services may not be billed on 21x, 32x, 33x, 34x, 71x, 73x, 81x, or 82x bill types.

Source: CMS Transmittal AB-02-134, CR 2383

Implementation of Certain Initial Determination and Appeal Provisions

Section 1869 of the Social Security Act (the Act), as amended by section 521 of the Benefit Improvement and Protection Act of 2000, substantially revises the Medicare claim appeal process. Implementation of certain initial determination and appeal provisions is effective October 1, 2002. However, changes to Medicare standard systems required by implementation of this provision are effective January 1, 2003, allowing the date by which an appeal must be filed with a contractor to be automatically calculated and printed on the Medicare summary notice (MSN). In addition, changes will be made to the remittance advice (RA) and standard appeals information on the back of the MSN to reflect the new filing timeframes for appeals of initial determinations.

New Time Limits for Filing a Request for Appeal

Section 1869(a)(3)(C) of the Act eliminates the distinction between the time limits for requesting a Part A reconsideration and Part B review by creating a 120-day time limit for filing requests for appeal of all initial determinations.

Changes to the RA and MSN

Although the RA codes do not identify a particular filing date for provider or supplier appeals, the codes do identify the applicable Part A and Part B filing timeframes. The MSN specifies the date by which a beneficiary must file an appeal of a denied claim.

Remittance Advice (RA)

The following RA remark codes have been updated to reflect the changes in the filing deadlines. The changes to the messages are identified in the chart below in bold typeface.

RA Remark Code — **Message**

M25 Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim **either within 6 months of the date of this notice, if this notice is dated September 30, 2002 or earlier, or within 120 days of the date of this notice, if this notice is dated October 1, 2002 or later.** If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.

M26 Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice.

The law permits exceptions to the refund requirement in two cases:

- If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or
- If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service.

If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days. Your request for review should include any additional information necessary to support your position.

If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.

The law also permits you to request review at any time **within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later.** However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.

The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. Please contact this office if you have any questions about this notice.

M27 The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.

Implementation of Certain Initial Determination and Appeal Provisions (continued)

You may appeal this determination provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the patient or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal.

You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed **within 60 days of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later (or, for a medical insurance review, within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later)**. You may make the request through any Social Security office or through this office.

MA01(Initial Part B determination, Medicare carrier or intermediary)—If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us **within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later**, unless you have a good reason for being late. An institutional provider, e.g., hospital, SNF, HHA or hospice may appeal only if the claim involves a medical necessity denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.

MA02(Initial Medicare Part A determination)—If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration **within 60 days of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later**. Decisions made by a QIO must be appealed to that QIO **within 60 days**. (An institutional provider, e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under section 1879 of the Social Security Act, and the patient chooses not to appeal.)

Medicare Summary Notice (MSN)

The appeal timeframe for Part A and Part B services is now 120 days from the date shown in the front of the MSN. Changes to the MSN will be made to January 1, 2003. The appeal section of he MSN will print the appropriate appeal language based on the claim information for Part A, Part B, or both services. The last date that the initial determination can be appealed will be automatically printed on the MSN.

Reduction of the Amount in Controversy Required to Request a Part B Administrative Law Judge Hearing

Beneficiaries, physicians, and suppliers wishing to file appeals must satisfy the amount in controversy (AIC) requirement to obtain a Part B administrative law judge (ALJ) hearing. To be consistent with the AIC requirement for Part A ALJ hearings, the AIC requirement for Part B ALJ requests will be $100, for initial determinations made on or after October 1, 2002. ❖

Source: CMS Transmittal AB-02-111, CR 2251

Timely Claim Filing Guidelines for All Medicare Providers

All Medicare claims must be submitted to the contractor within the established timeliness parameters. For timeliness purposes, services furnished in the last quarter of the calendar year are considered furnished in the following calendar year. The time parameters are:

Dates of Service	*Last Filing Date*
October 1, 2000 – September 30, 2001	by December 31, 2002
October 1, 2001 – September 30, 2002	by December 31, 2003
October 1, 2002 – September 30, 2003	by December 31, 2004
October 1, 2003 – September 30, 2004	by December 31, 2005*****

*****If December 31 falls on a federal nonworking day, the last filing date is extended to the next succeeding workday. A federal nonworking day is considered a Saturday, Sunday, legal holiday, or a day declared by statute or executive order as a nonworking day for federal employees.

Claims must be submitted complete and free of errors. Any claim filed with invalid or incomplete information, and returned to provider (RTP) for correction, is not protected from the timely filing guidelines. ❖

HCPCS Updates to the Prosthetics and Orthotics Fee Schedule

The codes listed below were added to the Healthcare Common Procedure Coding System (HCPCS) effective October 1, 2002. These codes fall under the fee schedule category for prosthetics and orthotics, and replace codes L5660, L5662, L5663, and L5664, which are invalid for Medicare use effective October 1, 2002.

Code Descriptor

K0556 Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism

K0557 Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism

K0558 Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code K0556 or K0557)

K0559 Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code K0556 or K0557)

Interim Billing Instructions

The Centers for Medicare & Medicaid Services (CMS) has advised fiscal intermediaries that replacement orthotic/prosthetic "K" codes for discontinued "L" codes listed below are not recognized by the outpatient code editor (OCE) software until the January 2003 OCE update is implemented, even though the "K" codes are effective October 1, 2002. The HCPCS codes affected are:

HCPCS "L" Codes	HCPCS "K" Codes
L5660	K0556
L5662	K0557
L5663	K0558
L5664	K0559

Providers are advised to continue billing for the "L" HCPCS codes during the grace period of October 1, 2002, through December 31, 2002.

The October 2002 OCE will reject claims submitted during this period containing "K" codes with edit reason code 06 (Invalid procedure code), and the claim will be returned to the provider.

Once the January 2003 OCE update is implemented, providers must start billing for these services with the new "K" HCPCS codes. ❖

Source: CMS Transmittal AB-02-104, CR 2245
CMS Transmittal A-02-097, CR 2409

Durable Medical Equipment Ordered with Surrogate Unique Physician Identification Numbers

Section 1833(q) of the Social Security Act requires that all physicians who meet section 1861(r), definition of a physician, must have a unique physician identification number (UPIN). All claims for services ordered or referred by a physician must include the name and UPIN of the ordering/referring physician.

A physician or supplier who bills Medicare for a service or item must show the name and UPIN of the ordering/referring physician on the claim form, if that service or item was the result of an order or referral from a physician. If the ordering physician is also the performing physician, the physician must enter his/her name and assigned UPIN as the ordering physician. If the ordering/referring physician is not assigned a UPIN, the biller may use a surrogate UPIN.

A physician or supplier who submits a claim for a service or item is responsible for ensuring that the name and UPIN of the ordering/referring physician is obtained and submitted on Form CMS-1500. Physician names and UPINs can be found in the UPIN directory. If the physician's UPIN has not yet been issued, a surrogate UPIN is to be used only until an individual UPIN has been assigned. Surrogate UPINs are used under these conditions:

OTH000: To be used when the ordering/referring physician has not yet been assigned and does not qualify for one of the other surrogate UPINs.
Note: Medicare will monitor the excessive use of surrogate UPINS. If a UPIN has been assigned, the physician will be notified of the assigned UPIN. If a UPIN has not been assigned, the physician will be notified of the need to file an application for a UPIN and sent an application form.

RES000: To be used by physicians meeting the description of "intern," "resident," or "fellow."

VAD000: To be used by physicians serving on active duty in the United States military and those employed by the Department of Veterans Affairs.

PHS000: To be used by physicians serving in the Public Health Service, including the Indian Health Service.

RET000: To be used by retired physicians who have not been issued a UPIN. (Retired physicians who have been assigned a UPIN must use the assigned UPIN.)

It is CMS's goal to assign a UPIN to every physician/health care practitioner and group practice that meets the Medicare definition. ❖

Source: CMS Transmittal AB-02-125, CR 2268

Medicare Beneficiaries in State or Local Custody under a Penal Authority

Under Sections 1862(a)(2) and (3) of the Social Security Act (the Act), the Medicare program does not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. These provisions are implemented by regulations 42 CFR 411.4(a) and 411.4 (b), respectively.

Regulations at 42 CFR 411.4(b) state that "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:

(1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and

(2) The state or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

The Centers for Medicare & Medicaid Services (CMS) presumes that a state or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of health care items and services. Therefore, Medicare denies payment for items and services furnished to beneficiaries in state or local government custody. However, providers that furnish services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) must indicate this fact on the claim by using condition code 63.

Effective January 1, 2003, Medicare contractors must deny claims identified by the Common Working File (CWF) as noncovered under 42 CFR 411.4(a) and 411.4(b). These noncovered charges will be adjudicated with remark code N103: "Social Security records indicate that this beneficiary was in the custody of a state or local government when the service was rendered. Medicare does not cover items and services furnished to beneficiaries while they are in state or local government custody under a penal authority, unless under state or local law, the beneficiary is personally liable for the cost of his or her health care while in such custody and the state or local government pursues such debt in the same way and with the same vigor as any other debt."

Appeal Rights

A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that, on the date of service, (1) the conditions of 42 CFR 411.4(b) were met, or (2) the beneficiary was not, in fact, in the custody of a state or local government under authority of a penal statute. ❖

Source: CMS Transmittal AB-02-097, CR 2022

Overpayment Interest Rate

Medicare assesses interest on overpaid amounts that are not refunded timely. Interest will be assessed if the overpaid amount is not refunded within 30 days from the date of the overpayment demand letter. The interest rate on overpayments is based on the higher of the private consumer rate (PCR) or the current value of funds rate.

Effective August 8, 2002, the interest rate applied to Medicare overpayments is **12.625 percent**, based on the revised PCR. The following table lists previous interest rates.

Period	Interest Rate
May 8, 2002 – August 7, 2002	11.75%
February 1, 2002 – May 7, 2002	12.625%
October 31, 2001 – January 31, 2002	13.25%
August 7, 2001 – October 30, 2001	13.25%
April 26, 2001 – August 6, 2001	13.75%
February 7, 2001 – April 25, 2001	14.125%
October 24, 2000 – February 6, 2001	13.875%
August 1, 2000 – October 23, 2000	13.875%
May 3, 2000 – July 31, 2000	13.75%
February 2, 2000 – May 2, 2000	13.50%
October 28, 1999 – February 1, 2000	13.375%
August 4, 1999 – October 27, 1999	13.25%
May 5, 1999 – August 3, 1999	13.375%
February 1, 1999 – May 4, 1999	13.75%
October 23, 1998 –- January 31, 1999	13.50%
July 31, 1998 – October 22, 1998	13.75%
May 13, 1998 – July 30, 1998	14.00 %
January 28, 1998 – May 12, 1998	14.50%
October 24, 1997 – January 27, 1998	13.875% ❖

Source: Transmittal AB-02-118, CR 1899

Diabetes Self-Management Training Fee Schedule Payment

Services for diabetes self-management training (DSMT) furnished in a hospital outpatient setting **on or after February 27, 2001**, are reimbursed based on the comprehensive outpatient rehabilitation facility fee schedule.

Outpatient rehabilitation services are reimbursed based on the provider geographical locality. For Florida, the fee schedules are:

HCPCS Code	Loc 01/02	Loc 03	Loc 04
G0108	28.54	30.90	32.14
G0109	16.90	18.37	19.19

Providers may adjust claims for DSMT services furnished **on or after February 27, 2001**, and processed **prior to October 1, 2002**.

If not previously submitted, providers furnishing DSMT services must submit a copy of the American Diabetes Association (ADA) certificate to the following address:

Medicare Registration – ADA
P. O. Box 2078
Jacksonville, FL 32231-2078

Medicare cannot issue payment for DSMT services if the ADA recognition certificate is not in the provider Medicare records. ❖

Source: CMS Transmittal A-02-032, CR 2049

Home Health Agency Responsibilities Regarding Patient Notification

The Centers for Medicare & Medicaid Services (CMS) has requested the publication of this article to alert home health agencies (HHAs) of their responsibilities concerning consolidation billing and patient notification. The article is informational for fiscal intermediary providers.

The following gives detailed information regarding home health consolidated billing, and the important role that patient notification by home health agencies plays in alleviating the problems currently being encountered by some independent providers as a result of the enforcement of home health consolidated billing.

Home Health Consolidated Billing

The law governing the development of the home health prospective payment, implemented in October 2000, requires the consolidated billing of all Medicare-covered home health services [except durable medical equipment (DME)] while a beneficiary is under a home health plan of care authorized by a physician. Billing for all Medicare-covered home health services (except DME) is to be made by the home health agency that establishes the plan of care for the episode. The home health agency that establishes the patient's plan of care for the episode is known as the "primary" agency. The primary agency has responsibility for consolidated billing under the home health prospective payment system.

Since the implementation of the home health prospective payment system in October 2000, the enforcement of the consolidated billing requirements have been refined. Some independent practitioners have raised concerns about their ability to determine whether a patient is under a home health plan of care and subject to the consolidated billing requirements governing home health prospective payment. The consolidated billing requirements prevent an independent provider from billing Medicare Part B directly for payment for various medical supplies and therapies while a patient is under a home health plan of care.

Types of services that are subject to the home health consolidated billing provision include the following:

- Skilled nursing care
- Home health aide services
- Physical therapy
- Speech-language pathology
- Occupational therapy
- Medical social services
- Routine and non-routine medical supplies
- Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of a HHA that is affiliated or under common control with that hospital
- Care for homebound patients involving equipment too cumbersome to take to the home.

Patient Notification

Under the Medicare Home Health Services Conditions of Participation: ***Patient rights***, (42 CFR, section 484.10 (c) (i)), the HHA must advise the patient, in advance, of the disciplines that will furnish care, and the frequency of visits proposed to be furnished. It is, therefore, the responsibility of the HHA to fully inform beneficiaries that all services, including therapies and supplies, will be provided by his/her primary HHA.

In addition, under the Conditions of Participation: ***Patient liability for payment***, (42 CFR, section 484.10 (e)), HHAs are responsible for advising the patient, in advance, about the extent to which payment is expected from Medicare or other sources***, including the patient.*** Information regarding patient liability for payment must be provided by the HHA both orally and in writing. This should assist in alerting the beneficiary to the possibility of payment liability if he/she were to obtain services from anyone other than their primary HHA.

An inquiry capability for home health information, via carrier systems, is scheduled for implementation in April 2003, as part of the 270/271 HIPAA transaction standard. The implementation of this capability means that independent providers will be able to obtain information regarding a patient's status in a home health plan of care. In the meantime, as required in the Medicare Conditions of Participation for home health Agencies, HHAs should inform beneficiaries of the disciplines that will be furnishing their care. It is imperative that HHAs ensure that these responsibilities are properly carried out, especially since beneficiaries are not always reliable sources of information to other providers.

HHA adherence to these requirements will help to ensure that all home health services are provided within the appropriate venue. ❖

Source: CMS Transmittal A-02-104, CR 2320

Telephone Hours of Operation for Medicare Customer Service Call Centers

Effective October 1, 2002, there are new extended telephone hours of operation in the Medicare Customer Service call centers:

- The new hours of operation for the **Provider Part A** call center are 9:00 a.m. to 4:30 p.m., Monday through Friday, in Eastern and Central time zones (excluding holiday closings).
- The new hours of operation for the **Provider Part B** call center are 9:00 a.m. to 3:30 p.m., Monday through Friday in Eastern and Central time zones (excluding holiday closings).
- The new hours of operation for the **Beneficiary Part A & B** call center are 9:00 a.m. to 4:30 p.m., Monday through Friday, in Eastern and Central time zones (excluding holiday closings). ❖

Annual Update of HCPCS Codes for Home Health Consolidated Billing

In April 2001, the Centers for Medicare & Medicaid Services (CMS) established the process of periodically updating the lists of Healthcare Common Procedure Coding System (HCPCS) codes subject to the consolidated billing provision of the home health prospective payment system (HH PPS). Services appearing on this list submitted on claims to both Medicare fiscal intermediaries and carriers (including durable medical equipment regional carriers) will not be paid on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Items incident to physician services, as well as supplies used in institutional settings, are not subject to HH consolidated billing.

Updates of the HH consolidated billing code list will occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., "K" codes). These temporary codes may describe services subject to consolidated billing in addition to the permanent list of HCPCS codes that is updated annually.

This notification is the first quarterly HH consolidated billing update for calendar year 2003. It incorporates new temporary codes, as well as the annual update of all HCPCS codes and *CPT* codes that are subject to consolidated billing. Updates for the remaining quarters of the calendar year will occur as needed prior to the next annual update, due to creation of new temporary codes representing services subject to HH consolidated billing.

The new coding identified in each update describes the same services used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Section 1895 of the Social Security Act codifies the HH PPS.

Comprehensive List of *CPT*/HCPCS Codes Subject to Home Health Consolidated Billing January 2003 Update

Therapy Codes

G0193	G0194	G0195	G0196	G0197
G0198	G0199	G0200	G0201	G0279
G0280	G0281	G0282	G0283	0019T
0020T	64550	90901	90911	92506
92507	92508	92510	92526	92601
92602	92603	92604	92605	92606
92607	92608	92609	92610	92611
92612	92614	92616	95831	95832
95833	95834	95851	95852	96000
96001	96002	96003	96105	97001
97002	97003	97004	97012	97014
97016	97018	97020	97022	97024
97026	97028	97032	97033	97034
97035	97036	97039	97110	97112
97113	97116	97124	97139	97140
97150	97504	97520	97530	97532
97533	97535	97537	97542	97545
97546	97601	97602	97703	97750
97799				

Supply Codes

A4212	A4310	A4311	A4312	A4313
A4314	A4315	A4316	A4319	A4320
A4321	A4322	A4323	A4324	A4325
A4326	A4327	A4328	A4330	A4331
A4332	A4333	A4334	A4335	A4338
A4340	A4344	A4346	A4347	A4348
A4351	A4352	A4353	A4354	A4355
A4356	A4357	A4358	A4359	A4361
A4362	A4364	A4365	A4367	A4368
A4368	A4369	A4371	A4372	A4373
A4375	A4376	A4377	A4378	A4379
A4380	A4381	A4382	A4383	A4384
A4385	A4387	A4388	A4389	A4390
A4391	A4392	A4393	A4394	A4395
A4396	A4397	A4398	A4399	A4400
A4402	A4404	A4405	A4406	A4407
A4408	A4409	A4410	A4413	A4414
A4415	A4421	A4422	A4455	A4458
A4460	A4462	A4481	A4622	A4623
A4625	A4626	A4649	A4656	A4657
A4712	A4930	A5051	A5052	A5053
A5054	A5055	A5061	A5062	A5063
A5071	A5072	A5073	A5081	A5082
A5093	A5102	A5105	A5112	A5113
A5114	A5119	A5121	A5122	A5126
A5131	A6010	A6011	A6020	A6021
A6022	A6023	A6024	A6154	A6196
A6197	A6198	A6199	A6200	A6201
A6202	A6203	A6204	A6205	A6206
A6207	A6208	A6209	A6210	A6211
A6212	A6213	A6214	A6215	A6219
A6220	A6221	A6222	A6223	A6224
A6228	A6229	A6230	A6231	A6232
A6233	A6234	A6235	A6236	A6237
A6238	A6239	A6240	A6241	A6242
A6243	A6244	A6245	A6246	A6247
A6248	A6251	A6252	A6253	A6254
A6255	A6256	A6257	A6258	A6259
A6261	A6262	A6266	A6402	A6403
A6404	A6405	A6406	A6410	A7043
A7501	A7502	A7503	A7504	A7505
A7506	A7507	A7508	A7509	K0581
K0582	K0583	K0584	K0585	K0586
K0587	K0588	K0589	K0590	K0591
K0592	K0593	K0594	K0595	K0596
K0597 ❖				

Source: CMS Transmittal A/B-02-137, CR 2402

Advance Beneficiary Notice Initiative

The Centers for Medicare & Medicaid Services (CMS) recently issued program memorandum (PM) AB-02-114, change request 2219, and instructed Medicare contractors to publish this PM on their Web sites. Information on PM AB-02-114 is available to Medicare providers by accessing the provider education Web site at *www.floridamedicare.com* in the Part A section, under the CMS Pubs (A) link.

Requirements and standards published in PM AB-02-114 replace information contained in PM A-01-77, change request 1192 published in the Second Quarter 2002 *Medicare A Bulletin* (pages 7-10).

PM AB-02-114 contains requirements and instructions regarding:

- Implementation on standards for providing Medicare beneficiaries with advance beneficiary notices (ABNs) prior to furnished services and items believe to be noncovered by Medicare
- Implementation of Form CMS-R-131 –Advance Beneficiary Notice (ABN)
- Limitations on beneficiary liability for medical equipment and supplies
- Instructions on ABN standards for certain hospice claim.

Instructions in PM AB-02-114 supersede any conflicting current instructions in the following manuals:

- Medicare Carriers Manual sections 7300-7300.10 and 7330
- Medicare Intermediary Manual sections 3430-3445 and 3719-3730.2
- Hospital Manual sections 291- 297.1, 406, and 414ff
- Skilled Nursing Facility Manual sections 350-362.3
- Hospice Manual sections 270-276
- Medicare Program Integrity Manual, Chapter 5.

Advance Beneficiary Notice Requirements

Instructions on the use of ABNs apply to all claims for Part B services furnished by institutional providers and/or processed by fiscal intermediaries.

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient. For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions (always coded to the highest level of specificity).
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. ABNs advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment. ABNs allow beneficiaries to make informed consumer decisions about receiving items or services for which they may have to pay out-of-pocket, and to be more active participants in their own health care treatment decisions. An ABN must meet the following requirements:

- The ABN must be on an approved Form CMS-R-131 (see "New Patient Liability Notice" below).
- The ABN must be given in writing, in advance of furnishing the service or item.
- The ABN must include the patient's name, date(s) and description of the service or item, and the reason(s) why the service or item may not be considered medically reasonable and necessary (e.g., the service is not covered based on the patient's diagnosis, the frequency of the service was in excess of accepted standards of medical practice, etc.).
- The notice must be signed and dated by the patient, indicating the patient assumes financial responsibility for the service if payment is denied as being not medically reasonable and necessary for reason(s) indicated on the advance notice. The signature of the provider of service is not required.
- The ABN should be maintained with the patient's medical record.

New Patient Liability Notice

Form CMS-R-131 is the new approved ABN, ***required for services provided on or after October 1, 200***2. Form CMS-R-131 was developed as part of CMS Beneficiary Notices Initiative (BNI), and was approved by the OMB (Office of Management and Budget) on June 18, 2002. The new ABNs are designed to be more beneficiary-friendly, more readable and understandable, with patient options more clearly defined.

There are two ABN forms - the General Use form (CMS-R-131G) and the Laboratory Tests form (CMS-R-131L). Both are standard forms that *may not be modified*; however, both contain customizable boxes for the individual requirements of users, following the guidance in CMS PM AB-02-114.

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found on CMS's BNI Web site at *www.cms.hhs.gov/medicare/bn*i. ❖

Source: CMS Transmittal A/B 02114, CR 2219

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.*

2003 Holiday Schedule

First Coast Service Options, Inc. will observe the following holiday schedule in 2003:

January 1, (Wednesday)	New Year's Day
January 20, (Monday)	Martin Luther King Jr. Day
April 18, (Friday)	Good Friday
May 30, (Monday)	Memorial Day
July 4, (Friday)	Independence Day
September 1, (Monday)	Labor Day
November 27, (Thursday)	Thanksgiving Holiday
November 28, (Friday)	Thanksgiving Holiday
December 25, (Thursday)	Christmas Holiday
December 26, (Friday)	Christmas Holiday. ❖

Coordination of Benefits Trading Partner Update

The following trading partner has been added to the Florida Medicare Part A crossover insurer list.

Trading Partner number:	KYMD40621
Trading Partner Name:	Kentucky Medicaid

For a complete list of the active trading partners with First Coast Service Options, Inc. Medicare Part A as it relates to electronic coordination of benefits, see the Third Quarter 2002 *Medicare A Bulletin* (page 7). ❖

AMBULANCE SERVICES

Clarification of Medicare Policy Regarding the Implementation of the Ambulance Fee Schedule

The Centers for Medicare & Medicaid Service (CMS) has provided additional guidance and clarifications on issues concerning the interpretation of Medicare policy during implementation of the ambulance fee schedule. These guidance and clarifications supplement previously issued instructions regarding implementation of the ambulance fee schedule. This article does not intend to replace previously issued instructions and does not encompass all issues that have been addressed to date through informal processes.

The following clarifications reflect Medicare policy regarding the implementation of the ambulance fee schedule.

Implementation of the Ambulance Fee Schedule

The ambulance final rule published on February 27, 2002, establishes a fee schedule for the payment of ambulance services under the Medicare program, thereby implementing section 1834(l) of the Social Security Act. The ambulance fee schedule is effective for claims with dates of service **on or after April 1, 2002**. The final rule established a five-year transition period, during which time payment will be based on a blended amount, based in part on the ambulance fee schedule and in part on reasonable cost or reasonable charge, as applicable.

During the transition period, the fee schedule amount, blended with a provider's reasonable cost or supplier's reasonable charge portion of the payment, will determine the ambulance fee schedule blended rate for each transition year. Percentages for the blended rate during the transition period are provided on page 17.

The fee schedule effective date is based on the date of service for the claim, not the date of processing. Claims with a date of service prior to April 1, 2002, may not be resubmitted for processing under the new ambulance fee schedule guidelines. These claims are processed using the reasonable cost or reasonable charge methodology, as applicable, which was in place prior to the fee schedule.

Sources of Additional Information

Fee Schedule Formula/Payment Calculations. The ambulance fee schedule final rule, published in the *Federal Register* (67 FR 9100) on February 27, 2002, provides the formula for calculating the ambulance fee schedule amount and examples of payment rate calculations.

ZIP Code File and Fee Schedule File. The ZIP code public use file that can be used to determine the locality that applies for a particular geographic area, and the ambulance fee schedule public use file are posted on the CMS Web site located at *www.cms.hhs.gov/medlearn* (under Ambulance Fee Schedule, ZIP Code File for Ambulance Services).

No Transport

The Medicare ambulance benefit is a transportation benefit. If no transport of a Medicare beneficiary occurs, then there is no Medicare-covered service. This policy applies to situations in which the beneficiary refuses to be transported, even if medical services are provided prior to loading the beneficiary onto the ambulance (e.g., BLS or ALS assessment). However, an entity that furnishes a noncovered service to a Medicare beneficiary may bill the beneficiary for the service.

ZIP Codes

Under the ambulance fee schedule, the point of pickup as reported by its five-digit ZIP code determines the basis for payment. The ZIP code of the point of pickup determines both the applicable locality fee schedule amount, and whether a rural adjustment applies. If the ambulance transport required a second or subsequent leg, then the ZIP

Clarification of Medicare Policy Regarding the Implementation of the Ambulance Fee Schedule (continued)

code of the point of pickup of the second or subsequent leg determines both the applicable fee for such leg and whether a rural adjustment applies. Accordingly, the ZIP code of the point of pickup *must* be reported on every claim to determine both the correct fee schedule amount and, if applicable, any rural adjustment.

Areas without a ZIP Code. In areas without an apparent ZIP code, it is the provider's/supplier's responsibility to confirm that the point-of-pickup does not have a ZIP code that has been assigned by the U.S. Postal Service (USPS). If the provider/supplier has made a good-faith effort to confirm that no ZIP code for the point-of-pickup exists, it may use the ZIP code nearest to the point-of-pickup. Providers and suppliers should document their confirmation with the USPS, or other authoritative source, that the point-of-pickup does not have an assigned ZIP code and annotate the claim to indicate that a surrogate ZIP code has been used (e.g., "Surrogate ZIP code; POP in No- ZIP"). Providers and suppliers should maintain this documentation and provide it to Medicare upon request. Additional documentation will be requested from providers/suppliers when a claim submitted using a surrogate ZIP code does not contain sufficient information to determine a ZIP code does not exist for the point-of-pickup.

New ZIP Codes. New ZIP codes are considered urban until CMS determines a ZIP code is located in a rural area. Thus, until a ZIP code is added to the Medicare ZIP code file with a rural designation, it will be considered an urban ZIP code. However, despite the default designation of new ZIP codes as "urban," Medicare contractors have discretion to determine that a new ZIP code is rural until designated otherwise. If the contractor designates a new ZIP code as rural, and CMS later changes the designation to urban, then the contractor, as well as any provider or supplier paid for mileage or for air services with a rural adjustment, will be held harmless for this adjustment. Providers and suppliers should annotate claims using a new ZIP code with a remark to that effect. Providers and suppliers should maintain documentation of the new ZIP code and provide it to their contractor upon request. If the provider or supplier believes a new ZIP code the contractor has designated as urban should be designated as rural (under the standard established by the Medicare fee schedule regulation), it may request an adjustment from the intermediary or appeal the determination with the carrier, as applicable, in accordance with standard procedures.

Reporting Inaccurate ZIP Code Information. Providers and suppliers that knowingly and willfully report a surrogate ZIP code because they do not know the proper ZIP code may be engaging in abusive and/or potentially fraudulent billing. Furthermore, a provider or supplier that specifies a surrogate rural ZIP code on a claim when not appropriate to do so, for the purpose of receiving a higher payment than would have been paid otherwise, may be committing abuse and/or potential fraud.

Basic Life Support (BLS)/Advanced Life Support (ALS) Joint Responses

In situations where a BLS entity provides transport of the beneficiary and an ALS entity provides a service that meets the fee schedule definition of an ALS intervention (e.g., ALS assessment, paramedic intercept services, etc.), the BLS supplier may bill Medicare the ALS rate provided that a written agreement between the BLS and ALS entities exists. Providers/suppliers must provide a copy of the agreement or other such evidence (e.g., signed attestation) as determined by their intermediary or carrier upon request.

While there must be a written agreement in place between the BLS supplier that furnishes the transport and the ALS entity that furnishes the ALS service, Medicare does not regulate the compensation between the BLS entity and ALS entity. If there is no agreement between the BLS ambulance supplier and ALS entity furnishing the service, then only BLS level of payment may be made. In this situation, the ALS entity's services are not covered and the beneficiary is liable for the expense of ALS services to the extent these services are beyond the scope of BLS level of payment.

Ground to Air Ambulance Transports

When a beneficiary is transported by ground ambulance and transferred to an air ambulance, the ground ambulance may bill Medicare for the level of service provided, and mileage from the point-of-pickup to the point-of-transfer to the air ambulance.

Mileage

Local Billing Practices for Carrier-Based Mileage Calculations. Payment is allowed for all medically necessary mileage. That is, Medicare allows payment for mileage incurred transporting the beneficiary to the nearest appropriate facility (or transfer point in the case of an air to ground or ground to air transfer).

Rural Adjustment Versus Lower of Submitted Charge or Fee Schedule Amount. Although a transport with a point-of-pickup located in a rural area is subject to a rural adjustment for mileage, Medicare still pays the lesser of the billed charge or the applicable fee schedule amount for mileage. Thus, when rural mileage is involved, compare the fee schedule rural mileage payment rate blended with the reasonable cost/charge mileage amount to the provider's/supplier's actual charge for mileage, and pay the lesser amount.

Billing Rural Mileage. Providers and suppliers must report all medically necessary mileage, including the mileage subject to a rural adjustment, in a single line item on the CMS-1500/CMS-1491/CMS-1450/electronic claim form.

Calculating the Rural Adjustment. If the point-of-pickup is a rural ZIP code, the rural adjustment for ground mileage is 1.5 times the urban mileage allowance for the first 17 loaded miles, and 1.25 times the urban mileage allowance for any loaded miles between 18 and 50, inclusive. The rural adjustment for air ambulance services (fixed wing or rotary wing) is 1.5 times both the applicable air service base rate and total mileage amount.

Clarification of Medicare Policy Regarding the Implementation of the Ambulance Fee Schedule (continued)

Additional Air Mileage. The contractor may allow additional air mileage in situations where additional mileage is incurred, due to circumstances beyond the pilot's control. These circumstances include, but are not limited to, the following:

- Military base and other restricted zones, air-defense zones, and similar FAA (Federal Aviation Administration) restrictions and prohibitions.
- Hazardous weather.
- Variances in departure patterns and clearance routes required by an air traffic controller.

If the air transport meets the criteria for medical necessity, Medicare pays the actual miles flown for legitimate reasons as determined by the Medicare contractor, once the Medicare beneficiary is loaded onto the air ambulance.

Payment for Supplies and Ancillary Services

Payment for supplies and ancillary services furnished incident to the ambulance transport are included in the ground and air base rates. Medicare will not make a separate, additional payment for supplies and services under the fee schedule. Under the ambulance fee schedule, this policy is unchanged. ❖

Source: CMS Transmittal AB-02-131, CR 2297

Transition Schedule for Implementation of the Ambulance Fee Schedule

On April 1, 2002, the Centers for Medicare & Medicaid Services (CMS) implemented a fee schedule that applies to all ambulance services, including volunteer, municipal, private, independent, and institutional providers, i.e., hospitals, critical access hospitals, and skilled nursing facilities. The fee schedule was effective for claims with dates of service on or after April 1, 2002. Under the fee schedule, ambulance services covered under Medicare will be paid based on the lower of the actual billed amount or the ambulance fee schedule amount.

The fee schedule will be phased in over a five-year period. When fully implemented, the fee schedule will replace the current retrospective reasonable cost reimbursement system for providers and the reasonable charge system for ambulance suppliers.

The transition schedule is as follows:

Year	Fee Schedule Percentage	Cost/Charge Percentage
Year 1(4/1/02–12/31/02)	20%	80%
Year 2 (CY 2003)	40%	60%
Year 3 (CY 2004)	60%	40%
Year 4 (CY 2005)	80%	20%
Year 5 (CY 2006 and thereafter)	100%	0%

The schedule signifies that, during the transition schedule, the Medicare allowed amount for ambulance services and separately billable supplies furnished, and mileage incurred, will comprise a blended rate. The blended rate will include a portion of the fee schedule, and a portion of the provider's reasonable cost or the supplier's reasonable charge.

- During Year 1, the fee schedule amount comprises 20 percent of the blended amount and the remaining 80 percent of the blended amount is based on the supplier's reasonable charge.
- During Year 2, the fee schedule amount will comprise 40 percent of the blended amount and the supplier's reasonable charge will comprise the remaining 60 percent.
- During Year 3, the fee schedule amount will comprise 60 percent of the blended amount and the supplier's reasonable charge will comprise the remaining 40 percent.
- During Year 4, the fee schedule amount will comprise 80 percent of the blended amount and the supplier's reasonable charge will comprise the remaining 20 percent.
- Beginning with Year 5, and each year thereafter, the full fee schedule comprises the entire Medicare allowed amount and no portion of the supplier's reasonable charge shall be considered. ❖

Source: CMS Transmittal AB-02-117, CR 2303

Applicable Types of Bill for Ambulance Services

The Centers for Medicare & Medicaid Services has revised the types of bill (TOB) that can be reported for ambulance services (revenue code 540). This revision supercedes the applicable TOB mandated by section 3660.1.B of the Medicare Intermediary Manual. However, it does not supersede any requirements other than the applicable TOB for ambulance services.

Effective January 1, 2003, *only* TOB 12x, 13x, 18x, 21x, 22x, 23x, 83x and 85x may be reported with revenue code 540. Any subsequent claims reporting ambulance services (revenue code 540) on a TOB 32x, 33x or 34x will be returned to provider.

TOB 18x and 21x may be reported with revenue code 540, even though no separate payment will be made.

Providers (including critical access hospitals) who bill on a TOB 12x may report ambulance services (revenue code 540) following the instructions for reporting ambulance services in PM AB-01-185. Critical access hospitals that are exempt from the ambulance fee schedule (PM A-02-004) and bill ambulance services on a TOB 12x would remain exempt from the ambulance fee schedule.

Types of bill 13x, 22x, 23x, 83x and 85x may continue to report ambulance services (revenue code 540). ❖

Source CMS: Transmittal A-02-062, CR 2175 and A-02-085, CR 2324

Definitions of Ambulance Services

The ambulance fee schedule final rule, published in the February 27, 2002, *Federal Register* established a fee schedule for payment of ambulance services covered under the Medicare program. After a transition period, the fee schedule described in this final rule will replace the former retrospective reasonable cost payment system for providers and the former reasonable charge system for suppliers of ambulance services. This final rule defined various levels of ambulance services.

The definitions below apply to both land and water (hereafter collectively referred to as "ground") ambulance services unless otherwise specified as applying to air ambulance services. These definitions and accompanying policy applications are in effect upon implementation of the ambulance fee schedule, April 1, 2002.

Adjusted Base Rate
Definition: Adjusted base rate is the payment made to a provider/supplier for ambulance services exclusive of mileage.
Application: With respect to ground service levels, the **adjusted base rate** is the payment amount that results from multiplying the **conversion factor** (CF) by the applicable relative value unit (RVU) and applying the **geographic adjustment factor** (GAF). With respect to fixed wing and rotary wing services, the **adjusted base rate** is equal to the national base rate (which, in the case of air ambulance services, is announced as part of the fee schedule (FS) and is not calculated by means of a CF and RVU) adjusted by the provider's/supplier's GAF.

Advanced Life Support Assessment
Definition: Advanced life support (ALS) assessment is an assessment performed by an ALS crew as part of an **emergency response** that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.
Application: The determination to respond emergently with an ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the state or, if there is no similar jurisdiction within the state, then the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

Advanced Life Support Intervention
Definition: Advanced life support (ALS) intervention is a procedure that is, in accordance with state and local laws, beyond the scope of practice of an emergency medical technician-basic (EMT-Basic).
Application: An ALS intervention must be medically necessary to qualify as an intervention for payment of an ALS level of service. An ALS intervention applies only to ground transports.

Advanced Life Support, Level 1
Definition: Advanced life support, level 1 (ALS1) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an **ALS assessment** or at least one **ALS intervention**.

Advanced Life Support, Level 2
Definition: Advanced life support, level 2 (ALS2) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including (1) at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids) or (2) ground ambulance transport and the provision of at least one of the ALS2 procedures listed below.
Application: Crystalloid fluids include fluids such as five percent dextrose in water, saline and lactated Ringer's. Medications that are administered by other means, for example: intramuscular/subcutaneous injection, oral, sublingually or nebulized, do not qualify to determine whether the ALS2 level rate is payable. However, this is not an all-inclusive list. Likewise, a single dose of medication administered fractionally (e.g., one-third of a single dose quantity) on three separate occasions does not qualify for the ALS2 payment rate. The criterion of multiple administrations of the same drug requires a suitable quantity and amount of time between administrations that is in accordance with standard medical practice guidelines. The fractional administration of a single dose (for this purpose meaning a standard or protocol dose) on three separate occasions does not qualify for ALS2 payment. In other words, the administration of one third of a qualifying dose three times does not equate to three qualifying doses for purposes of indicating ALS2 care. One-third of X given three times might = X (where X is a standard/protocol drug amount), but the same sequence does not equal three times X. Thus, if three administrations of the same drug are required to show that ALS2 care was given, each of those administrations must be in accord with local protocols. The run will not qualify on the basis of drug administration if that administration was not according to protocol. An example of a single dose of medication administered fractionally on three separate occasions that would not qualify for the ALS2 payment rate would be the use of intravenous (IV) epinephrine in the treatment of pulseless ventricular tachycardia/ventricular fibrillation (VF/VT) in the adult patient. Administering this medication in increments of 0.25 mg, 0.25 mg, and 0.50 mg would not qualify for the ALS2 level of payment. This medication, according to the American Heart Association (AHA) advanced cardiac life support (ACLS) protocol, calls for epinephrine to be administered in 1 mg increments every three to five minutes. Therefore, in order to receive payment for an ALS2 level of service, three separate administrations of Epinephrine in 1 mg increments must be

Definitions of Ambulance Services (continued)

administered for the treatment of pulseless VF/VT. A second example that would not qualify for the ALS2 payment level is the use of Adenosine in increments of 2 mg, 2 mg, and 2 mg for a total of 6 mg in the treatment of an adult patient with paroxysmal supraventricular tachycardia (PSVT). According to ACLS guidelines, 6 mg of adenosine should be given by rapid intravenous push (IVP) over 1 to 2 seconds. If the first dose does not result in the elimination of the supraventricular tachycardia within 1 to 2 minutes, 12 mg of adenosine should be administered IVP. If the supraventricular tachycardia persists, a second 12 mg dose of adenosine can be administered for a total of 30 mg of adenosine. Three separate administrations of the drug adenosine in the dosage amounts outlined in the later case would qualify for ALS2 payment.

For purposes of this definition, the ALS2 procedures are:

(1) Manual defibrillation/cardioversion
(2) Endotracheal intubation
(3) Central venous line
(4) Cardiac pacing
(5) Chest decompression
(6) Surgical airway
(7) Intraosseous line

Endotracheal intubation is one of the services that qualifies for the ALS2 level of payment; therefore, it is not necessary to consider medications administered by endotracheal intubation for the purpose of determining whether the ALS2 rate is payable. The monitoring and maintenance of an endotracheal tube that was previously inserted prior to the transport also qualifies as an ALS2 procedure.

Advanced Life Support (ALS) Personnel
Definition: ALS personnel are individuals trained to the level of the emergency medical technician-intermediate (**EMT-Intermediate**) or paramedic.

Basic Life Support
Definition: Basic life support (BLS) is transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the state. The ambulance must be staffed by an individual who is qualified in accordance with state and local laws as an emergency medical technician-basic (EMT-Basic). These laws may vary from state to state or within a state. For example, only in some jurisdictions is an EMT-Basic permitted to operate limited equipment onboard the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a peripheral intravenous (IV) line.

Conversion Factor (CF)
Definition: CF is the nationally uniform dollar value that, when multiplied by **relative value units** for a service, results in the **unadjusted base rate** amount for that service.
Application: The CF is, in effect, equal to the unadjusted national ground base rate for a BLS transport. The CF is updated annually for inflation by a factor specified in the statute. The inflated CF is applied to the RVUs of the different levels of ground ambulance service resulting in payment amounts under the ambulance fee schedule.

Emergency Response
Definition: Emergency response is a BLS or ALS1 level of service has been provided in immediate response to a 911 call or the equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call.
Application: The phrase "911 call or equivalent" is intended to establish the standard that the nature of the call at the time of dispatch is the determining factor. Regardless of the medium by which the call is made (e.g., a radio call could be appropriate) the call is of an emergent nature when, based on the information available to the dispatcher at the time of the call, it is reasonable for the dispatcher to issue an emergency dispatch in light of accepted, standard dispatch protocol. An emergency call need not come through 911 even in areas where a 911-call system exists. However, the determination to respond emergently must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol and the dispatcher's actions must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then both the protocol and the dispatcher's actions must meet, at a minimum, the standards of the dispatch protocol in another similar jurisdiction within the state, or if there is no similar jurisdiction, then the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

EMT-Intermediate
Definition: EMT-Intermediate is an individual who is qualified, in accordance with state and local laws, as an EMT-Basic and who is also certified in accordance with state and local laws to perform essential advanced techniques and to administer a limited number of medications.

EMT-Paramedic
Definition: EMT-Paramedic possesses the qualifications of the **EMT-Intermediate** and, in accordance with state and local laws, has enhanced skills that include being able to administer additional interventions and medications.

Fixed Wing (FW) Air Ambulance
Definition: FW air ambulance is the transportation by a fixed wing aircraft that is certified by the Federal Aviation Administration (FAA) as a **fixed wing air ambulance** and the provision of medically necessary services and supplies.

Geographic Adjustment Factor
Definition: Geographic adjustment factor (GAF) is a value that is applied to a portion of the **unadjusted base rate** amount in order to reflect the relative costs of furnishing ambulance services from one area of the country to another. The GAF is equal to the practice expense (PE) portion of the geographic practice cost index (GPCI) from the physician fee schedule.

Definitions of Ambulance Services (continued)

Application: For ground ambulance services, the PE portion of the GPCI is applied to 70 percent of the **unadjusted base rate**. For air ambulance services, the PE portion of the GPCI is applied to 50 percent of the **unadjusted base rate**.

Goldsmith Modification
Definition: Goldsmith modification is the methodology for the identification of rural census tracts that are located within large metropolitan counties of at least 1,225 square miles, but are so isolated from the metropolitan core of that county by distance or physical features as to be more rural than urban in character.

Loaded Mileage
Definition: Loaded mileage is the number of miles for which the Medicare beneficiary is transported in the ambulance vehicle.
Application: Payment is made for each loaded mile. Air mileage is based on loaded miles flown, as expressed in statute miles. There are three mileage payment rates: 1) for ground and water; 2) for FW; and 3) for rotary wing (RW). For air ambulance, the point of origin includes the beneficiary loading point and runway taxiing until the beneficiary is offloaded from the air ambulance.

Point of Pick-Up
Definition: Point of pick-up is the location of the beneficiary at the time he or she is placed on board the ambulance.
Application: The zip code of the **point of pick-up** must be reported on each claim for ambulance services, so that the correct GAF and **rural adjustment factor** (RAF) may be applied, as appropriate.

Relative Value Units
Definition: Relative value units (RVUs) measure the value of ambulance services relative to the value of a base level ambulance service.
Application: The RVUs for the ambulance fee schedule are as follows:

Service Level	RVUs
BLS	1.00
BLS – Emergency	1.60
ALS1	1.20
ALS1 – Emergency	1.90
ALS2	2.75
SCT	3.25
PI	1.75

RVUs are not applicable to FW and RW services.

Rotary Wing (RW) Air Ambulance
Definition: RW air ambulance is the transportation by a helicopter that is certified by the FAA as a rotary wing ambulance, including the provision of medically necessary supplies and services.

Rural Adjustment Factor (RAF)
Definition: RAF is an adjustment applied to the payment amount for ambulance services when the **point of pick-up** is in a rural area.
Application: For ground ambulance services, a 50 percent increase is applied to the ambulance fee schedule mileage rate for each of the first 17 miles; a 25 percent increase is applied to the ambulance fee schedule mileage rate for mileage between 18 and 50 miles; and the urban ambulance fee schedule mileage rate applies to every mile over 50 miles. For air ambulance services, a 50 percent increase is applied to the total air ambulance fee schedule amount for air services; that is, the adjustment applies to the sum of the **adjusted base rate** and ambulance fee schedule rate for all of the loaded air mileage.

Services in a Rural Area
Definition: Services in a rural area are services that are furnished (1) in an area outside a Metropolitan Statistical Area (MSA); or, (2) in New England, outside a New England County Metropolitan Area (NECMA); or, (3) an area identified as rural using the **Goldsmith modification** even though the area is within an MSA.

Specialty Care Transport
Definition: Specialty care transport (SCT) is hospital-to-hospital transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the **EMT-Paramedic**. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.
Application: SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area. The **EMT-Paramedic** level of care is set by each state. Care above that level that is medically necessary and that is furnished at a level of service above the **EMT-Paramedic** level of care is considered SCT. That is to say, if **EMT-Paramedics**—without specialty care certification or qualification—are permitted to furnish a given service in a state, then that service does **not** qualify for SCT. The phrase "**EMT-Paramedic** with additional training" recognizes that a state may permit a person who is not only certified as an **EMT-Paramedic**, but who also has successfully completed additional education as determined by the state in furnishing higher level medical services required by critically ill or critically injured patients, to furnish a level of service that otherwise would require a health professional in an appropriate specialty care area (for example, a nurse) to provide. "Additional training" means the specific additional training that a state requires a paramedic to complete in order to qualify to furnish specialty care to a critically ill or injured patient during an SCT.

Unadjusted Base Rate
Definition: Unadjusted base rate is the national general payment amount for ambulance services exclusive of mileage without application of the GAF. These are general national numbers that do not relate to an individual provider/supplier until the GAF is applied to them.
Application: The **unadjusted base rate** is the payment amount that results from multiplying the CF by the RVU without applying the GAF. ❖

Source: CMS Transmittal AB-02-130, CR 2295

INPATIENT HOSPITAL SERVICES

Long-Term Care Hospital Prospective Payment System Implementation

Long-term care hospitals (LTCHs) are certified under Medicare as short-term acute-care hospitals that have been excluded from the hospital inpatient prospective payment system (PPS) under section 1886(d)((1)(B)(iv) of the Social Security Act, and for the purpose of Medicare payment are defined as having an average inpatient length of stay of greater than 25 days. The implementation of the LTCH PPS replaces the existing reasonable cost-based payment system under which the LTCHs are currently paid.

Statutory Requirements

The Balanced Budget Refinement Act (BBRA) of 1999, as amended by the Medicare, Medicaid, SCHIP (State Children Health Insurance Program) Benefits Improvement and Protection Act (BIPA) of 2000, requires that a budget neutral, per discharge PPS for LTCHs based on diagnosis-related groups (DRGs) be implemented for **cost reporting periods beginning on or after October 1, 2002**, to replace the reasonable cost-based Tax Equity and Fiscal Responsibility Act (TEFRA) payment system.

In the event that the Secretary is unable to implement a PPS by October 1, 2002, the statute requires implementation of a PPS using the "existing hospital DRGs, modified where feasible" to account for differences in resource use by LTCHs.

The Centers for Medicare & Medicaid Services (CMS) has satisfied the statutory implementation requirement by establishing October 2, 2002 as the effective date of the LTCH PPS. Payments for LTCH services delivered for cost reporting periods starting on or after October 1, 2002 will be based on the policies set forth in the final rule published in the August 30, 2002, *Federal Register* (67FR55954).

Affected Medicare Providers

LTCHs are certified under Medicare as short-term acute-care hospitals and for the purpose of Medicare payment are defined as having an average inpatient length of stay of greater than 25 days. LTCHs are identified by the last four digits of the Medicare provider number, which range between "2000" and "2299."

Currently the average length of stay is based on all inpatient-hospital stays (both Medicare and non-Medicare).

Veterans Administration hospitals, hospitals that are reimbursed under state cost control systems approved under 42 CFR Part 403, and hospitals that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90-248 (42 U. S. C. 1395b-1) or section 222(a) of Public Law 92-603 (42 U. S. C. 1395b-1) are not included in the LTCH PPS. Payment to foreign hospitals will be made in accordance with the provisions set forth in section 413.74 of the regulation. See section 412.22(c).

Two of four LTCH in Maryland that are included on CMS' OSCAR (online survey certification and reporting) database are presently paid in accordance with demonstration projects (i.e. the Maryland "Waiver") and therefore not subject to payments under the LTCH PPS.

As established in the Medicare Program Integrity Manual (Rev. 24, 04-05-02), fiscal intermediaries (FIs) are authorized to conduct medical review (MR) of LTCH PPS claims notwithstanding the agreements required between LTCHs and QIOs, under the LTCH PPS, for admission and quality review. All FIs are required to conduct data analysis to identify potential errors and prioritize workload. If an identified aberrancy becomes a priority within the contractor's MR strategy, contractors will institute progressive corrective action (PCA) concepts.

Revision of the Qualification Criterion for LTCHs

Under the PPS, the 25-day calculation will be based only on a hospital's Medicare inpatients, counting total medically necessary days, not only covered days. For cost reporting periods beginning **on or after October 1, 2002,** LTCHs must meet this revised qualification established under the LTCH PPS that counts only Medicare patients in the average 25-day LOS calculation. The FI will review the LTCH's most recent cost report following the effective date of the PPS and will notify the LTCH if it satisfies the new criteria. The LTCH becomes subject to this new criterion for its first cost reporting period beginning on or after October 1, 2002. If the FI determines that the LTCH will not qualify, FIs will follow procedures already established in section 3001.4 of CMS Pub. 15-1.

For payment purposes, Medicare will not cover any patient stay, even if the patient has remaining Medicare days, if that stay has been determined not to have met the medical necessity, reasonableness, and appropriateness standards of the MR procedure established under the final rule. In such case, the days of a stay failing MR, will be excluded from the qualification computation for the LTCH's cost reporting period.

Payment Provisions Under LTCH PPS

Section 123 of Public Law 106-113, the BBRA of 1999, as amended by section 307 of Public Law 106-554, the BIPA of 2000, authorizes the establishment of federal payment rates under PPS for LTCHs.

Note: Presently, each LTCH is paid on a hospital-specific basis under the TEFRA payment system. When the PPS is totally phased-in, after the 5-year transition period, all payments to LTCHs will be based on a standardized amount per patient discharge, a "federal payment rate."

BIPA confers broad authority on the Secretary to determine what payment system adjustments should be included in the LTCH PPS, both on a facility level and on a case-level, in order to ensure that payment most accurately reflects cost.

Long-Term Care Hospital Prospective Payment System Implementation (continued)

Budget Neutrality

BBRA requires that total payments under the PPS must equal the amount that would have been paid if the PPS had not been implemented.

Budget Neutrality Offset

Budget neutrality offset is a reduction factor to **all** Medicare payments during the transition to account for the monetary effect of the 5-year transition from the present cost-based payment system and the PPS and the policy to permit LTCHs to elect payment solely under the PPS rather than based on the blend during the transition.

If a LTCH is paid under the transition blend methodology the budget neutrality offset will be applied to **both** the TEFRA rate percentage and the federal rate percentage.

The budget neutrality offset equals one minus the ratio of the estimated TEFRA reasonable cost-based payments that would have been made had the LTCH PPS not been implemented to the projected total Medicare program payments that would be made under the transition methodology and the option to elect payment based on 100 percent of the federal rate.

The budget neutrality offset for fiscal year (FY) 2003 is 0.934; that is, **all** LTCH PPS payments in FY 2003 will be reduced by 6.6 percent.

The federal rates per discharge under the PPS will be based on average LTCH costs in a base year updated for inflation to the first effective period of the system.

The LTCH PPS will be updated annually as is done with the inpatient hospital, inpatient rehabilitation facility (IRF), and skilled nursing facility (SNF)/swing bed prospective payment systems.

Beneficiary Liability

Beneficiary liability will operate the same as under the current TEFRA payment system. Even if Medicare payments are below cost of care for a patient under prospective payment, the patient cannot be billed for the difference in any case.

As under the present TEFRA payment system, beneficiaries (or their Medigap insurance) are responsible for all noncovered days at the same rate that Medicare would have paid had there been continued coverage.

Once a stay triggers a full long-term care (LTC)-DRG payment (i.e., it exceeds the short-stay outlier threshold), Medicare will pay for the entire stay up to the high cost outlier threshold as it does under the inpatient PPS, regardless of patient coverage. But Medicare will pay only for covered days for lengths of stay equal to or below 5/6th of the average length of stay for a specific LTC-DRG.

For LTC-DRG where the ALOS is 30, 25 days (5/6th of 30) would be the short-stay outlier threshold. If a patient's stay is 25 days or less, Medicare will pay it as a short-stay outlier. So, if for example, a patient has only 15 remaining days of Medicare coverage and stays 24 days in the LTCH, Medicare will only pay for 15 days. If the patient stays 27 days, however, a full LTC-DRG will be paid since the stay has exceeded the short-stay outlier threshold and now will generate a full LTC-DRG payment, which will constitute Medicare payment until and unless it becomes a high cost outlier.

Once the beneficiary exceeds the 5/6th short-stay outlier threshold and receives the full LTC-DRG payment, consistent with inpatient PPS, the remaining "inlier" days of the stay (and associated charges) are considered covered until the high cost outlier is reached even though the beneficiary is not using any Medicare covered days. Once the beneficiary reaches the high cost outlier threshold, the beneficiary may choose to use the lifetime reserve days.

Policy regarding the use of lifetime reserve days is the same as under the inpatient PPS. [In the case of a stay that is categorized as a short-stay outlier for payment purposes (because the patient has run out of regular benefit days prior to exceeding the short-stay outlier threshold of 5/6th of the ALOS for the specific LTC-DRG), the remaining days of the patient's stay will be counted towards the beneficiary's lifetime reserve days (in the absence of an election not to use them) for the remainder of the episode of care, that is, until either the patient is discharged or the lifetime reserve days are exhausted.] Once a beneficiary starts using lifetime reserve days, each remaining day of hospitalization for that episode of care will be counted against those reserve days, even if no additional Medicare payments are generated until the high cost outlier threshold is reached.

Consistent with the policy under inpatient PPS, Medicare will pay for high cost outlier payments only for covered days, that is, days for which the beneficiary has either regular benefit days or lifetime reserve days for the period (or portion) of the stay beyond the high cost outlier threshold, for example:

- Beneficiary "A" is admitted to the LTCH with 26 remaining days of regular Medicare coverage and is grouped to an LTC-DRG with an ALOS of 30 days. "A" has sufficient regular benefit days to trigger a full LTC-DRG payment (greater than 5/6th of the ALOS for that LTC-DRG) for this stay without going into lifetime reserve days. "A" would only need to consider using lifetime reserve days should the stay become a high cost outlier.
- Beneficiary "B" is grouped to the same LTC-DRG as "A" but has only ten remaining days of regular Medicare coverage. Lifetime reserve days will be used for the entire remainder of the stay (unless "B" elects not to use them and to otherwise assume responsibility for payments) and the day count will continue, uninterrupted, until the patient is either discharged or the days are exhausted.

Patient Classification System

The BBRA required the use of DRGs for patient classification purposes in the PPS for LTCHs. In general, a case will be grouped based on the clinical characteristics of the Medicare beneficiary.

The patient classification system groupings are called LTC-DRGs, which are based on the existing CMS DRGs used under the hospital inpatient PPS.

Patient discharges would be grouped using ICD-9-CM codes based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient.

Long-Term Care Hospital Prospective Payment System Implementation (continued)

The same GROUPER software developed by 3M for hospital inpatient PPS, will be used but with LTCH-specific relative weights reflecting the resources used to treat the medically complex LTCH patients. Version 20.0 of the hospital inpatient PPS GROUPER (FY 2003) will be used for FY 2003.

Relative Weights

Payment weights assigning a specific value representing the relative resource use of each LTC-DRG have been determined by the "hospital-specific relative value method." This methodology normalizes charges within each hospital and then compares them across hospitals. Relative weights will be updated annually using the most recent available claims data.

Relative weights and the geometric average length of stay are in the PRICER program.

Payment Rate

Payments to LTCHs under the LTCH PPS will be based on a single standard federal rate for both the inpatient operating and capital-related costs (including routine and ancillary services), but not certain pass through costs (i.e. bad debts, direct medical education, new technologies and blood clotting factors). The LTCH PPS standard federal rate is $34,956.15.

This single standard federal rate will be updated annually by the excluded hospital with capital market basket index.

The formula for an unadjusted LTCH PPS prospective payment is:

Federal Prospective Payment = LTC-DRG relative weight x standard federal rate.

Case-Level Adjustments

Payments will be based on the LTC-DRG described as well as possible adjustments specific to the case. Because LTCHs are distinguished from other inpatient hospital settings by an average length of stay of greater than 25 days, it was necessary to establish payment categories for certain cases that have stays of considerably less than the average length of stay. The following case-level adjustments will be applied to cases that, based on length of stay at the LTCH, receive significantly less than the full course of treatment for a specific LTC-DRG.

Short-stay outliers

A short-stay outlier is a case that has a length of stay between one day and up to and including 5/6th of the average length of stay for the LTC-DRG to which the case is grouped. A short-stay outlier will be paid the least of one of the following:

- 120 percent of the cost of the case (determined using the facility-specific cost to charge ratio and covered charges from the bill)
- 120 percent of the LTC-DRG specific per diem payment (determined using the LTC-DRG relative weight, the average length of stay of the LTC-DRG, and the length of stay of the case)
- The full LTC-DRG payment.

Interrupted stays

An interrupted stay is a case in which a LTCH patient that is transferred upon discharge to an inpatient acute care hospital, an IRF, a SNF, or swing bed and returns to the same LTCH within a specified period of time. The periods of time are as follows:

- Acute care hospital: nine days or less
- IRF: 27 days or less
- SNF: 45 days or less
- Swing bed: 45 days or less.

For example: The LTCH discharges a patient to an acute care hospital on 9/2/02. The patient is readmitted to the LTCH on 9/10/02, this is an interrupted stay. If the patient is readmitted on 9/11/02, it counts as a separate admission.

An interrupted stay case is treated as **one discharge** for the purposes of payment; only **one LTCH PPS payment** is made. (The provider should cancel the bill generated by the original stay in the LTCH or may do a debit/credit adjustment).

Multiple interrupted stays should be entered as one claim but each interrupted stay should be evaluated individually for the rule regarding the appropriate number of days at the intervening facility.

If the length of stay at the "receiving" site of care exceeds the above-specified period of time, the return to the LTCH will be a new admission. This means that the original transfer to that site will be treated as a discharge for payment purposes.

For the percentage of payments that will be made under the TEFRA system during the 5-year transition, the FI will treat each segment of the interrupted stay as a separate discharge.

Payments for special cases

Payments for short-stay outliers are determined in the PRICER logic.

Payments for interrupted stays are based on properly submitted bills by the LTCHs, which are described in billing instructions.

More than one case-level adjustment may apply to the same case. For example, a case may be a short-stay outlier and also be an interrupted stay.

There are no special payment policies for transfer cases or deaths. For example, if a patient in LTCH "A" is transferred to LTCH "B" each LTCH will receive a separate LTC-DRG payment based on the number of days the patient is in the respective LTCH.

Payment policy for co-located providers (hospitals within hospitals, satellite facilities, and on site SNFs) is as follows:

- **Onsite acute care hospitals:** If during a cost reporting period, a LTCH readmits more than five percent of its patients who were discharged to an onsite acute care hospital, only one LTC-DRG payment (with adjustments made for length of stay, as necessary) would be made to the LTCH for all such discharges and readmittances during that cost reporting period.

Long-Term Care Hospital Prospective Payment System Implementation (continued)

- **Onsite SNFs, IRFs or psychiatric facilities:** If during a cost reporting period, more than five percent (separate from the five percent for acute care hospitals) of the LTCH patients are discharged to an onsite SNF, IRF, or psychiatric facility and then readmitted to the LTCH, only one LTC-DRG payment would be made to the LTCH for all such discharges during that cost reporting period.

LTCHs must notify their FIs about the providers with which they are co-located within 60 days of their first cost reporting period that begins on or after October 1, 2002. A change in co-located status must also be reported to the FIs within 60-days of such event. The implementation of the onsite policy is based on information maintained by FIs on other Medicare providers co-located with LTCHs. FIs will notify the CMS regional office of such arrangements.

Payments under this policy will be determined at cost report settlement.

High Cost Outlier Cases

Additional payments will be made for those cases that are high cost outliers. A case will fall into this category if the estimated cost of the case exceeds the outlier threshold (LTC-DRG payment plus a fixed loss amount). Short-stay outliers are also eligible for outlier payments if their costs exceed the outlier threshold. The applicable short-stay outlier payment is used to determine the outlier threshold for short stay outlier cases.

The fixed loss amount is determined such that projected outlier payments are equal to eight percent of total LTCH PPS payments. The fixed loss amount for FY 2003 is $24,450.

If the estimated cost of the case is greater than the outlier threshold an additional payment will be added to the LTC-DRG payment amount.

The outlier payment will be **80 percent** of the difference between the estimated cost of the case and the outlier threshold (the LTC-DRG payment plus a fixed loss amount).

The estimated cost of the case will be calculated by multiplying the Medicare allowable charge on the claim by the LTCH's overall cost-to-charge ratio obtained from the latest settled cost report.

Facility-level adjustments

Facility-level adjustments are based on individual LTCH characteristics. The BIPA confers broad authority on the Secretary to include "appropriate adjustments to the long-term hospital payment system..." Variables examined include an area wage adjustment, adjustment for geographic reclassification, disproportionate share patient (DSH) percentage, and an adjustment for indirect medical education (IME).

The system will include an area wage adjustment that will be phased in over five years. Multiplying the labor-related share of the standard federal rate by the applicable wage index value will make the wage adjustment. For FY 2003, the labor-related share of the standard federal rate is 72.885 percent.

A LTCH's wage index is based on the Metropolitan Statistical Area (MSA) or rural area in which the hospital is physically located, without regard to geographic reclassification under sections 1886(d)(8) – (10) of the Act. For FY 2003, the wage index value is 1/5th of the value of the pre-reclassification, no floor hospital inpatient wage index.

Based on analyses of patient charge data from FYs 2000 and 2001 MedPAR data, and cost report data from FY 1998 and 1999 HCRIS data, there was no empirical evidence to support other adjustments. Therefore, there will be no adjustment for DSH, IME, or geographic reclass.

Phase-in Implementation

The PPS for LTCHs will be phased-in over five **years** from cost-based reimbursement to federal prospective payment. During this transition period, payment is based on an increasing percentage of the LTCH prospective payment and a decreasing percentage of each LTCH's cost-based reimbursement rate for each discharge as follows:

Cost Reporting Periods Beginning On or After	LTCH PPS Federal Rate Percentage	TEFRA Rate Percentage
October 1, 2002 through September 30, 2003	20	80
October 1, 2003 through September 30, 2004	40	60
October 1, 2004 through September 30, 2005	60	40
October 1, 2005 through September 30, 2006	80	20
October 1, 2006	100	0

LTCHs may exercise a one-time opportunity to elect payment based on 100 percent of the federal rate rather than transition from cost-based reimbursement to prospective payment. To exercise this option, for cost reporting periods beginning on or after October 1, 2002 and before December 1, 2002, the LTCH must notify its FI of this election in writing and be received by the FI no later than November 1, 2002. To exercise this option, for cost reporting periods beginning on or after December 1, 2002, the LTCH must notify its FI in writing 30 days prior to the start of the LTCH's next cost reporting period.

Payments to new LTCHs, i.e. a hospital that has its first cost reporting period as a LTCH beginning on or after October 1, 2002, are made based on 100 percent of the standard federal rate.

Note: Under the BIPA, during cost reporting periods beginning in FY 2001, target amounts under TEFRA were increased by 25 percent. This increase will continue to be in effect for the TEFRA portion of transition payments.

Claims Processing and Billing Requirements

LTCH claims submitted between October 1, 2002 and January 1, 2003, will be processed under the current methodology. On or after January 1, 2003, these claims will be mass adjusted to process under the PPS payment methodology.

Long-Term Care Hospital Prospective Payment System Implementation (continued)

System changes necessary to accommodate claim processing and payment under the LTCH PPS will be in place by January 1, 2003. However, beginning October 16, 2002, all LTCHs are required to comply with the Health Insurance Portability & Accountability Act – Administrative Simplification Standards, unless they have obtained an extension in compliance with the Administrative Compliance Act to submit claims in compliance with the standards at 42 CFR 162.1002 and 45 CFR 162.1192 using the ICD-9-CM coding. All ICD-9-CM coding must be used for LTCH providers with cost reporting periods beginning on or after October 1, 2002.

Billing Requirements Under LTCH PPS

Effective with cost reporting periods beginning on or after October 1, 2002, LTCHs must incorporate the following requirements so that FIs can accurately price and pay a claim under the LTCH PPS:

- LTCH claims must be submitted on type of bill (TOB) 11x.
- This initiative is a DRG- based payment system; therefore the LTCH DRG is determined by the grouping of ICD-9-CM codes based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient on the claim. GROUPER version 20.0 will determine DRG assignment.
- Each bill from a LTCH must contain the complete diagnosis and procedure coding for purposes of the GROUPER software. Normal adjustments will be allowed. LTCH providers will submit one admit through discharge claim for the stay. Final PPS payment is based upon the discharge bill.

Stays Prior to and Discharge after PPS Implementation Date

If the patient's stay begins prior to and ends on or after the provider's first fiscal year begin date under LTCH PPS, payment to the facility is based on LTCH PPS rates and rules. There is no split billing. If the facility submitted an interim bill, a debit/credit adjustment must be made prior to PPS payment (according to section 3603 A of the MIM). If the facility submits multiple interim bills, the provider will need to submit cancels for all bills and then rebill once the cancels are accepted.

LTCHs can submit adjustment bills, but late charge bills will not be allowed, like wit inpatient and IRF PPS.

All patient statuses (i.e. discharge disposition codes for TOB 11x) are valid, but there are no special payment policies related to transfers; for example, discounted or per diem payments in transfer situations. The same patient status codes applicable under inpatient PPS for same day transfers (with condition code 40) are applicable under LTCH PPS.

Regarding patient status codes and benefit application, there are no changes to the way it is currently handled under inpatient IPPS.

LTCHs will be paid under the LTCH PPS beginning on the first day of their cost reporting period that begins on or after October 1, 2002.

Billing Ancillary Services Under LTCH PPS

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes will continue to be shown in field locator (FL) 42, in conjunction with the appropriate entries in Service Units (FL 46), and Total Charges (FL 47).

LTCHs are required to report the number of units in FL 46 based on the procedure or service.

LTCHs are required to report the actual charge for each line item, in Total Charges (FL 47).

In general the current policy applies for billing ancillary services and nothing changes with the implementation of this PPS. Refer to MIM section 3626.1.

Benefits Exhausted

If a beneficiary's Part A benefits exhaust during the stay, providers may code an occurrence code A3-C3 (RT 40, field 8-21), (2300 loop HI code BH). If benefits are exhausted prior to the stay, providers may submit a no-pay claim that will be coded by the FI with no pay code B.

LTCH PPS uses occurrence code 47 to indicate the first full day of cost outlier status and also uses occurrence span code 70 for covered non-utilization periods beyond the short-stay outlier threshold. There is an exception if there are not enough regular days to reach the short-stay outlier threshold point. For the beneficiary to continue coverage, LTR days must be utilized for the remainder of the entire stay, as available. Similarly, for the beneficiary to continue coverage, if only LTR days are available, they must be used on a continuous basis throughout the entire stay, as available.

Periodic Interim Payment

Periodic interim payment (PIP) applies to this PPS. Outlier payments in regards to PIP will be handled the way they currently are under other inpatient PPS systems.

Interim Billing

Interim bills are allowed every 60 days. If the facility submits multiple interim bills, the provider must cancel and rebill once the cancels are accepted. See section 3603A of the MIM for instructions on interim billing.

LTCH PRICER Software

CMS has developed a LTCH PRICER program that calculates the Medicare payment rate.

The PRICER software will pay a short-stay outlier if the stay is between one day and up to and including 5/6th of the average length of stay for the LTC-DRG. The PRICER software will incorporate the five-year phase-in period for those providers that choose to be paid on the blended rate. Additional training materials, and other relevant information on long-term care hospital prospective payment system are available on the CMS's Web site at *www.cms.hhs.gov/medlearn*. ❖

Source: CMS Transmittal A-02-093, CR 2288

Patient Notification at Discharge Planning and Home Health Consolidated Billing

The Centers for Medicare & Medicaid Services (CMS) has requested the publication of this article to inform hospitals concerning their responsibilities regarding post-hospital care, and the need to refer patients to appropriate facilities or agencies for follow-up care as part of their discharge planning.

The following gives detailed information regarding home health consolidated billing, and the important role that hospital discharge planning plays in alleviating the problems currently being encountered by some independent providers as a result of the enforcement of home health consolidated billing.

Home Health Consolidated Billing

The law governing the development of the home health prospective payment, implemented in October 2000, requires the consolidated billing of all Medicare covered home health services [except durable medical equipment (DME)] while a beneficiary is under a home health plan of care authorized by a physician. Billing for all Medicare covered home health services (except DME) is to be made by the home health agency that establishes the plan of care for the episode. The home health agency that establishes the patient's plan of care for the episode is known as the "primary" agency. The primary agency has responsibility for consolidated billing under the home health prospective payment system.

Since the implementation of the home health prospective payment system in October 2000, the enforcement of the consolidated billing requirements have been refined. Some independent practitioners have raised concerns about their ability to determine whether a patient is under a home health plan of care and subject to the consolidated billing requirements governing home health prospective payment. The consolidated billing requirements prevent an independent provider from billing Medicare Part B directly for payment for various medical supplies and therapies while a patient is under a home health plan of care.

Intermediaries have had home health inquiry capability since the implementation of the home health prospective payment system in October 2000. An inquiry capability for home health information, via carrier systems, is scheduled for implementation on April 1, 2003 as part of the 270/271 Health Insurance Portability and Accountability Act (HIPAA) transaction standard. The implementation of this capability means that independent providers will be able to obtain information regarding a patient's status in a home health plan of care.

Discharge Planning

Under the Medicare Conditions of Participation (COP) for Hospitals: ***Discharge planning,*** (42 CFR, section 482.43 (b) (3) and (6)), hospitals must have in effect a discharge planning process that applies to all patients, and the discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services. The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and the hospital must discuss the results of the evaluation with the patient or individual acting on his or her behalf. In addition, under 42 CFR, section 482.43 (c) (5), the patient and family members must be counseled to prepare them for post-hospital care and under 42 CFR, section 482.43 (d) ***Transfer or referral,*** the hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.

Hospitals, therefore, should counsel beneficiaries being discharged to receive home health services, that his/her "primary" home health agency; i.e., the agency establishing his/her plan of care, will provide all services. Hospitals should provide a list of home health agencies for beneficiaries to choose from; in addition, when referring the beneficiary to his/her chosen home health agency, the hospital should notify the agency and include any counseling notes, which should serve as a reminder to the home health agency to also notify the beneficiary that **all** services will be provided by them as the "primary" home health agency. Hospitals play a key role in making patients, and/or their caregivers, aware of Medicare home health coverage policies to help ensure that those services are provided within the appropriate venue. ❖

Source: CMS Transmittal A-02106, CR 2319

OUTPATIENT HOSPITAL SERVICES

Certified Registered Nurse Anesthetist Services Furnished by Outpatient Prospective Payment System Hospitals

Currently, outpatient services of certified registered nurse anesthetists (CRNAs) furnished by hospitals subject to outpatient prospective payment system (OPPS) that qualify for cost-based payment under 42 CFR 412.113(c) are made through biweekly interim payments subject to retrospective adjustments based on a settled cost report. Services rendered on or after August 1, 2000, billed under revenue code 964 have not been recognized due to system limitations. As a result, charges for CRNA services needed for reconciling cost-based payment on the cost report will not appear in the Provider Statistical and Reimbursement Report (PS&R).

The Centers for Medicare & Medicaid Services (CMS) is providing interim instructions that will allow these small rural hospitals that qualify for cost-based CRNA services to bill and be properly paid for these services, until related outpatient code editor (OCE) and shared system changes can be made to accommodate billing of these services under revenue code 964 – Anesthetists CRNA.

Interim Billing Instructions

Hospitals that qualify for cost-based CRNA services should temporarily bill for CRNA services under revenue code 379 without a HCPCS code instead of under revenue code 964 for CRNA services furnished on or after August 1, 2000.

Hospitals may adjust or submit a claim for CRNA services using revenue code 379 if a claim containing CRNA services has been previously processed and the charges reported under revenue code 964 were removed from the claim.

Note: Providers must report only CRNA services under revenue code 379 during this interim period until a notification of the system changes is issued. Other anesthesia charges must not be reported under this revenue code. ❖

Source: CMS transmittal A 02-089, CR 2326

Admitting Diagnosis for Observation Services for Outpatient Prospective Payment System

An article published in the "Outpatient Prospective Payment System" section of the Third Quarter 2002 *Medicare A Bulletin* (page 47) addressing payment for observation services stated the admitting diagnosis will not be taken into account to determine that a patient has a qualifying diagnosis for payment of observation services.

Because the admitting diagnosis is not now being passed to the outpatient code editor by the shared system maintainers (SSMs), claims for observation services currently are returned to the provider as not meeting the criteria for separate observation payment if the qualifying diagnosis for observation is entered only in the admitting diagnosis field. Changes to Medicare SSMs effective January 1, 2003, will pass the admitting diagnosis field (form locator number 76 or the electronic equivalent) on Form UB-92 CMS-1450 to the outpatient code editor.

New Requirement

Admitting diagnosis will be taken into account when determining separate observation payment for services furnished **on or after April 1, 2002**, when the bill is submitted or resubmitted, or when an adjustment bill is submitted on or after January 1, 2003. ❖

Source: CMS Transmittal A-02-075, CR 2289

Billing for Group Therapy Services

Medicare pays for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services. The individuals can be, but need not be performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.

The question and answer below clarifies information on this issue:

Q What is the proper billing for therapy services in a hospital outpatient setting when a licensed therapist is treating two or more patients simultaneously?

A The provider should bill the group therapy *CPT* code 97150 [Therapeutic procedure(s) group (2 or more individuals] one time for each of the participants.

Source: CMS Transmittal 1753

GENERAL COVERAGE

Coverage and Billing for Percutaneous Image-Guided Breast Biopsy

Percutaneous image-guided breast biopsy is a method of obtaining a breast biopsy through a percutaneous incision by employing image guidance systems. Image guidance systems may be either ultrasound or stereotactic. For services furnished **on or after January 1, 2003,** Medicare will cover percutaneous image-guided breast biopsy using stereotactic or ultrasound imaging for the following breast lesions:

- **Nonpalpable Breast Lesions –** A radiographic abnormality that is nonpalpable and is graded as a breast imaging reporting and data system (BIRADS) III (probably benign), IV (suspicious abnormality) or V (abnormality).
- **Palpable Breast Lesions –** Palpable lesions that are difficult to biopsy using palpation alone. Contractors have discretion to determine what types of palpable lesions are difficult to biopsy using palpation.

Billing Guidelines for Percutaneous Image-Guided Breast Biopsy

Percutaneous Image-Guided Breast Biopsy are billed based on the general bill review instructions in section 3604 of the Medicare Intermediary manual, Part 3, using Form UB-92 CMS-1450 or the electronic equivalent.

Applicable CPT Codes

19102 [biopsy of breast;] *percutaneous needle core, using imaging guidance*

19103 *percutaneous automated vacuum assisted or rotating biopsy device, using imaging guidance*

10022 *Fine needle aspiration; with imaging guidance*

Note: For imaging guidance performed in conjunction with 19102 and 19103 see codes 76095, 76096, 76360, 76393 and 76942.

Applicable Types of Bill

The applicable bill types are 12x, 13x, 14x and 85x.

Applicable Revenue Codes

Hospitals not subject to outpatient prospective payment system (OPPS), the applicable revenue code is 320 (Radiology-Diagnostic).

Hospitals subject to OPPS may report these services under revenue code 320 or any other appropriate revenue code.

Critical access hospitals (CAHs), method I and method II (technical), the applicable revenue code is 320.

CAHs, method II (professional), may report these services under revenue code 96x, 97x, or 98x.

Payment Requirements

These *CPT* codes are paid under the OPPS and represent the technical component associated with the procedures when furnished to hospital outpatients.

For critical access hospitals:

- Method I and method II (technical) – reimbursement under reasonable cost
- Method II (professional) – reimbursement under the Medicare physician fee schedule (MPFS).

Revisions due to this initiative will be made via the quarterly outpatient code editor update process and the annual January update of the MPFS, respectively. ❖

Source: CMS Transmittal AB-02-128, CR 2232

MEDICAL POLICIES

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), Medicare contractors no longer distribute full-text local medical review policies (LMRPs) to providers in hardcopy format. Providers may obtain full-text LMRPs on the provider education Web site, *www.floridamedicare.com*. Final LMRPs, draft LMRPs available for comment, LMRP statuses, and LMRP 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 focused medical review initiatives. Both initiatives are designed to ensure the appropriateness of medical care and that the carrier'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 claims are *processed*, not the date of service (unless otherwise noted in the policy). Medicare contractors are required to offer a 45-day notice period for LMRPs; the date the LMRP is posted to the Web site is considered the notice date.

Electronic Notification

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

More Information

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

Medical Policy
First Coast Service Options, Inc.
P.O. Box 2078
Jacksonville, FL 32231-0048
Or call (904) 791-8465

Medical Policy Table of Contents

Additions and Revisions to Previously Published Final Medical Policies

Widespread Medical Review Probes

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 *www.floridamedicare.com*.

Local Medical Review Policy Reconsideration Process for the Florida Medicare Part A Intermediary

The "Local Medical Review Policy (LMRP) Reconsideration Process" is a process by which interested parties can request a revision to a Florida Part A Medicare LMRP. First Coast Service Options, Inc. (FCSO), the Florida Medicare fiscal intermediary, will gladly consider all requests for LMRP reconsideration received from Medicare beneficiaries who reside (or receive care) in Florida, or from providers who do business in Florida. Additionally, Florida Medicare Part A will review requests received from other interested parties and, at its discretion, reconsider LMRPs based on such requests.

Individuals using the LMRP reconsideration process can request that the fiscal intermediary modify any section of an existing LMRP. Generally, requests for policy modification will involve requests that information be added to or deleted from an LMRP. For example, one might request that changes be made to the "Indications and Limitations" section of an LMRP, or that additional diagnoses be added to the "Diagnoses that Support Medical Necessity" section of an LMRP.

All LMRP reconsideration requests must be submitted in writing and must clearly state the specific revisions/ modifications that the requestor is seeking. Requests must include a justification supported by evidence, which may materially affect the LMRP's content or basis. Copies of published evidence (e.g., peer-reviewed medical literature, published studies, etc.) must be included with the revision request.

Once the fiscal intermediary receives a written request for an LMRP reconsideration, the fiscal intermediary will, within 30 days, determine if the request is valid (i.e., satisfies the requirements outlined above). If the request is invalid, Florida Medicare Part A will respond, in writing, to the requestor explaining why the request was invalid. If the request is valid, Florida Medicare Part A will, within 90 days of the day the request was received, make a final LMRP reconsideration decision, and notify the requestor of the decision along with the rationale for the decision. Decisions made by Florida Medicare Part A might include one of the following:

- retirement of the policy
- no revision of the policy
- revision to a more restrictive policy
- revision to a less restrictive policy.

If the decision is either to retire the LMRP or to make no revision to the LMRP, within 90 days of the day the request was received, Florida Medicare Part A will inform the requestor of its decision and the rationale for the decision. If the decision is to revise the LMRP, the normal process for LMRP development will be followed.

Requests for LMRP reconsideration should be sent to the following address, fax, or email:

First Coast Service Options, Inc., Medicare Part A
Attn: Medical Policy Department, LMRP Reconsideration
P.O. Box 2078
Jacksonville, Florida 32231-0048
Fax: 904-791-8006
Email: www.medical.policy@fcso.com

Note: Please note that the LMRP reconsideration process applies only to finalized, active, Florida Medicare Part A LMRPs. These LMRPS are posted on the Florida Medicare Web site at *www.floridamedicare.com*. The "LMRP Reconsideration Process" does not apply to the following:

- National coverage decisions (NCDs). Coverage provisions in the Medicare Carriers Manual, Coverage Issue Manual, Federal Register, Code of Federal Regulations, etc.
- Draft LMRPs
- Template LMRPs
- Retired LMRPs
- Individual claim determinations
- Bulletins, articles or training materials
- Any instance in which no LMRP exists (for example, a request to develop a LMRP).

Information concerning the process for requesting modification of a NCD can be found at *www.cms.hhs.gov/coverage/8a1.asp*. ❖

***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.*

10060: Incision and Drainage of Abscess of Skin, Subcutaneous and Accessory Structures—Addition to Policy

The local medical review policy for Incision and Drainage of Abscess of Skin, Subcutaneous and Accessory Structures – 10060 was published in the First Quarter 2002 *Medicare A Bulletin* (pages 26-27). Since that time, diagnosis code 681.02 for onychia and paronychia of the finger has been added to the "ICD-9 CM Codes that Support Medical Necessity" section of this policy.

In addition, critical access hospital – 85x has been added to the "Type of Bill Code" section of the policy.

Effective Date

This revision is effective for claims processed **on or after August 30, 2002**. ❖

Full-text for this local medical review policy is available on the provider education Web site at *www.floridamedicare.com*.

20974: Osteogenic Stimulation—Addition to Policy

The local medical review policy for Osteogenic Stimulation – 20974 was published in the Second Quarter 2002 *Medicare A Bulletin* (pages 21-22). Since that time, the following diagnosis codes have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of this policy:

For *CPT* code 20974:
724.9 other unspecified back disorders

For *CPT* code 20975:
724.9 other unspecified back disorders
909.3 late effect of complications of surgical and medical care
V45.4 arthrodesis status

Effective Date

This revision is effective for claims processed **on or after October 17, 2002**. ❖

29540: Strapping—Addition to Policy

The local medical review policy for Strapping – 29540 was published in the First Quarter 2002 *Medicare A Bulletin* (pages 31-32). Since that time, diagnosis code 459.81 (venous peripheral insufficiency, unspecified) has been added to the "ICD-9-CM Codes that Support Medical Necessity" section of this policy.

Effective Date

This revision is effective for claims processed **on or after August 30, 2002**. ❖

67221: Ocular Photodynamic Therapy (OPT) with Verteporfin

Revision Overview: The policy has been revised to reflect the information in CMS Transmittal 157, Change Request 2335, for Coverage Issues Manual Section 35-100.

Ocular photodynamic therapy (OPT) is a form of treatment for the "wet" or exudative form of age-related macular degeneration (AMD). The wet form of macular degeneration involves the growth of abnormal blood vessels called choroidal neovascularization (CNV) beneath the retina resulting in leakage and bleeding. Without treatment, a majority of patients eventually develop scar tissue beneath the macula, which results in loss of central vision. The concept of OPT is to selectively close the abnormal blood vessels, eliminate the bleeding and leakage, and stabilize or improve the vision.

OPT is similar to traditional laser ablation in that abnormal blood vessels are destroyed; however, it is unique in that the low intensity laser activation of the drug verteporfin (VISUDYNE™) preserves the surrounding structures from destruction, which is an unfortunate side effect of traditional thermal laser. This feature allows use of this treatment for preservation of vision when the CNV occurs close to the center of the macula.

OPT is a two-step process. In the first step, the patient receives an intravenous injection of verteporfin. The verteporfin circulates through the body and adheres to the walls of the abnormal blood vessels beneath the macula. A laser is then used to shine light into the back of the eye. When this light beam activates the verteporfin, there is closure of the blood vessel. Over time, the body is able to absorb the blood and fluid, which results in stabilization or improvement of visual function.

Over the course of 1-3 months, the blood vessels that have been treated with OPT typically open again and leakage may recur. Treatment is performed at three-month intervals if there is evidence of continued leakage from the blood vessels.

Effective Date

This revision is effective **on or after August 20, 2001.** ❖

70544: Magnetic Resonance Angiography (MRA)—Revision to Policy

The local medical review policy for Magnetic Resonance Angiography – 70544 was published in the Second Quarter 2001 *Medicare A Bulletin* (pages 28-30). Since that time, new C-codes were established for use by hospitals to differentiate payment under outpatient prospective payment system for certain MRA and magnetic resonance imaging services furnished with or without contrast. These C-codes were added under the "Indications and Limitations of Coverage" and/or "Medical Necessity" and the "CPT/HCPCS Codes" sections of this policy and correspond with the following CPT codes:

CPT code 74185: New C-codes are C8900, C8901 and C8902
CPT code 71555: New C-codes are C8909, C8910 and C8911
CPT code 73725: New C-codes are C8912, C8913, and C8914

In addition, critical access hospital – 85x has been added, and rural health clinic – 71x and end-stage renal disease facility – 72x have been removed from the "Type of Bill Code" section of the policy.

Effective Date

This revision is effective for claims processed **on or after October 1, 2001**. ❖

Full-text for these local medical review policies are available on the provider education Web site at *www.floridamedicare.com*.

78460: Myocardial Perfusion Imaging—Revision to Policy

The local medical review policy for Myocardial Perfusion Imaging – 78460 was published in the First Quarter 2002 *Medicare A Bulletin* (pages 39-41). Since that time, a revision to the policy has been made based on Program Memorandum, Transmittal AB-02-112, Change Request 2282. *CPT* codes 78478 and 78480 are no longer considered secondary codes.

Effective Date

This revision is effective for dates of services **on or after January 1, 2002**. ❖

87536: HIV-1 Viral Load Testing—Revision to Policy

This local medical review policy (LMRP) for HIV-1 viral load testing has been effective since December of 1997. Since that time, the ICD-9-CM diagnosis codes that support medical necessity have been expanded to include the following diagnosis codes:

079.53	Human immunodeficiency virus, type 2 (HIV-2)
647.60-647.64	Infectious and parasitic conditions in the mother classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium, other viral diseases
795.71	Nonspecific serologic evidence of human immunodeficiency virus (HIV)
V08	Asymptomatic human immunodeficiency virus (HIV) infection status.

Effective Date

This revision is effective for claims processed **on or after October 3, 2002**. ❖

93025: Microvolt T-wave Alternans—Addition to Policy

The local medical review policy for Microvolt T-wave Alternans – 93025 was published in the Fourth Quarter 2002 *Medicare Part A Bulletin* (pages 70-71). Since that time, medical literature was submitted supporting use of microvolt T-wave Alternans in patients with acute myocardial infarction. Therefore, diagnosis code range 410.00-410.92 was added to the policy. In addition, language in the "Coding Guidelines" section of the policy was changed to read, "Florida Medicare considers an electrocardiogram (procedure code 93000-93010) and the sensors/electrodes (procedure code 99070) used in the performance of the test an integral part of Microvolt TWA, and therefore, are not to be billed separately. Additional national correct coding relationships may exist."

Effective Date

This revision is effective for claims processed **on or after September 23, 2002.** ❖

85651: Sedimentation Rate, Erythrocyte—Addition to Policy

The local medical review policy for Sedimentation Rate, Erythrocyte – 85651 was published in the February 25, 1997 *Medicare A Bulletin*. Since that time, diagnosis codes 362.34 (amaurosis fugax), 379.91 (ocular pain), and 784.0 (headache) were added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy.

Effective Date

This revision is effective for claims processed **on or after October 17, 2002**. ❖

92567: Tympanometry—Addition to Policy

The local medical review policy for Tympanometry – 92567 was published in the Fourth Quarter 2002 *Medicare A Bulletin* (pages 65-66). Since that time, the following diagnosis codes have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of this policy:

386.11	Benign paroxysmal positional vertigo
386.12	Vestibular neuronitis
386.19	Other peripheral vertigo
386.2	Vertigo of central origin
386.30-386.35	Labyrinthitis
387.0-387.9	Otosclerosis
388.30-388.32	Tinnitus
389.10-389.18	Sensorineural hearing loss
389.2	Mixed conductive and sensorineural hearing loss

Effective Date

This revision is effective for claims processed **on or after October 23, 2002**. ❖

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

The local medical review policy for Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator – 93724 was published in the Fourth Quarter 2002 *Medicare A Bulletin* (pages 72-75). Since that time, the statement regarding noncoverage of transtelephonic monitoring of a pacer cardioverter-defibrillator was removed from the "Reasons for Denial" section of the policy.

Effective Date

This revision is effective for claims processed **on or after June 20, 2002**. ❖

Full-text for these local medical review policies are available on the provider education Web site at *www.floridamedicare.com*.

G0030: Positron Emission Tomography (PET) Scans

Revision Overview: The policy has been revised to reflect the information in CMS Program Memorandum AB-02-065.

PET is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images, which are obtained from positron emitting radioactive tracer substances (radiopharmaceutical) such as FDG (2-{flourine-18}-fluoro-2-dexoy-D-glucose) that are usually administered intravenously to the patient. At this time, Medicare only covers FDG PET Scans.

This revision is effective for services furnished **on or after Ocotber 1, 2002**. ❖

J1561: Intravenous Immune Globulin

Revision Overview: The policy has been revised to reflect the information in CMS Program Memoranda AB-02-060 and AB-02-093.

Intravenous immune globulin is a solution of human immunoglobulins specifically prepared for intravenous infusion. Immunoglobulin contains a broad range of antibodies that specifically act against bacterial and viral antigens.

Effective Date

This revision is effective for services furnished **on or after October 1, 2002**. ❖

J9212: Interferon—Revision to Policy

The local medical review policy for Interferon – J9212 was published in the Fourth Quarter 2001 *Medicare A Bulletin* (pages 79-81). Since that time, the Centers for Medicare & Medicaid Services has indicated that drugs delivered by intramuscular injection are usually presumed to be ***not*** self-administered by the patient and lists Avonex (J1825), specifically. Therefore, HCPCS code J1825 has been removed from the "Indications and Limitations of Coverage and/or Medical Necessity" and "Reasons for Denials" sections of the policy.

This revision is effective for dates of service **on or after August 1, 2002.**

In addition, revisions to the "Type of Bill Code" section of the policy were made: rural health clinic – 71x, end stage renal disease facility – 72x, and comprehensive outpatient rehabilitation facility – 75x were removed from the policy; critical access hospital – 85x was added to the policy.

This revision is effective for claims processed **on or after August 1, 2002**. ❖

J1745: Infliximab (Remicade™)—Addition to Policy

The local medical review policy for Infliximab – J1745 was published in the Fourth Quarter 2001 *Medicare A Bulletin* (pages 77-78). Since that time, ICD-9-CM diagnosis codes 696.0 (psoriatic arthropathy) and 720.0 (ankylosing spondylitis) have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy.

Effective Date

This addition is effective for claims processed **on or after October 2, 2002**. ❖

J9999: Antineoplastic Drugs—Revision to Policy

The local medical review policy for Antineoplastic Drugs – J9999 was published in the First Quarter 2002 *Medicare A Bulletin!* (pages 70-77). Since that time, several drugs in the policy have received additional indications based on literature evaluations and/or Compendia updates. For the most up to date version, please visit the provider education Web site at *www.floridamedicare.com*.

The J9999 Antineoplastic policy was recently revised to include the following indications:

J9170	Docetaxel-Pancreatic carcinoma (ICD-9-CM codes 157.0-157.9)
J9201	Gemcitabine-Testicular germ cell tumor (ICD-9-CM codes 186.0-186.9)
J9310	Rituximab-Idiopathic Thrombocytopenia Purpura (ICD-9-CM code 287.3)

Effective Date

This addition is effective for claims processed **on or after October 17, 2002**. ❖

VISCO: Viscosupplementation Therapy for Knee—Revision to Policy

In the pathological joint, synovial fluid is more abundant and less viscous (i.e., the concentration of hyaluronan is decreased). Viscosupplementation attempts to return the synovial fluid to its pre-pathological state. Hyaluronic preprations (Hyalgan ®, Synvisc® Hylan G-F 20, and Supartz™) are drugs used for viscosupplementation of the knee's synovial space for those patients with mild to moderate osteoarthritis of the knee. The appropriate codes for hyaluronic preprations are:

J7320	Hylan G-F 20, 16mg, for intra-articular injection
Q3030	Sodium Hyaluronate, per 20 to 25mg dose, for intra articular injection

An article was originally published in the Fourth Quarter 2002 *Medicare A Bulletin* advising this change in coding. The local medical review policy for this service is available on the provider education Web site at *www.florida medicare.com*. ❖

Full-text for these local medical review policies are available on the provider education Web site at *www.floridamedicare.com*.

Intracoronary (Intravascular) Brachytherapy

Recurrent coronary stenosis is a major limitation of coronary stenting. One of the major causes of in-stent restenosis following coronary angioplasty is excessive neointimal formation, an exaggerated healing response to the balloon/stent injury to the coronary vessel that causes narrowing of the stented area. Intracoronary brachytherapy involves the application of radiation therapy in the management of in-stent restenosis of the coronary artery. The angiographic data at six to nine months show significant reductions in the restenosis rate (>50%) in patients treated with brachytherapy.

The delivery of intracoronary brachytherapy is performed by a multidisciplinary team consisting of a cardiologist, radiation therapist, and/or a medical physicist. The two major types of radiation utilized for intracoronary brachytherapy are beta and gamma radiation. Beta radiation emits electrons, which penetrate only a few millimeters and offers the advantage of a shorter treatment time (2-5 minutes) because of its higher energy, increased tissue absorption and shorter penetration which reduces radiation exposure to surrounding tissue and personnel. Gamma radiation emits photons that penetrate tissues deeply and offers the advantage of higher penetration and uniform delivery to all blood vessel layers and is not shielded by stents. Gamma radiation is given for 15-20 minutes and requires medical personnel to leave the room to avoid exposure to radiation.

Currently there is no specific *CPT* or HCPCS code for intracoronary brachytherapy, therefore, the team involved with the planning and delivery of this technology will bill separately. It is expected that the cardiologist bill *CPT* code 92974 (*transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy*) in addition to the primary code (*percutaneous transluminal coronary balloon angioplasty*). The radiation therapy component will be billed by the radiation therapist utilizing the *CPT* codes in the 77000 section of the *CPT*. These may include brachytherapy isodose calculation (procedure codes 77326-77328) remote afterloading high intensity brachytherapy (*CPT* codes 77781-77784), and other radiation treatment delivery services.

Based on the above information, First Coast Service Options, Inc. considers intracoronary (intravascular) brachytherapy medically reasonable and necessary for treatment of in-stent restenosis of a native coronary artery when the Food and Drugs Administration (FDA) approved device is used according to the FDA-approved labeling. ❖

2003 ICD-9-CM Part A LMRP Changes

The 2003 update to the ICD-9-CM diagnosis coding structure is effective October 1, 2002. Providers are required to use the 2003-updated ICD-9-CM coding effective for all hospital discharges and outpatient services occurring **on or after October 1, 2002.** Due to the direct relationship between coding and reimbursement, it is particularly important that providers reimbursed under the outpatient prospective payment system (OPPS) use the appropriate ICD-9-CM coding. Other providers that code diagnoses and procedures (non-OPPS providers) are also affected. In addition, the new diagnosis coding is used in hospital outpatient billing.

Florida Medicare has revised local medical review policies (LMRPs), for procedure codes with specific diagnosis criteria that are affected by the 2003 ICD-9-CM update. The following table lists the LMRPs affected and the specific conditions revised as a result of the 2003 ICD-9-CM update:

LMRP Title	Publications Listing	2003 Changes
29540: Strapping	1st Quarter 2002 *Bulletin* (page 31)	Add 454.8 (Varicose veins of the lower extremities with other complications) for procedure code 29580
36470: Sclerotherapy of Varicose Veins	*Bulletin* G-360, 01/21/1999	Add 454.8 (Varicose veins of the lower extremities with other complications)
70450: Computerized Tomography Scans	1st Quarter 2002 *Bulletin* (page 78 & 79) 4th Quarter 2001 *Bulletin* (page 86) 3rd Quarter 2001 *Bulletin* (page 38)	Add 765.20-765.29 (Weeks of gestation) for procedure codes 70450, 70460, and 70470 Change 770.8 to 770.81-770.89 (Other respiratory problems after birth) for procedure codes 70450, 70460, and 70470 Change 780.9 to 780.91-780.99 (Other general symptoms) for procedure codes 70450, 70460, and 70470
70551: Magnetic Resonance Imaging of the Brain	1st Quarter 2002 *Bulletin* (page 79) 2nd Quarter 2001 *Bulletin* (page 31)	Change 780.9 to 780.91-780.99 (Other general symptoms)
71010: Chest X-ray	4th Quarter 2002 *Bulletin* (page 97) 1st Quarter 2002 *Bulletin* (page 79) 1st Quarter 2001 *Bulletin* (page 19) Aug /Sept 2000 *Bulletin* (page 24)	Change 277.00-277.01 to 277.00-277.09 (Cystic fibrosis) Remove "congestive" from the descriptors for 404.00-404.01, 404.03, 404.11, 404.13, 404.91, and 404.93

2003 ICD-9-CM Part A LMRP Changes (continued)

LMRP Title	Publications Listing	2003 Changes
76075: Bone Mineral Density Studies	1st Quarter 2002 *Bulletin* (page 35 & 79)	Change descriptor for 627.2 to read *Symptomatic* menopausal or female climacteric states
78460: Myocardial Perfusion Imaging	1st Quarter 2002 *Bulletin* (page 39 & 79)	Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart) Add 414.12 (Dissection of coronary artery) Change descriptor for 428.0 to read Congestive heart failure, *unspecified* Add 428.20-428.23 (Systolic heart failure), 428.30-428.33 (Diastolic heart failure), and 428.40-428.43 (Combined systolic and diastolic heart failure)
78472: Cardiac Blood Pool Imaging	1st Quarter 2002 *Bulletin* (page 79) Oct/Nov 2000 *Bulletin* (page 22)	Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart)
80061: Lipid Profile/Cholesterol Testing	1st Quarter 2002 *Bulletin* (page 42)	Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart) Change descriptor for 414.10-414.19 to read Aneurysm *and dissection* of heart
82435: Chloride	2nd Quarter 2001 *Bulletin* (page 46)	Change descriptor for 428.0 to read Congestive heart failure, *unspecified*
82784: Gammaglobulin (Immunoglobulins); IgA, IgD, IgG, IgM, each	Oct/Nov 2000 *Bulletin* (page 54) *Bulletin* G-354, 12/07/1998	Change 414.0 to 414.00-414.06 (Coronary atherosclerosis)
82947: Blood Glucose Testing	3rd Quarter 2001 *Bulletin* (page 46)	Change 357.8 to 357.81-357.89 (Other inflammatory and toxic neuropathy)
83735: Magnesium	Jun/Jul 2000 *Bulletin* (page 27)	Change descriptor for 428.0 to read Congestive heart failure, *unspecified*
84100: Serum Phosphorus	4th Quarter 2002 *Bulletin* (page 57)	Remove "congestive" from the descriptors for 404.03 and 404.13
85007: Complete Blood Count	1st Quarter 2002 *Bulletin* (page 78) 4th Quarter 2001 *Bulletin* (page 38)	Change 780.9 to 780.91-780.99 (Other general symptoms)
85610: Prothrombin Time	*Bulletin* G-306, 12/01/1997	Change 459.1 to 459.10-459.19 (Postphlebetic syndrome)
86706: Hepatitis B Surface Antibody and Surface Antigen	4th Quarter 2002 *Bulletin* (page 60)	Remove "congestive" from the descriptors for 404.03 and 404.13
87621: Human Papillomavirus DNA Assay, Amplified Probe Technique	Aug/Sept 2000 *Bulletin* (page 47) Jun/July 2000 *Bulletin* (page 30)	Change 795.0 to 795.00-795.09 (Nonspecific abnormal Papanicolaou smear of cervix)
88141: Pap Smears	4th Quarter 2001 *Bulletin* (page 42)	Change descriptor for 627.2 to read *Symptomatic* menopausal or female climacteric states Change 795.0 to 795.00-795.09 (Nonspecific abnormal Papanicolaou smear of cervix)
93000: Electrocardiography	4th Quarter 2002 *Bulletin* (page 67)	Change 277.00-277.01 to 277.00-277.09 (Cystic fibrosis)
93224: Electrocardiographic Monitoring for 24 Hours (Holter Monitoring)	1st Quarter 2002 *Bulletin* (page 51 & 80)	Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart)

Full-text for these local medical review policies are available on the provider education Web site at *www.floridamedicare.com*.

2003 ICD-9-CM Part A LMRP Changes (continued)

LMRP Title	Publications Listing	2003 Changes
93303: Transthoracic and Doppler Echocardiography and Doppler Color Flow Velocity Mapping	1st Quarter 2002 *Bulletin* (page 80) 4th Quarter 2001 *Bulletin* (page 49)	Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart) for procedure codes 93307, 93308, 93320, 93321, and 93325 Change descriptor for 414.10-414.19 to read Aneurysm *and dissection* of heart for procedure codes 93307, 93308, 93320, 93321, and 93325 Remove "congestive" from the descriptors for 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, and 404.93 for procedure codes 93320, 93321, and 93325
93312: Transesophageal Echocardiogram	1st Quarter 2002 *Bulletin* (page 80) 2nd Quarter 2001 *Bulletin* (page 53)	Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart) Change descriptor for 414.10-414.19 to read Aneurysm *and dissection* of heart
93350: Stress Echocardiography	1st Quarter 2002 *Bulletin* (page 54 & 80)	Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart) Add 414.12 (Dissection of coronary artery) Change descriptor for 428.0 to read Congestive heart failure, *unspecified* Add 428.20-428.23 (Systolic heart failure), 428.30-428.33 (Diastolic heart failure), and 428.40-428.43 (Combined systolic and diastolic heart failure)
93501: Cardiac Catheterization	1st Quarter 2002 *Bulletin* (page 78) Apr/May 2000 *Bulletin* (page 21) Feb/Mar 2000 *Bulletin* (page 26)	Remove "congestive" from the descriptors for 402.01, 402.11, and 402.91 for procedure codes 93526, 93527, 93528, and 93529
93701: Cardiac Output by Electrical Bioimpedance	2nd Quarter 2002 *Bulletin* (page 80) 4th Quarter 2001 *Bulletin* (page 82)	Remove "congestive" from the descriptors for 402.11, 402.91, 404.11, 404.13, 404.91, and 404.93
93925: Duplex Scan of Lower Extremity Arteries	Feb/Mar 2000 *Bulletin* (page 30)	Add 823.40-823.42 (Torus fracture)
93965: Noninvasive Evaluation of Extremity Veins	2nd Quarter 2001 *Bulletin* (page 92) Aug/Sept 2000 *Bulletin* (page 39)	Add 454.8 (Varicose veins of the lower extremities with other complications) Change descriptor for 454.9 to read *Asymtomatic* varicose veins of lower extremities Change 459.1 to 459.10-459.19 (Postphlebetic syndrome)
94760: Non-invasive Ear or Pulse Oximetry for Oxygen Saturation	4th Quarter 2002 *Bulletin* (page 98) Feb/Mar 2000 *Bulletin* (page 35)	Remove "congestive" from the descriptors for 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, and 404.93 Change descriptor for 428.0 to read Congestive heart failure, *unspecified* Add 428.20-428.23 (Systolic heart failure), 428.30-428.33 (Diastolic heart failure), and 428.40-428.43 (Combined systolic and diastolic heart failure)
94799: Pulmonary Rehabilitation Services	Oct/Nov 2000 *Bulletin* (page 55) *Bulletin* G-353, 11/02/1998 *Bulletin* G-336, 06/17/1998	Change 277.00-277.01 to 277.00-277.09 (Cystic fibrosis)
A0425: Ground Ambulance Services	4th Quarter 2002 *Bulletin* (page 81)	Change descriptor for 414.10-414.19 to read Aneurysm *and dissection* of heart
A4644: Low Osmolar Contrast Media (LOCM)	Oct/Nov 2000 *Bulletin* (page 55) December 1999 Special Issue *Bulletin* (page 17) Bulletin *G-348, 09/18/1998*	Remove "congestive" from the descriptors for 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 404.00, 404.01, 404.03, 404.10, 404.11, 404.13, 404.90, 404.91, and 404.93 Change descriptor for 428.0 to read Congestive heart failure, *unspecified*

Full-text for these local medical review policies are available on the provider education Web site at *www.floridamedicare.com*.

2003 ICD-9-CM Part A LMRP Changes (continued)

LMRP Title	Publications Listing	2003 Changes
G0030: Positron Emission Tomography (PET) Scan	2nd Quarter 2002 *Bulletin* (page 63)	Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart) for procedure codes G0030-G0047
J0150: Adenosine (Adenocard, Adenoscan)	1st Quarter 2002 *Bulletin* (page 65)	Add 414.06 (Coronary atherosclerosis of coronary artery of transplanted heart) Change descriptor for 414.10-414.19 to read Aneurysm *and dissection* of heart
J1561: Intravenous Immune Globulin	4th Quarter 2002 *Bulletin* (page 99) 3rd Quarter 2002 *Bulletin* (page 34)	Change 357.8 to 357.81 (Chronic inflammatory demyelinating polyneuritis [CIDP])

The latest versions of the ICD-9-CM manuals (as well as a variety of other coding materials) may be obtained from:

HealthCare Consultants of America	Medicode Publications	St. Anthony's Publishing
(800) 253-4945	(800) 999-4600	(800) 632-0123

ICD-9-CM and other coding materials may also be obtained from local medical publishing and consulting firms.

Detailed information regarding the 2003 ICD-9-CM update is available by accessing Florida Medicare provider education Web site at *www.floridamedicare.com*. ❖

WIDESPREAD MEDICAL REVIEW PROBES

Widespread Probe Medical Reviews

Progressive corrective action (PCA) is a concept designed by the Centers for Medicare & Medicaid Services (CMS) for Medicare contractors to use when deploying resources and tools to conduct medical review activities. PCA ensures that medical review activities are targeted at identified problem areas and corrective actions imposed are appropriate for the severity of the infraction of Medicare rules and regulations.

The decision to conduct medical review will be driven by data analysis. Data analysis is the starting point in PCA to determine aberrancies in billing patterns that might suggest improper billing or payment. Based upon in-depth data analysis, a widespread probe (service specific review) may be indicated to aid in the development of local medical review policy. A widespread probe review generally will not exceed 100 claims distributed among the identified provider universe. All providers subject to a widespread probe review will be notified in writing that a probe review is being conducted, and will be notified in writing of the results. Providers or facilities will be asked to provide all documentation applicable to the claims in question.

The widespread probe review process was developed according to guidelines found in CMS Program Memorandum AB-00-72, dated August 07, 2000. ❖

36245: Extracardiac Arteriography Associated and Billed with Primary Cardiac Catheterizations

The New York Peer Review Organization (PRO) in conjunction with the Centers for Medicare & Medicaid Services (CMS) PRO staff has performed a recent study in response to a carrier referral related to potential nonmedically necessary payments for diagnostic procedures performed in conjunction with primary cardiac catheterizations. The study focused on a review of Medicare beneficiaries who undergo renal arteriogram during inpatient admission for cardiac catheterization. The NY carrier medical director, through claims data, had determined that a number of physicians were billing for both a cardiac catheterization and renal arteriogram, on the same day. Because the carrier and fiscal intermediary do not have jurisdiction over inpatient quality of care and medical necessity for the inpatient portion of the service, a collaborative team was formed to address these issues from a more global standpoint. Both Medicare Part A and B data was extracted to identify if any significant billing/performing patterns were visible. The study focused on inpatient medical records of more than 1,000 Medicare beneficiaries admitted to the top 36 hospitals for cardiac catheterization, who based on the analysis of data, also underwent extracardiac arteriography, particularly renal arteriograms. The study focused on the following:

- Cardiologists performing the renal arteriograms
- Renal arteriograms carried out at the same time as the cardiac catheterization
- Renal studies determination of medically necessary
- Pattern of performance constitute poor quality of care.

36245: Extracardiac Arteriography Associated and Billed with Primary Cardiac Catheterizations (continued)

Preliminary findings demonstrated that the medical necessity for the renal arteriogram was not substantiated by documentation in the medical record. They also identified quality of care concerns related to **performing a nonmedically necessary invasive procedure** associated with high risk.

The study group, NY PRO/CMS/contractor, have been presenting their findings to the medical community, especially the cardiologists, and at hospitals on both a local and regional level. The hope is that a follow-up study of the same will demonstrate more appropriate use of renal artery arteriography consistent with current medical evidence post provider education.

The Florida data analysis staff has noted the following:

- From January through September 2001, $2,875,602.52 was paid to all performing providers in Florida, who billed a renal arteriogram procedure on the same day/session as a primary cardiac catheterization.
- During the same time frame, 261 providers billed 8,953 renal arteriograms.
- From January through September 2001, $9,894, accounting for 53 services, was paid to the seven performing providers in Connecticut who billed a renal arteriogram procedure on the same day/session as a primary cardiac catheterization.

First Coast Service Options will be performing a widespread medical review, across Florida and Connecticut, which may result in specific medical necessity guidelines, PRO referrals and/or provider education. Providers must ensure that when billing these two services (*CPT* 36245 with *CPT* 93512 or 93526), the renal arteriogram is both medically necessary and is performed in accordance with the intention of the *CPT* editorial panel. ❖

70540: Widespread Probe Review

Overview

This Part A widespread probe for *CPT* code 70540 was performed based on a request from the Intermediary Medical Director after review of initial preliminary findings noted below and due to informal observations of medical records by Part A review nurses regarding lack of medical necessity of these services. Another purpose of this probe was to determine if services billed to Medicare were documented as having been performed, and to determine medical conditions for which the service was being performed. The widespread probe consisted of 100 claims from 16 providers for the period of October 1, 2001, to March 31, 2002.

The Part B widespread probe for *CPT* code 70540 indicated services were performed for complaints of hearing loss, both chronic and acute, as well as bilateral and unilateral. Services were also performed for complaints of dizziness and various visual disturbances, both chronic and new onset. Incidentally, a magnetic resonance imaging (MRI) of the brain was also performed on 77 beneficiaries in addition to procedure code 70540. Medical necessity for performance of an MRI of the brain was very vague in most instances.

Summary

The summary of the findings is as follows:

- Eighty-one claims were allowed as billed. Nineteen claims were denied due to lack of a physician's order and/or documentation that they were performed.
- Services performed were for complaints of hearing loss, both chronic and acute, as well as bilateral and unilateral. Services were also performed for complaints of dizziness and various neck masses.
- Approximately 39 percent of the 100 services reviewed, indicated a brain MRI (70551-70553) was obtained in addition to 70540.
- Based on documentation submitted, it was difficult to establish an accurate timeframe of occurrence of symptoms and what other diagnostic interventions had been performed.
- Evidence that the results of the tests were used acutely in the management of patient care was not generally found.
- Many of the denials may be attributed to billing errors.

A local medical review policy, which will include MRI codes 70540, 70542, and 70543, will be developed in the near future. A policy is needed to address indications for coverage and define criteria for performing an MRI of the orbit, face and neck, both with contrast and without. Additionally, criteria will be defined for appropriateness of performing an MRI of the brain in addition to an MRI of the orbit, face, and neck. ❖

76375: Widespread Probe Review

Overview

Procedure code 76375 was chosen for focused medical review for fiscal year 2000 based on the fact it was paid at a higher rate per 1,000 Medicare enrollees than was paid nationally. This code was also selected as aberrancy and analyzed as part of the Medicare Part A Focused Medical Review process for 1999 and 2000. Based on the conclusions of the findings, a recommendation was made to develop a local medical review policy to define indications for this add-on procedure. However, based on the limited information available in current medical literature, a widespread probe review of 100 claims from 19 providers billing to the fiscal intermediary for the period of October 1, 2002, to March 31, 2002 was performed. The purpose of the review was to determine if services billed to Medicare were documented as having been performed, which tomographic modality the reconstruction code was performed with, and evaluate rationales that warrant additional views.

76375: Widespread Probe Review (continued)

Summary

The results of the widespread probe review revealed the following:

- Procedure code 76375 was billed with computerized tomography (CT) scans, magnetic resonance imagings (MRIs), magnetic resonance angiographies (MRAs), and radiation oncology services. The majority of reconstruction services performed were on patients having CT scans.
- The *CPT* instructs providers to bill procedure code 76375 for coronal, sagittal, and/or oblique views in addition to the base CT code.
- Prior to January 1, 2001, providers were instructed to bill CT angiography using the base CT code, in addition to the reconstruction code 76375. As of January 1, 2001, new procedure codes were established for CT angiography. Information provided in the July 2001 *cpt Assistant* indicates CT angiography includes three-dimensional or volume-rendered reconstructions and therefore, *CPT* code 76375 should not be billed separately for CT angiography studies.
- Many radiation oncology codes were billed on the same day as 76375; based on the *CPT*, code 77295 includes three-dimensional reconstruction. Therefore, *CPT* code 76375 should not be paid in addition to code 77295. Further clarification was received after the review regarding additional radiation oncology codes. Based on information received from the Code Utilization and Application Subcommittee of the ACR/ASTRO Joint Economics Committee, it is inappropriate to bill *CPT* code 76375 in addition to *CPT* codes 77315, 77328, and 77412-77416. These codes include such descriptors as "rotational beam" or "special spatial reconstruction."
- According to the September 2001 *cpt Assistant*, MRA entails 2-D or 3-D, time-of-flight or phase contrast gradient echo sequences sensitive to blood flow covering the anatomic region of interest. The images are processed to produce maximum intensity projections (MIPs). Post processing of the source images to create the MIP images is included in these codes and thus the separate reconstruction code, 76375 should not be reported for MRA examinations.
- The referring physician did not order the majority of the reconstruction services. It appeared the radiologist performed this service to eliminate overlapping structures, rotate the vessels into different obliquities to find the best view to detect the abnormality, and to visualize the abnormality from different visual planes, which confirms the accuracy of the diagnosis.
- Medical necessity of the base service was established for many of the services.

Based on the above information, *CPT* code 76375 is included in all CT angiography services, all MRA services, and the following radiation oncology services: *CPT* codes 77295, 77315, 77328, and 77412-77416. Therefore, billing separately for procedure code 76375 is not appropriate.

It is expected the referring provider indicates that additional views and/or reconstruction is needed and is included in the order for the base procedure.

New Additional Data Findings

The Comprehensive Data Analysis (CDA) team has recently become aware of a second specific Florida Medicare program vulnerability. The *CPT* code description for 76375 indicates this service is a reconstruction of a computerized tomography (CT), magnetic resonance imaging (MRI), or other tomographic modality. It is an add-on code and must be billed with a primary CT, MRI, or other tomographic modality. Florida claim history data demonstrates this service is being billed as a stand-alone procedure without a qualifying primary procedure. Providers must evaluate their billing procedures for the presence of this billing error and implement any necessary changes. The CDA team will continue to determine all causes of this payment error and propose corrective actions. ❖

90857: Widespread Probe Review

Overview

Procedure code 90857 was chosen for a widespread probe review based on the fact the *cpt Assistant* defines "interactive" individual psychotherapy as therapy "using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication." However, "interactive" group psychotherapy is not further defined. Medical review of individual providers providing partial hospitalization services demonstrated that *CPT* code 90857 was being billed incorrectly. Providers should have been billing *CPT* code 90853 *(Group psychotherapy)*, rather than *CPT* code 90857 *(Interactive group psychotherapy)*. A widespread probe review of 75 claims for 518 services from ten providers for the period of June 1, 2001, to May 31, 2002 was performed. The purposes of the review were to determine the extent to which this procedure is being billed incorrectly and whether a local medical review policy is necessary to further define medical necessity of "interactive" group psychotherapy.

Summary

- All services were billed with a DSM-IV psychiatric diagnosis.
- Only two of the ten facilities were billing and utilizing *CPT* code 90857 appropriately.
- Medical necessity and appropriate billing of *CPT* code 90857 was established for 143 of the 518 services.
- One hundred twenty-one services were denied because no documentation was submitted for review.
- Thirty-eight services were denied because the documentation submitted was not for the dates of service in question.
- Two services were denied because they were performed nonlicensed personnel, and there was no required recertification for the partial hospitalization program (PHP) services.

90857: Widespread Probe Review (continued)

- Fifteen services were denied because the services were actually educational services billed as 90857 and were not medically necessary.
- Sixty-one services were denied for insufficient documentation.
- One service was changed to procedure code 90847.
- One service was changed to procedure code 90804.
- One hundred thirty-six services were changed to procedure code 90853.
- Overall, 43 claims were paid, seven claims were partially paid, and 25 claims were denied.
- The *cpt Assistant* defines "interactive" individual psychotherapy as therapy "using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication." This definition was used as a guide to determine if services performed were "interactive" in nature and represented "interactive" group psychotherapy.

The contractor will develop a local medical review policy to define indications and limitations of coverage and/or medical necessity for procedure code 90857. ❖

92507 and 92508 Widespread Probe Review

Overview

CPT codes 92507 and 92508 were identified as aberrant in accordance with the Medicare Part A HCPCS Growth Trending report developed by Statistical Medical Data Analysis (SMDA). Due to the widespread problem, it was recommended that a local medical review policy (LMRP) be developed to address the following; define the service, identify medical necessity with expected utilization in an outpatient setting including discharge criteria, describe the documentation requirements and a unit of service. The codes are described below:

92507 *Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual.*

92508 *Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group, two or more individuals.*

CPT codes 92507 and 92508 were chosen for a widespread probe review of 90 claims. This review included 503 services from 19 providers. *CPT* code 92507 was billed 472 times for 472 dates of service. *CPT* code 92508 was billed 31 times for 31 dates of service. Records were requested from 19 providers for 90 claims.

The purpose of the review was to identify any other areas to be addressed by a LMRP. The records were reviewed to determine if the services billed to Medicare were documented as having been performed, medically reasonable and necessary and covered Medicare services. All relevant documents and pertinent information such as the initial assessment plan of treatment, and progress notes were reviewed. The Centers for Medicare & Medicaid Services (CMS) guidelines for speech pathology services furnished by hospitals, skilled nursing facilities, and outpatient rehabilitation facilities, were used during this review.

Summary

A total of 503 services were reviewed for *CPT* codes 92507 and 92508. Four hundred and seventy two services were billed for *CPT* code 92507. Thirty-one services were billed for *CPT* code 92508. Forty-five services for 92507 were denied.

- Nine services were denied due to no records received for one beneficiary.
- Seventeen services were denied due to no plan of treatment in documentation.
- Six services were denied due to an incomplete plan of treatment.
- Three services were denied due to no documentation received.
- Five services were denied due to the documentation did not support the services billed.
- Five services were denied due to no physician signature on the recertification for five dates of service.
- *CPT* code 92507 was billed with a diagnosis of Parkinson's disease and/or cerebral vascular accident (CVA) the majority of the time. The treatment diagnoses were dysarthria and aphasia. Other diagnoses billed included vocal cord polyp, Bell's palsy, and head trauma.
- *CPT* code 92508 was billed 31 times by two providers. Some of these providers performed individual therapy as well as group therapy for the same beneficiaries for the same dates of service.
- Many services for dysphagia (92526) were also billed on the same day the beneficiary received speech therapy (92507).

92507 and 92508 Widespread Probe Review (continued)

- Documentation in the weekly progress notes varied according to provider. Some were very detailed and specific regarding services provided and patient's response to treatments. Others were very brief and non-descriptive.
- *CPT* code 97110 (therapeutic exercise) was billed as speech pathology as well as occupational therapy for the same beneficiary on the same dates of service. The daily notes did not reflect the additional therapy provided.
- *CPT* codes 97124 (therapeutic procedure, massage) and 97530 (therapeutic activities) were also billed as speech pathology.
- Three providers billed *CPT* code 97110 for 95 services. *CPT* code 97112 was billed for 17 services. The majority of the codes were billed with one unit. A few were billed with two and three units.
- Three providers billed *CPT* code 97530 for 11 services. *CPT* code 97532 was billed for 12 services.

The contractor will develop a local medical review policy to define the indications and limitations of coverage and/or medical necessity for *CPT* codes 92507 and 92508. ❖

97112, 97530; and 97140, 97535 Widespread Probe Review

Overview

For 2001, *CPT* codes 97112, 97140, 97530, and 97535 were identified as aberrant, in accordance with the Medicare Part A HCPCS Growth Trending report developed by Statistical Medical Data Analysis (SMDA) utilizing SAS® software. The four codes are described below:

97112 *Therapeutic procedure, one or more areas, each 15 minutes: neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception for sitting and/or standing activities*

97140 *Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes*

97530 *Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes*

97535 *Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes.*

Based on conclusions of the findings, performance of these services was considered a widespread problem; therefore, a recommendation to perform widespread probes was made by the SMDA area. It was determined that two separate probes, one examining utilization of codes 97112 and 97530, and other examining utilization of codes 97140 and 97535 would be beneficial. The annual total reimbursement for the four specific *CPT* codes was $75,480,741.

The first widespread probe, which included procedure codes 97112 and 97530, examined 107 claims from 11 providers. The claims, which were for various dates of service, were chosen from the period of December 1, 2001, to May 31, 2002.

The second probe, which included procedure codes 97140 and 97535, was conducted on 100 claims. The claims included 709 services encompassing ten providers, for dates of service December 1, 2001, to May 31, 2002.

The purposes of the two widespread probes were to determine if the services billed to Medicare were documented as having been performed, the medical conditions for which the services were being performed, if the services were medically necessary, and if the services were being performed excessively.

Summary

The summary of the findings of the first probe for *CPT* codes 97112 and 97530 is as follows:

- Sixty claims were denied due to lack of medical necessity being established in the documentation. Partial denial was obtained for 30 claims due to lack of medical necessity being established. Seventeen were allowed as billed.
- The majority of services had adequate documentation to substantiate the services were provided. However, medical necessity was not substantiated in the plan of care and/or progress notes. In most instances, documentation revealed repetitive exercises and/or activities were being performed that did not require the skills of a therapist to supervise or perform.
- In most cases, duration of the services lasted for months and necessity for these prolonged services was not substantiated in the documentation. Based on a casual review of claims in the fiscal intermediary shared system, one beneficiary received therapy for more than a year, even though no progress was noted in the documentation. Also, some beneficiaries had less than a 30-day interruption in therapy and then resumed therapy at the same or another institution.
- Very rarely was a beneficiary treated for an acute condition. The majority of beneficiaries were treated for chronic problems such as spinal stenosis, back/

97112, 97140; and 97530, 97535 Widespread Probe Review (continued)

neck pain, and arthritis for which they have received multiple series of therapy in the past. Although exacerbations are to be expected, notes failed to substantiate that a functional deficit was present.

- Nine providers performed physical therapy (PT), as well as occupational therapy (OT), services for each beneficiary. Units of therapy billed for each client per day per therapy was in most cases, excessive, if not medically unbelievable.
- For those beneficiaries who received both PT and OT, discrepancies were found between the two disciplines, with regard to the beneficiary's functional abilities documented on the respective plans of care and/or progress notes.

The summary of findings of the second probe for *CPT* codes 97140 and 97535 is as follows:

- A total of 100 claims encompassing 709 services were reviewed. Two hundred sixty-nine services were allowed for code 97140. Two hundred forty-seven services were denied for code 97140. Ninety-nine services were allowed for code 97535. Ninety-four services were denied for code 97535.
- Reasons for denial of services include the following:
  - Records were not submitted for review
  - Progress notes were vague
  - No progress noted for several visits
  - No evidence the service billed was performed
  - No plan of treatment submitted
  - Plan of treatment signed several weeks/months after start of care
  - Incomplete plan of treatment submitted
    - No frequency
    - No date
    - No signature
    - Not updated
    - Did not include the dates of service billed
  - No functional deficit noted in the submitted documentation
  - No evidence beneficiary is making progress toward performing complex decongestive physiotherapy at home.

As a result of the widespread probes, the following local medical review policies will be updated in the near future to include utilization parameters regarding these procedure codes:

- Physical Medicine and Rehabilitation – A97010
- Occupational Therapy – A97003
- Complex Decongestive Physiotherapy – 97110. ❖

SKILLED NURSING FACILITY SERVICES

Skilled Nursing Facility Demand Bills

When a provider informs a beneficiary who is occupying a Medicare certified bed that Medicare payment can no longer be made for his or her stay, and the beneficiary or authorized representative disputes this decision, he or she may request the provider submit a demand bill to Medicare for review, to determine if a skilled level of care is still indicated.

The beneficiary or the appointed representative who has legal authorization to handle the beneficiary's affairs, may request a demand bill. However, it is the responsibility of the skilled nursing facility (SNF) to assure that the representative requesting the demand bill review has been given legal authorization to conduct the beneficiary's financial affairs (durable power of attorney, etc.). The intermediary may request documentation to support the representative requesting a review on behalf of the beneficiary is authorized to do so.

When determining if a beneficiary is eligible for Part A payment, medical and technical criteria must be present. Technical criteria must be established first. Failure to meet technical criteria results in the inability for Medicare to make payment even if clinical conditions for coverage exist.

In order to meet technical criteria, one of the following situations must exist:

- A three-day qualifying inpatient hospital stay, not counting the day of discharge.
- Transfer to the SNF within 30 days of hospital discharge. This window can be extended by a physician's order to hold therapy.
- Certification by a physician, nurse practitioner or clinical nurse specialist upon admission the beneficiary requires skilled care in a skilled nursing home.
- Beneficiary is treated in the SNF for a condition that was treated during the qualifying hospital stay, or for one that arose during the stay.
- Beneficiary is enrolled in Part A and has benefit days to use.
- Beneficiary must reside in a Medicare-certified bed.

If the resident fails to meet technical criteria, the provider should issue a notice of noncoverage, but should submit the claim using condition code 21.

Instructions for issuing notices of noncoverage are outlined in CMS Publication 12, sections 357-358. The provider is also required to use appropriate noncoverage letters as outlined in CMS Publication 12 section 358.

Note: It is the provider's responsibility to assure the notice of noncoverage is complete. Notices of noncoverage must contain all the important written components found in noncoverage letter exhibits 1-5 of Publication 12 section 358. All notices must contain the date the beneficiary or legal representative received the notice. Failure to provide a timely and completed notice will result in the provider being held liable for the noncovered services.

After it has been determined the beneficiary meets technical criteria, the provider must determine if the beneficiary meets medical criteria by applying the rules governing Medicare SNF prospective payment system presumption of coverage and level of care criteria. Upon notification to the beneficiary or authorized representative that his or her medical condition no longer meets medical necessity for skilled care and the beneficiary or his or her legal representative disagrees, a demand bill must be submitted to the fiscal intermediary for a review.

Prior to submitting the demand bill to the fiscal intermediary, the provider must assure the following has occurred:

- The previous bill must reflect that the beneficiary is still a patient in the facility (patient status 30) and dates of services must not overlap with the demand bill. The demand bill must have only the days that the patient remained in the facility (e.g., the patient was in the SNF from 05/01/02-05/25/02. The dates of service for a covered stay are from 05/01/02-05/10/02. The dates of service for a noncovered level of care stay are from 05/11/02-05/25/02). The demand bill must be submitted with noncovered dates of service and charges (not for the entire bill of 05/31/02) and condition code 20 must be placed in form locator 24.
- The health insurance prospective payment system code and revenue code 0022 must be present on the demand bill. If a minimum data set (MDS) has been completed, the provider must use the resource utilization group (RUG)-III group from that MDS, even if it is one of the top 26 RUG-III groups. If no assessment was completed, the provider may use the default code submitted on the claim.
- Liability is based on whether or not the notice of noncoverage was issued by the provider and properly acknowledged by the beneficiary.

A medical review of the records will not be performed on claims submitted for denials. These claims should be submitted with condition code 21 in form locator 24. It is recommended the provider write remarks indicating the specific reason for the denial (e.g., benefit exhaust, no qualifying stay, denial for secondary insurance, etc.). ❖

Psychotropic Drug Use in Skilled Nursing Facilities

The Centers for Medicare & Medicaid Services (CMS) has requested the publication of this article to remind the provider community about the Medicare guidelines for psychotropic drug use in skilled nursing facilities (SNFs).

In response to concerns expressed by the Senate Special Committee on Aging, the Office of Inspector General (OIG) studied the extent to which psychotropic drugs are being used in nursing homes as inappropriate chemical restraints. The OIG found that, in general, these drugs are being used appropriately. Where there are problems, they are related to inappropriate dosage, chronic use, lack of documented benefit to the resident, and unnecessary duplicate drug therapy. This article explains Medicare's guidelines for psychotropic drug use in SNFs including the definition of an unnecessary drug, justification for drug use outside guidelines, and antipsychotic drugs.

Definition of an Unnecessary Drug

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

- In excessive dose (including duplicate drug therapy)
- For excessive duration
- Without adequate monitoring
- Without adequate indications for its use
- In the presence of adverse consequences which indicate the dose should be reduced or discontinued
- Any combination of the above reasons.

Note: When a resident receives duplicate drug therapy, an evaluation should be completed for accumulation of the adverse effects.

Note: Adequate indications for use means that there is a valid clinical reason for the resident to receive the drug based on some, but not necessarily all, of the following:

- Resident assessment
- Plan of care
- Reports of significant change
- Progress notes
- Laboratory reports
- Professional consults
- Drug orders
- Observation and interview of the resident.

Justification for Drug Use Outside Guidelines

A drug used outside these guidelines must be based on sound risk-benefit analysis of the resident's symptoms and potential adverse effects of the drug. Some examples of evidence that would support a justification as to why a drug is being used outside these guidelines, but in the best interest of the resident, may include:

- A physician's note indicating that the dosage, duration, indication, and monitoring are clinically appropriate and the reasons as to why they are clinically appropriate. The note should demonstrate that the physician has carefully considered the risk/benefit to the resident in using a drug outside the guidelines.
- A medical or psychiatric consultation or evaluation (e.g., geriatric depression scale) confirming the physician's judgment that use of a drug outside the guidelines is in the best interest of the resident.
- Documentation of a physician, nursing, or other health professional indicating that the resident is being monitored for adverse consequences or complications of the drug therapy.
- Documentation confirming that previous attempts at dosage reduction have been unsuccessful.
- Documentation (including MDS documentation) showing the resident's subjective or objective improvement or maintenance of function while taking the medication.
- Documentation showing that the resident's decline or deterioration has been evaluated by the interdisciplinary team to determine whether a particular drug, a particular dose, or duration of therapy may be the cause.
- Documentation showing why the resident's age, weight, or other factors would require a unique drug dose or drug duration, indication, or monitoring.

Guidelines for Use of Antipsychotic Drugs

SNFs must ensure, based on a comprehensive assessment of the resident, that:

When an antipsychotic drug has not been used in the past, it is not given unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record. Antipsychotic drugs should not be used unless the clinical record documents that the resident has one or more of the following specific conditions:

- Schizophrenia
- Schizo-affective disorder
- Delusional disorder
- Psychotic mood disorders (including mania and depression with psychotic features)
- Acute psychotic episodes
- Brief reactive psychosis
- Schizophreniform disorder
- Atypical psychosis
- Tourette's disorder
- Huntington's disease
- Organic mental syndromes (now called delirium, dementia, and amnestic and other cognitive disorders by DSM-IV) with associated psychotic and/or agitated behaviors which:
  - Have been quantitatively and objectively documented. This documentation is necessary to assist in:
    - Assessing whether the resident's behavioral symptom is in need of some form of intervention.
    - Determining whether the behavioral symptom is transitory or permanent.
    - Relating the behavioral symptom to other events in the resident's life in order to learn about potential causes (e.g., death in the family, not adhering to the resident's customary daily routine).

Psychotropic Drug Use in Skilled Nursing Facilities (continued)

  - Ruling out environmental causes (e.g., excessive heat, noise, overcrowding).
  - Ruling out medical causes (e.g., pain, constipation, fever, infection).
- Are persistent.
- Are not caused by preventable reasons.
- Cause the resident to:
  - Present a danger to himself/herself or to others.
  - Continuously scream, yell, or pace and results in an impairment of functional capacity.
  - Experience psychotic symptoms (e.g., hallucinations, paranoia, delusions) that are not exhibited as dangerous behaviors or as screaming, yelling, or pacing but result in distress or impairment of functional capacity.

- Short-term (7 day) symptomatic treatment of hiccups, nausea, vomiting or pruritus. Residents with nausea and vomiting secondary to cancer or cancer chemotherapy can be treated for longer periods of time.

Antipsychotics should not be used if the only indication is one or more of the following:

- Wandering
- Poor self-care
- Restlessness
- Impaired memory
- Anxiety
- Depression (without psychotic features)
- Insomnia
- Unsociability
- Indifference to surroundings
- Fidgeting
- Nervousness
- Uncooperativeness
- Agitated behaviors that do not represent danger to the resident or others.

Unless clinically contraindicated, gradual dose reductions of the antipsychotic drug and behavioral interventions are considered in an effort to discontinue the drug. Close supervision should be provided when gradual dose reductions are carried out. If the gradual dose reduction causes an adverse effect on the resident and is discontinued, documentation of this decision and the reasons for it should be included in the clinical record. Gradual dose reductions consist of tapering the daily dose to determine whether symptoms can be controlled by a lower dose or the drug can be altogether eliminated.

Note: A behavior intervention is a modification of the resident's behavior or environment, including staff approaches to care, to the largest degree possible to accommodate the behavioral symptoms.

Note: Clinically contraindicated means that gradual dose reductions or behavioral interventions need not be undertaken if:

- The resident has a history of recurrence of psychotic symptoms (e.g., delusions, hallucinations) that have been stabilized with a maintenance dose of a antipsychotic drug without incurring significant side effects and has one of the following specific conditions:
  - Schizophrenia
  - Schizo-affective disorder
  - Delusional disorder
  - Psychotic mood disorders (including mania and depression with psychotic features)
  - Acute psychotic episodes
  - Brief reactive psychosis
  - Schizophreniform disorder
  - Atypical psychosis
  - Tourette's disorder
  - Huntington's disease
- The resident has organic mental syndrome, and gradual dose reductions have been attempted twice in one year that resulted in the return of symptoms for which the drug was prescribed to a degree that a cessation in the gradual dose reduction or a return to previous dose reduction was necessary.
- The resident's physician provides a justification as to why the continued use of the drug and the dose of the drug are clinically appropriate. This justification should include:
  - A diagnosis that includes a description of the symptoms (not simply a diagnostic label or code)
  - A discussion of the differential psychiatric and medical diagnosis (e.g., why the resident's behavioral symptom is thought to be the result of a dementia with associated psychosis and/or agitated behaviors and not the result of an unrecognized painful medical condition or a psychosocial or environmental stressor)
  - A description of the justification for the choice of a particular treatment or treatments
  - A discussion of why the present dose is necessary to manage the resident's symptoms. ❖

Source: CMS Transmittal AB-02-143, CR 2318

CRITICAL ACCESS HOSPITAL SERVICES

October 2002 Update to the Medicare Outpatient Code Editor

The Medicare outpatient code editor (OCE) specifications (version 18.0) have been updated with new additions, changes, and deletions to the *Current Procedural Terminology*/Healthcare Common Procedure Coding System (*CPT*/HCPCS) codes and the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes.

This OCE update is used to process bills from hospitals that are not paid under the outpatient prospective payment system such as Indian health service hospitals, critical access hospitals, Maryland hospitals, and hospitals located in American Samoa, Guam, and Saipan. Claims from Virgin Islands hospitals with dates of service on or after January 1, 2002, are also processed through this OCE. Below are the specifications to the October 2003 update to the Medicare OCE (version 18.0).

New ICD-9-CM Diagnosis Codes

The following new diagnosis codes were added to the list of valid ICD-9-CM diagnosis codes, effective October 1, 2002:

04082	0664	27702
27703	27709	35781
35782	35789	35981
35989	36583	41406
41412	42820-42823	42830–42833
42840–42843	4386	4387
43883–43885	44321–44324	44329
44501	44502	44581
44589	4548	45910–45913
45919	45930–45933	45939
53784	56986	63300
63301	63310	63311
63320	63321	63380
63381	63390	63391
74783	76520–76529	77081–77084
77089	77181–77183	77189
77981	77982	77989
78091	78092	78099
78193	79500–79502	79509
79531	79539	81345
82340–82342	99590–99594	99831
99832	V01.81	V01.89
V13.21	V1329	V23.41
V2349	V462	V5410–V5417
V5419–V5427	V5429	V5481
V5489	V5842	V5843
V5871–V5878	V7182	V7183
V8381	V8389	E8850
E9225	E9557	E9790–E9799
E9857	E9990	E9991

Deleted ICD-9-CM Diagnosis Codes

The following diagnosis codes were deleted from the list of valid ICD-9-CM diagnosis codes, effective October 1, 2002, and removed from any associated edits to which they were assigned:

3578	3598	4591	6330–6332
6338	6339	7708	7718
7798	7809	7950	7953
9983	V018	V132	V234
V548	E999		

Revised ICD-9-CM Diagnosis Code Descriptions

The descriptors for the following ICD-9-CM diagnosis codes have been revised. See 2003 ICD-9-CM Coding Update *Medicare A Bulletin* Special Electronic Issue.

40200	40201	40210	40211
40290	40291	40400	40401
40403	40410	40411	40413
40490	40491	40493	41410
41411	41419	4280	4549
6272	6274	V4981	

New HCPCS Codes

The following HCPCS code was added to the list of valid codes for the OCE, for October 1, 2000–December 31, 2000:

J1650

The following HCPCS code was added to the list of valid codes for the OCE, effective April 1, 2002:

G0258

The following HCPCS code was added to the list of valid codes for the OCE, effective July 1, 2002:

Q3030

The following HCPCS codes were added to the list of valid codes for the OCE, effective October 1, 2002:

C9116–C9119 G0252–G0255

Medicare Outpatient Code Edits

Newborn Diagnoses–Age 0 years

The following new codes were added to the list of newborn diagnoses:

74783	76520–76529	77081–77084
77089	77181–77183	77189
77981	77982	77989

The following code was deleted from the list of newborn diagnoses:

7797

October 2002 Update to the Medicare Outpatient Code Editor (continued)

Pediatric Diagnoses–Age 0-17 years
The following codes were added to the list of pediatric diagnoses:

78091 78092

Maternity Diagnoses–Age 12-55 years

The following codes were added to the list of maternity diagnoses:

63300	63301	63310	63311
63320	63321	63380	63381
63390	63391	V2341	V2349

Diagnoses for Females Only

The following codes were added to the list of diagnoses allowed for females only:

63300	63301	63310	63311
63320	63321	63380	63381
63390	63391	79500–79502	79509
V1321	V1329	V234	V2349

Nonreportable *CPT*/HCPCS Codes

The following HCPCS codes were added to the list of nonreportable services, effective April 1, 2002:

G0244 G0258

The following HCPCS codes were added to the list of nonreportable services, effective October 1, 2002:

C9116–C9119 J7316

The following *CPT* codes were deleted from the list of nonreportable services, effective October 1, 2002:

78459 90780 90781

Noncovered HCPCS Codes

The following HCPCS codes were added to the list of noncovered services, effective July 1, 2002:

A6000 E0231 E0232

The following code was added to the list of noncovered services, effective October 1, 2002:

G0255 ❖

Source: CMS Transmittal A-02-080, CR 2310

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

October 2002 Update—Hospital Outpatient Prospective Payment System

The October 2002 update provides changes to the hospital outpatient prospective payment system (OPPS). Changes to the October 2002 outpatient code editor (OCE) and the OPPS PRICER will include HCPCS codes, ambulatory payment classifications (APCs), and diagnosis code additions and changes identified in this article.

For services furnished **on or after October 1, 2002,** C-codes C8915, C8916, C8917, C9116, and C9119 will be reportable under hospital OPPS.

New HCPCS Codes and Status under the Hospital OPPS

HCPCS Code	Effective Date	APC	Descriptor
G0252	10/1/02		PET imaging, *full and partial-ring PET scanners only,* for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g., initial staging of axillary lymph nodes), not covered by Medicare
G0253	10/1/02	285	PET imaging for breast cancer, full and partial-ring PET scanners only, staging/ restaging of local regional recurrence or distant metastases, i.e., Staging/restaging after or prior to course of treatment
G0254	10/1/02	285	PET imaging for breast cancer, full and partial-ring PET scanners only, evaluation of response to treatment, performed during course of treatment
G0255	10/1/02		Current perception threshold testing, per limb, all nerves (not covered by Medicare)
G0258	04/1/02	340	Intravenous infusion (s) during separately payable observation stay, per observation stay (must be reported with G0244)*

*G0258 is a new code to report infusion during observation. It must be billed with code G0244 to be payable. G0258 should be billed only for patients receiving an infusion. The code includes placement of the IV access. *CPT* code 36000 should not be reported in addition to G0258.

Modifications to Status of Existing HCPCS Codes

HCPCS Code	Effective Date of Change	APC	Descriptor
78459	10/1/02	285	Myocardial imaging, positron emission tomography (PET), metabolic evaluation
A6000	07/1/02		Noncontact warming cover for use with the noncontact warming device and warming card **Note:** Not covered by Medicare
E0231	07/1/02		Noncontact wound warming device (temperature control unit, AC adapter, and power cord) for use with warming card and wound cover **Note:** Not covered by Medicare
E0232	07/1/02		Warming card for use with noncontact wound warming device and noncontact warming wound cover **Note:** Not covered by Medicare
J1561	10/1/02		Injection, immune globulin, intravenous, 500 mg* **Note:** Not covered by Medicare
J1563	10/1/02	905	Injection, immune globulin, intravenous, 1 g*
J7316	10/1/02		Sodium hyaluronate, 5 mg for intra-articular injection **Note:** Not covered by Medicare

*Clarification: **The correct HCPCS code for reporting immune globulin injection is J1563 instead of code J1561 as previously instructed. HCPCS code J1563 has been assigned to APC 905, effective October 1, 2002.**

October 2002 Update—Hospital Outpatient Prospective Payment System (continued)

New Drugs Eligible for Pass-Through Payments

A determination that a drug is eligible for OPPS pass-through payment status determines only the method by which the drug is paid, if the Medicare Program covers it. It does not represent a determination that the Medicare Program covers the drug. Medicare contractors must determine whether the drug is: 1) reasonable and necessary to treat the beneficiary's condition; and 2) excluded from payment because it is usually self-administered by the patient.

HCPCS Code	Effective Date	Descriptor	APC
C9116	10/1/02	Injection, ertapenem sodium, per 1 gram vial	9116
C9119	10/1/02	Injection, pegfilgrastim, per 6 mg single vial dose	9119
Q3030**	07/1/02	Sodium hyaluronate, per 20 to 25 mg dose, for intra articular injection	7317

** Coding instruction for sodium hyaluronate are included in PM-AB-02-082, dated June 11, 2002.

Modified APC

Effective October 1, 2002, the descriptor for APC 905 has been modified to immune globulin.

Diagnosis Code Changes for the Observation Criteria

Effective October 1, 2002, the following new ICD-9-CM codes are additions to the list of acceptable codes for diagnosis of congestive heart failure:

428.20 Unspecified systolic heart failure
428.21 Acute systolic heart failure
428.22 Chronic systolic heart failure
428.23 Acute on chronic systolic heart failure
428.30 Unspecified diastolic heart failure
428.31 Acute diastolic heart failure
428.32 Chronic diastolic heart failure
428.33 Acute on chronic diastolic heart failure
428.40 Unspecified combined systolic and diastolic heart failure
428.41 Acute combined systolic and diastolic heart failure
428.42 Chronic combined systolic and diastolic heart failure
428.43 Acute on chronic combined systolic and diastolic heart failure. ❖

Source: CMS Transmittal A-02-111, CR 2399

FRAUD AND ABUSE

TriCenturion Selected as Program Safeguard Contractor for Florida and Connecticut

The Health Insurance Portability and Accountability Act of 1996 includes a provision which authorizes the Centers for Medicare & Medicaid Services (CMS) to enter into contracts with organizations other than traditional Medicare contractors to perform Medicare program safeguard activities (i.e., medical reviews, fraud investigations, cost report audits, and data analysis). The organizations that enter into contracts with CMS to perform these activities are known as program safeguards contractors (PSC). In response to this change, First Coast Service Options, Inc. (FCSO), Palmetto Government Benefits Administrators, and Trailblazer Health Enterprises entered into a partnership to form a new company called TriCenturion, LLC. In 1998, TriCenturion submitted a proposal and was selected by CMS, along with 12 other companies, to become a PSC. Since then, TriCenturion has successfully performed program safeguard work for CMS.

In early 2002, CMS began moving the fraud investigational functions from the traditional Medicare contractors to the PSCs. Beginning January 2003, the fraud investigational functions for Medicare Part A in Florida and Medicare Part B in Connecticut and Florida will be performed by TriCenturion. This transition of functions from FCSO will not affect Medicare providers, nor people with Medicare in either state, as FCSO will continue to accept and review allegations of suspected inappropriate activities to rule out billing errors, processing errors, or misunderstandings of information. TriCenturion will concentrate its efforts on investigating alleged fraudulent activities, proactively identifying potential fraud through data analysis, and working with federal and state agencies to protect the Medicare Trust Fund. Therefore, Medicare providers and beneficiaries who do wish to report allegations or complaints of suspected fraudulent or abusive activities may still report them to the FCSO addresses and/or telephone numbers listed in this publication (see page 63).

TriCenturion is currently operating as the fraud investigation PSC for six states and the District of Columbia (Part A–Colorado, New Mexico, Texas; Part B–Delaware, District of Columbia, Maryland, Texas, Virginia,), and as the durable medical equipment regional PSC for ten northeastern states (Region A). In addition to Connecticut and Florida, TriCenturion was recently named the fraud investigation PSC for Medicare Part A and B in South Carolina, and for home health services for 16 states, including Florida, South Carolina and Texas.

TriCenturion will maintain a close working relationship with FCSO to coordinate program safeguard activities for Florida and Connecticut. It will be hiring many qualified FCSO employees and will have an increased regional presence with offices in Meriden, Connecticut, and Jacksonville, Miami, and Palm Harbor, Florida. ❖

ELECTRONIC DATA INTERCHANGE

New Remittance Advice Remark Codes and Claim Adjustment Reason Codes

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that Medicare, and all other health insurance payers in the United States, comply with the electronic data interchange standards for health care as established by the Secretary of Health and Human Services.

The X12N 835 version 4010-implementation guide has been established as the standard for compliance for remittance advice transactions. The implementation guide for that format is available electronically at *www.wpc-edi.com/hipaa/HIPAA_40.asp*.

New and Revised Health Care Remittance Advice Remark Codes

The Centers for Medicare & Medicaid Services (CMS) is the national maintainer of remittance advice remark codes used by both Medicare and non-Medicare entities. The list of remark codes is updated continuously as needed, and both Medicare and non-Medicare entities can request new codes or modifications in the existing codes to address their business needs.

The list of remark codes is available at *www.cms.hhs.gov/medicare/edi/hipaadoc.asp* and *www.wpc-edi.com/Remittance_40.asp.* The list is updated each March, July, and November. The list may be downloaded from these Web sites during those three months to obtain the most current set of approved remark codes.

The following list summarizes additions and modifications made to the remark codes **through June 30, 2002.**

New Remark Codes

N113 **New Remark Code**

You or someone in your group practice has already submitted a claim for an initial visit for this beneficiary. Medicare pays only once per beneficiary per physician, group practice, or provider for an initial visit.

N114 **New Remark Code**

During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.

N115 **New Remark Code**

This decision is based on a local medical review policy (LMRP). An LMRP provides a guide to assist in determining whether a particular item or service is reasonable and necessary. A copy of this policy is available at *www.LMRP.net*.

N116 **New Remark Code**

This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care.

When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.

Modified Remark Codes

For modified descriptors on remark codes M25, M26, M27, MA01 and MA02 see pages 8-9 of this bulletin.

N103 **Modified to:**

Social Security records indicate that this beneficiary was a prisoner when the service was rendered. Medicare does not cover items and services furnished to beneficiaries while they are in State or local custody under a penal authority, unless under State or local law, the beneficiary is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.

Additionally, the following codes were modified **before February 28, 2002.**

Modified Remark Codes

MA49 **Modified to:**

Missing/Incomplete/invalid six-digit provider number of home health agency or hospice for physician(s) performing care plan oversight services.

MA50 **Modified to:**

Missing/Incomplete/invalid Investigational Device Exemption number for FDAapproved clinical trial services.

MA51 **Modified to:**

Missing/Incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.

MA82 **Modified to:**

Did not complete or enter the correct physician/physician assistant/nurse practitioner/clinical nurse specialist/supplier's billing number/NPI and/or billing name, address, city, state, ZIP code, and phone number.

New Remittance Advice Remark Codes and Claim Adjustment Reason Codes (continued)

MA112 Modified to:

Our records indicate that the performing physician/physician assistant/clinical nurse specialist/certified registered nurse anesthetist/anesthesia assistant/supplier/nurse practitioner is a member of a group practice; however, you did not complete or enter accurately the group's name, address, ZIP code and their carrier assigned individual and group PINs.

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 *www.wpc-edi.com/hipaa/*.

In most cases, reason code additions, modifications and retirements are requested by non-Medicare entities, Medicare may occasionally request changes. If the request comes from Medicare, it may be included in a Medicare instruction in addition to the regular code update program memorandum.

Code changes requested by entities other than Medicare would not be routinely included in a Medicare instruction as part of a policy change, but modification or retirement of an existing code could impact Medicare. CMS will issue notifications on a periodic basis to provide a summary of changes in the reason and remark codes introduced since the last notification.

The committee approved the following reason code changes in June 2002:

New Reason Codes

Code	Narrative
145	Premium payment withholding
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.
147	Provide contracted/negotiated rate expired or not in file 148 Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.

Modified Reason Codes

Code	Narrative
6	The procedure/revenue code is inconsistent with the patient's age.
7	he procedure/revenue code is inconsistent with the patient's gender.
8	The procedure/revenue code is inconsistent with the provider type/specialty (taxonomy).
108	Payment adjusted because rent/purchase guidelines were not met. ❖

Source: CMS Transmittal AB-02-142, CR 2395

Direct Data Entry Update—HIPAA Institutional 837 Health Care Claim

The information provided below identifies Health Insurance Portability and Accountability Act (HIPAA) changes to align direct data entry (DDE) with the data content and/or data condition requirements of the X12N 837 version 4010, standard health care claims transaction. The implementation date for this is set for January 6, 2003.

- **Investigational Device Exemption (IDE)**
  The IDE is a seven-digit alphanumeric field that contains the IDE authorization number assigned by the Food and Drug Administration. This field should only be used for revenue code 0624 and should always begin with a 'G'. You will no longer be able to enter more than one IDE per claim. The IDE field will be located on page 1 of the claim to the right of the DCN field.
- **Employment Status Code, Employer Name, or Employer Address**
  These fields are no longer required; therefore they are being removed from the screen and you will no longer have the option to use these fields. At the current time, do not submit this information via DDE.
- **Discharge Hour**
  Discharge hour information is required on all inpatient claims/encounters. The discharge hour and minute field will be expanded and the information will be in a numeric form of HHMM.
- **Other Subscriber Demographic Information**
  DDE will allow other subscriber demographic information (date of birth and gender) if the other subscriber is a person. On claim page 5, there will be a new section named "INSURED INFORMATION". Two new fields are added; a one-digit field defined as "SEX" that will accept the characters, "F," "M" or "U," and a field for the other subscriber's date of birth, defined as numeric, eight positions (CCYYMMDD). ❖

Source: CMS Transmittal A-02-078, CR 2211

HIPAA-AS Update

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA-AS) require that Medicare, and all other health insurance payers in the United States, comply with the EDI standards established by the Secretary of Health and Human Services for specified health care transactions. The implementation guides for each transaction are available electronically at *www.wpc-edi.com.*

This article contains important information about X12N ANSI version 4010 transactions, including:

- 837 Edit Changes
- 835 Remittance Advice Update
- 276/277 Enveloping Changes
- 270/271 TPC/IP Connectivitity

837 – INBOUND CLAIMS TRANSACTION – Edit changes

This companion document supplements, but does not contradict any requirements in the X12N 837 Institutional Implementation Guide. However, this updated information replaces the information previously reported on the initial companion document distributed in December 2001.

Units of service

Beginning Jannuary 1, 2003, Medicare will accept decimals in the units of service field (SV2 06) on incoming files. The X12N 837 Institutional Implementation guide allows for the units of service segment to contain a decimal. However, Medicare does not process units of service that contain decimals. Therefore, when the claim moves into the adjudication system with units of service that contain a decimal, the units will round into a whole number based on the following criteria: *If the number to the right of the decimal is 5 or greater round up, 4 or less round down.*

Diagnosis code

Beginning January 1, 2003, if Medicare receives a file that contains a decimal in the diagnosis code, and the decimal is in the "correct" position, the decimal will be dropped before going into the adjudication system.

Medicare policy has always been to not accept decimals in a diagnosis code field. However, decimals are allowed based on the X12N 837 Implementation Guide (HI segment containing a BF qualifier). If an incoming claim contains a diagnosis code with a decimal in an "incorrect" position, the field will move to the adjudication system with ampersands (&) in the field. This will result in the claim moving to an RTP location.

Note: The 'correct position' is assumed to be between the third and fourth digit unless the ICD-9 code starts with an "E". Then the decimal is assumed between the fourth and fifth position.

Testing

Testing will occur on a first-come, first-serve basis. Due to the large number of senders who will be testing, Medicare EDI encourages senders to begin their testing early. Senders who wait until the last few months of testing may not have enough time to prepare for the 4010 migration.

837 Inbound Claims Transaction

Some Frequently Asked Questions (FAQ) have surfaced in the course of helping vendors/senders prepare their testing. You may find the answers helpful as you prepare your 4010 837 testing.

SEGMENT/LOOP	QUESTION	ANSWER
1000A/NM109	What is the value needed?	Your individual sender number.
2010AA/2310AB	What value do I use in the NM109?	As XX is not yet a valid code, you must use 24 or 34 and the appropriate value in NM109.
2010AA	Where do I put the Provider number? Why are my claims not in the Adjudication system? I can't see them in DDE.	You must use a REF segment with a 1C in the 2010AA loop. Your provider number goes in the REF02. Without a valid provider number your claims will not process.
2310A,B, C	Where do I put the UPIN?	You must use a REF segment in the 2310 loop with a 1G qualifier. (NM1*71,NM1*72,NM1*73) If a UPIN for Other is not known OTH000 may be used.
2400	When I review my claims in DDE all the Revenue codes have changed to 999's.	Revenue codes sent in the SV2 segment must have a leading zero. Change the revenue code to 4 digits and resend the claim.
2400	My claims have rejected with Reason Code 15321.	The last revenue code sent in an SV2 segment must be 0001 – a total line of all revenue codes used in that claim.

HIPAA-AS Update (continued)

For additional information
Medicare A submitters who would like additional information about testing the ANSI 837 4010 should contact Audrey Lipinski at (904) 791-6865 or via email at audrey.lipinski@fcso.com.

835 – ELECTRONIC REMITANCE ADVICE – Update

Testing

General testing, while not required but recommended, has begun and is scheduled to continue through October 2003. Testing will occur on a first-come, first-served basis. Due to the large number of senders who will be testing, Medicare EDI encourages senders to begin their testing early. Senders who wait until the last few months of testing may not have enough time to prepare for the 4010 migration. Medicare will switch to exclusive use of the ANSI X12NN 835 Version 4010 as of October 2003.

If you currently receive electronic remittance advice, you may sign up to test the 4010 Medicare Part A Electronic Remittance Advice. Please contact Cynthia Moore via telephone at (904) 791-8254, or via email at cynthia.moore@fcso.com.

If you do not currently receive electronic remittance advice but would like to, you will need to complete an Electronic Data Request Form. You can obtain this form from the *www.floridamedicare.com* Web site, in the EDI section under the "Forms" subheading. Alternately, you may call the Marketing Team at (904) 791-8767.

New senders have asked if they have to accept the 4010 version of the remittance advice. Effective October 1, 2002, if one of the following situations is true, new senders **must** receive version 4010 of the remittance advice:

- A facility or provider applies for a new sender code (and does not currently receive remittance advice electronically) and the facility's or provider's support vendor has already been approved to receive ANSI 835 version 4010.
- A sender applies for a new sender code and their support vendor is a wholly new support vendor (with no existing Medicare clients).
- A sender's support vendor has already been approved to receive ANSI 835 version 4010.

New PLB Composite Adjustment Code Changes for the 835

Effective with version 4010, the following adjustment codes will be used as appropriate in the PLB segment:

- XF for outlier
- IM for Indirect Medical Education
- ZZ for Hemophilia

Forced Balancing Requirements and New Adjustment Reason Codes for the 4010 Remittance Advice

Every X12N 835 version 4010 transaction issued by an Intermediary must comply with the Implementation Guide (IG) requirements, including the requirement to balance at the service, claim and transaction levels.

To assist with meeting the IG requirement to balance at the service, claim, and transaction levels, the Intermediary adjudication system will make forced balancing as applicable. The following adjustment reason codes will be used to report instances when forced balancing has occurred:

- Adjustment reason code **A7** – presumptive payment adjustment – will be used to report the amount by which a line or claim is out of balance at the line or claim level.
- Adjustment reason code **CA** – manual claim payment adjustment – will be used to report the amount by which a transaction is out-of-balance as a PLB adjustment. PLB Medicare composite reason code CS/CA will be reported in this situation.

New and Revised Health Care Remittance Advice Remark Codes

The Centers for Medicare & Medicaid Services (CMS) is the national maintainer of remittance advice remark codes used by both Medicare and non- Medicare entities. The list of remark codes is updated continuously as needed, and both Medicare and non-Medicare entities can request new codes or modifications in the existing codes to address their business needs.

The complete list of remark codes is available at *www.wpc-edi.com/hipaa*. The list is updated each March, July, and November. The list may be downloaded from this Web site to obtain the most current set of approved remark codes.

For Additional Information

Medicare A submitters who would like additional information about testing the ANSI 835 4010 should contact Cynthia Moore at (904) 791-8254 or via email at cynthia.moore@fcso.com.

276/277 – CLAIM STATUS REQUEST/ RESPONSE – Enveloping changes

The initial flyer distributed dated May 16, 2002 contained erroneous information regarding the enveloping of the X12N 276/277 transactions. Please disregard the information pertaining to the enveloping which was contained in that publication. Please use the information contained in this flyer for your 276/277 transactions enveloping information.

Enveloping information for the 276 transaction must be as follows:

ELEMENT	CONTENT
ISA 05	28
ISA 06	Your mailbox number
ISA 07	**ZZ**
ISA 08	592015694
ISA 15	**T/P (T to represent test or P to represent production.)**
GS 02	Your sender number
GS 03	MEDACS00090
GS 08	004010X093
REF 02	**This segment is not used in the 276/277 transaction.**

HIPAA-AS Update (continued)

Enveloping information for the 277 transaction will be as follows:

ELEMENT	CONTENT
ISA 05	**ZZ**
ISA 06	592015694
ISA 07	28
ISA 08	Your mailbox number
ISA 15	**T/P (T to represent test or P to represent production.)**
GS 02	**Your sender number**
GS 03	**MEDACS00090**
GS 08	004010X093
REF 02	**This segment is not used in the 276/277 transaction.**

The applicable changes have been bolded for your convenience.

For Additional Information

Medicare A submitters who would like additional information about testing the X12N 276/277 4010 should contact Peggy Kelly at (904) 791-0912 or via email at peggy.kelly@fcso.com.

Implementation of the Transmission Control Protocol/Internet Protocol (TCP/IP) for the Health Insurance Portability and Accountability Act (HIPAA) Health Care Eligibility Benefit Inquiry and Response Transaction (270/271) Standard

Fiscal Intermediaries will support provider access to eligibility information via TCP/IP connectivity on or about January 1, 2003.

Fiscal intermediaries will build upon their existing network connectivity to provide a TCP/IP port connecting to the CWF supplied eligibility module, which provides a TCP/IP socket interface to the same eligibility function as the LU6.2 interface. The interface also runs in a CICS mainframe environment. Providers will be able to dial into the fiscal intermediaries' gateway and connect directly to the CWF module through an IP socket. Providers/vendors who want to use this connectivity are required to have supporting software and technical expertise to implement this communication method.

Further notifications will be forthcoming. These notifications will include information about testing dates, connectivity and specifications.

PC-ACE Pro32®

PC-ACE Pro32® continues to be involved with testing the Medicare ANSI 4010 production version of the program with a few select number of existing senders. We anticipate the product to be available to all existing PC-ACE Pro32® users in mid-October. Senders who have elected to download the program will be notified via email, and customers electing a CD will be notified via mail. If you have not migrated from the DOS version of PC-ACE to PC-ACE Pro32®, you should contact Technical Support **immediately** at (904) 355-0313. ❖

Source: CMS Transmittal A-02-069, CR 2134
CMS Transmittal A-02-070, CR 2233
CMS Transmittal A-02-065, CR 2234

PATIENT FRIENDLY ADVISORY

Easy Resources to Help your Patients with their Medicare

The Centers for Medicare & Medicaid Services (CMS) has announced several changes to the Medicare appeals process that will be implemented by October 1, 2002. These changes are a result of the Benefits Improvement and Protections Act of 1997.

People with Medicare have the right to appeal Medicare's decision about a health care payment or service. They may appeal if:

- They do not agree with the amount that is paid
- A service is not covered and they think it should be
- A service is stopped before they think it should be.

Previously, your patients had 60 days to file Part A appeal requests and six months to file Part B appeal requests. The new time frames for both Part A and Part B appeal requests is 120 days.

To help explain this change to your patients, we have included information from a flier published by CMS that you can copy and distribute to your patients. Remember, you can refer your patients to 1-800-MEDICARE (1-800-633-4227), or for the hearing and speech impaired, 1-877-486-2048 for the TTY/TTD line, for more information and answers to their Medicare questions. Or, for those who have access to the Internet, refer them to *www.medicare.gov*.

New Rules for the Medicare Appeals Process

Your Medicare Appeal Rights

You have the right to appeal any decision about your Medicare services. This is true whether you are in the Original Medicare plan or a Medicare managed care plan. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can appeal.

Appeal Rights Under the Original Medicare Plan:

If you are enrolled in the Original Medicare plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. The notice will also tell you why your bill was not paid and what appeal steps you can take.

New Appeals Timeframes

The timeframes for requesting an appeal have been changed as of October 1, 2002. If you disagree with any claim decisions on either Part A or Part B of your Medicare Summary Notice, you can request an appeal up to 120 days from the date shown on the front of your Medicare Summary Notice. Previously, Part A and Part B claims had different time frames for appeals.

Interim Timeframe Until January 1, 2003

Since it may take a few months to make the necessary changes in your Medicare contractor's computer systems, there is an interim timeframe until January 1, 2003. If your Medicare Summary Notice is dated September 30, 2002, or earlier, you will have 60 days to file Part A appeal requests and six months to file Part B appeal requests. If your Medicare Summary Notice is dated between October 1, 2002, and December 31, 2002, you will have 120 days to file Part A appeal requests and six months to file Part B appeal requests.

Appeals Instructions

Do not worry if you are concerned you may not remember these new time frames for appeals. The instructions on how to appeal will always be listed on the back of your Medicare Summary Notice. You can also call 1-800-MEDICARE (1-800-633-4227), or for the hearing and speech impaired, call 1-877-486-2048 for the TTY/TTD line, for more information and answers to your Medicare questions. Or, for those who have access to the Internet, visit *www.medicare.gov*. ❖

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.*

Please continue to look for
"The Patient Friendly Advisory"
in future issues of the Medicare A Bulletin

Editor Note: *The Patient Friendly Advisory section provides assistance to Medicare Part A facility medical staff in answering patients' questions and concerns related to the Medicare program. The Medicare Beneficiary Education staff provides the information in this section.*

EDUCATIONAL RESOURCES

Medicare Education and Outreach—Calendar of Upcoming Events

Below is a one month calendar for upcoming Medicare Education and Outreach events. Please refer to the symbol legend below to determine the type of event listed. Please note: any event with the legend (T) does not have a city listed because it is a teleconference and you are required to call.
When you find a listing you are interested in, please refer to our provider education Web site or fax a request for more information to (904) 791-6035.

Legend:

(W) **Workshop**: Cost-based event that includes interaction, exercises, in depth information

(E) **Expo**: Cost-based multi-specialty event that includes concurrent classes, workshops, and interactive sessions

(T) **Teleconference**: *Free* telephone session that deals with limited issues of a predetermined subject, and questions and answers

(SS) **Specialty Seminar**: Cost-based seminar providing in-depth material about a specific specialty

(BB) **Building Blocks**: *Free* seminar that gives overviews and general information on chosen subjects. *Note: These sessions do not include exercises and in-depth information.*

For further information, including subject matter and registration, please visit our provider education Web site *www.floridamedicare.com*, call our registration hotline at (904) 791-8103, check your *Medicare A Bulletin* or fax questions to (904) 791-6035. *Customized on-site sessions are available for a fee. Call: (904) 791-8114*

December 2002

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	**4** **(W)** "Basic Skills for Beginners" Part B: Ft Lauderdale **(M)** PCOM Advisory Part A Jacksonville	**5** **(W)** "Beyond the Basic" Part B: Ft Lauderdale	**6** **(M)** PCOM Advisory Part B: Miami	7
8	9	10	11	**12** **(T)** "Topic to be Announced" Part A	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

ORDER FORM - PART A MATERIALS

The following materials are available for purchase. To order, please complete and submit this form along with your check/money order (PAYABLE TO: BCBSFL-FCSO, account number 700284).

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NOTE: *The Medicare A Bulletin is available* ***free of charge*** *online at* ***www.floridamedicare.com****.*

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Procedure Codes

CPT Codes

Anesthesia/Surgery, 00100-69979

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
(904) 355-8899

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
(904) 355-8899

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
(904) 791-8103

ELECTRONIC CLAIM FILING

"DDE Startup"
Direct Data Entry (DDE)
P. O. Box 44071
Jacksonville, FL 32231-4071
(904) 791-8131

FRAUD AND ABUSE

Medicare Anti-fraud Branch
P. O. Box 45087
Jacksonville, FL 32232-5087
(904) 355-8899

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
(904) 791-8430

Phone Numbers

PROVIDERS

Customer Service Representatives:
877-602-8816

BENEFICIARY

800-333-7586

ELECTRONIC MEDIA CLAIMS

EMC Start-Up
904-791-8767, option 4

Electronic Eligibility
904-791-8131

Electronic Remittance Advice
904-791-6865

Direct Data Entry (DDE) Support:
904-791-8131

PC-ACE Support
904-355-0313

Testing
904-791-6865

Help Desk (Confirmation/Transmission)
904-905-8880

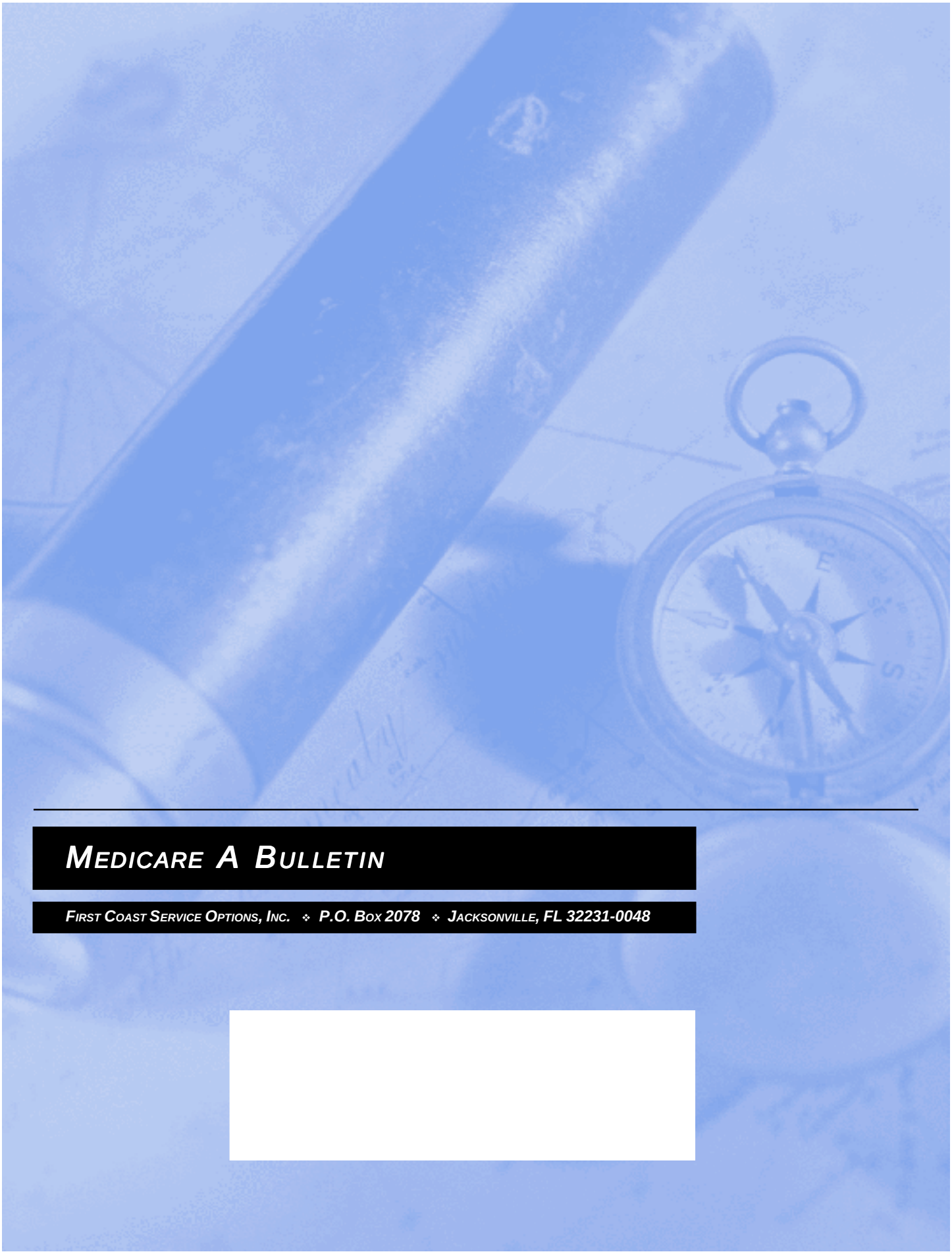
Medicare Web Sites

PROVIDERS

Florida Medicare Contractor
www.floridamedicare.com
Centers for Medicare & Medicaid Services
www.hcfa.gov and www.cms.hhs.gov

BENEFICIARIES

Florida Medicare Contractor
www.medicarefla.com
Centers for Medicare & Medicaid Services
www.medicare.gov



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