Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

Features

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

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

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

Routing Suggestions:

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

Millie C. Pérez
Shari Bailey
Bill Angel
Betty Alix

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

Medicare Part A Publications – 10T
P.O. Box 45270
Jacksonville, FL
32232-5270

A PHYSICIAN'S FOCUS

Do I Bill Inpatient, Outpatient, or Outpatient with Observation Hours?—Planned, Elective Procedures with Overnight Stay

A frequent Medicare issue for hospital compliance, billing and utilization management (UM) staff is planned elective procedures for patients who end up spending the night.

In the traditional Medicare program, the attending physician is responsible for patient care and determining the patient's status (inpatient, outpatient, or outpatient with observation hours). A hospital can only bill the intent of the physician as demonstrated by the orders (*admit inpatient, outpatient procedure, place in outpatient observation*) and the documentation of the actual care/services provided (clinical data, type of services, location, etc.).

a) The Intermediary manual states that "a patient is an inpatient when so ordered by a physician and there is the expectation the patient will stay at least overnight." However, if billed as an inpatient, the claim may not meet InterQual® criteria and the QIO (Quality Improvement Organization- formerly the PRO) could deny the claim if reviewed.

b) The Hospital manual states, in cases of minor surgery or other treatment that the patient is considered an outpatient regardless of the hour he came to hospital, whether he used a bed, or whether he stayed past midnight. However, if billed as an outpatient, given the intent of physician for an inpatient level of care as demonstrated by the type of procedure, frequent IV therapies, labs, etc., the FI (fiscal intermediary) could deny the claim.

c) Routine stays following surgery may not be billed as observation hours in the traditional Medicare program unless there is documentation of a significant patient complication and/or the patient's condition is unstable. Normal outpatient postoperative recovery time following surgery is included in the APC (ambulatory payment classification) for the procedure. The FI could deny observation hours or deny the claim if the documentation demonstrated that the intent of the physician was an inpatient level of care.

If the physician intends to keep the patient overnight, especially for 24 hours or more of care at an inpatient level of care (prolonged monitoring given co-morbidity, frequent laboratory studies, frequent IV therapy, etc.), then the physician should schedule an inpatient admission. Also, it is important that physicians document the indications for the procedure and the associated co-morbidities since the medical necessity of the procedure as well as the need for the overnight stay can be reviewed by the QIO. Late starting same day surgeries or routine one day procedures that go past midnight and use a hospital bed can be serviced and billed outpatient if the physician's intent is not to use an inpatient level of care. The physician's orders and documentation should support the outpatient status. These patient stays are of short duration and always less than 24 hours. If there is a complication intra-operatively or in the recovery room, the physician can document the need for change in status to outpatient observation or inpatient depending on the clinical situation.

If the intent of the physician as demonstrated by admission orders, documentation, or procedure planned is ambiguous, hospitals should clarify with the physician prior to the admission or within six hours of the hospitalization. For example, if the FI sees an outpatient claim with an admission order for 23-hour observation *prior* to a planned, elective procedure, a claim denial could occur even if observation hours are not billed. Given that the normal outpatient postoperative recovery time following surgery is included in the procedure, it appears to the FI that the physician's intent is to keep the patient overnight at an inpatient level of care. The claim payment decision will depend on review of documentation. In this example, an adverse payment outcome for the hospital can be avoided if the patient status is clarified before or in the early hours of the admission for the planned procedure. Many hospitals have nurse UM teams that can assist physicians with patient status issues. Hospital physician staff should work with the UM teams in establishing standards for their community as to appropriate procedures and patient criteria for outpatient versus inpatient procedures and the use of observation hours in the traditional Medicare program. Clerical errors may be corrected prior to discharge.

Of note, Medicare does designate certain procedures as "inpatient only" and these procedures should be ordered, serviced, and billed as inpatient for Medicare patients.

Finally, Medicare beneficiaries should be informed of their status and financial liability prior to an elective procedure. An outpatient procedure is a Part B service (hospital outpatient billed to the intermediary) as opposed to an inpatient procedure that is a Part A service (hospital inpatient billed to the intermediary). Most beneficiaries are enrolled in both Part A and B. Part B in 2003 has $100 deductible per year and 20 percent coinsurance for certain outpatient services. (There can be multiple procedures on an outpatient claim for which the coinsurance applies.) Part A in 2003 has $840 deductible and no coinsurance for a hospital inpatient stay of 1-60 days. As you can see, beneficiaries need clear information so they can make informed health care decisions.

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 (CMS) 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 $65.00. A subscription order form may be found in the Educational Resources section in each issue. Issues published since January 1997 may be downloaded from the provider education 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 reviews conducted by the fiscal intermediary. Whenever possible, the LMRP section will be placed in the center of the *Bulletin* to allow readers to remove it separately, without disturbing the rest of the publication.

The Educational Resources section includes educational material, such as seminar schedules, Medicare provider education Web site information, and reproducible forms. An index and important addresses and phone numbers are in the back of every issue.

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

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

Sign up to our *eNews* electronic mailing list

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

Providers Must Qualify and Register to Receive the *Medicare A Bulletin* in Hardcopy Format

Use of the Internet has become an accepted standard of communication throughout the world. Publications produced by First Coast Service Options, Inc. (FCSO) for our Medicare Part A customers are available on our provider education Web site (*www.floridamedicare.com*). Our Medicare publications are posted to the Web sites in PDF (portable document format) and may be viewed, printed, or downloaded free of charge. Hardcopy publications, by contrast, nationally cost Medicare a substantial amount of money for printing and postage. Reducing the number of hardcopies produced is one way Medicare contractors can reduce costs that may be better utilized elsewhere. In addition, enhancements to online publications can be made that are not possible in print.

Hardcopy distribution of the *Medicare A Bulletin* has previously been limited to individual providers and medical facilities that billed at least one Part A claim to the Florida Medicare fiscal intermediary for processing during the twelve months prior to the release of each issue. **Beginning with publications issued after June 1, 2003**, **Medicare providers who meet these criteria will have to register with us to continue to receive the *Bulletin* in hardcopy format.** Qualifying providers will be eligible to receive one hardcopy of that issue, *if* you can show a valid reason why you cannot utilize the electronic publication available on the Internet. "I just prefer hardcopy" is an invalid reason – a valid reason might be lack of a personal computer with Internet access, or other technical barrier.

If you believe you meet these criteria and wish to continue receiving hardcopies, you must complete and return the registration form that follows. If you include your email address or fax number, we will use one of those methods to notify you that you will continue to receive hardcopy publications. You will be required to re-register annually.

If you are willing and able to receive the *Bulletin* electronically, you do not need to reply to us. Providers and other entities that do not meet the criteria and desire a hardcopy may purchase an annual subscription to the *Bulletin* (please see the "2003 Part A Materials" order form in this issue).

> ***Note**: If you have a paid subscription, you will continue receiving a hardcopy of the* Medicare A Bulletin *through your subscription period.*

Features and Distribution

There are already advantages to accessing the *Bulletin* online: the electronic version is posted to the Web before print copies are distributed, and you may view, print, or download only those articles important to your business.

In addition, we will be enhancing the format of electronic newsletters to provide helpful features that do not appear in the current hardcopy format, including hyperlinks. A hyperlink is an element in an electronic document that links the user to another place in the same document, to an entirely different document, or to a Web site. This feature will provide users instant access to the following items:

- *Articles of Interest* – The newsletters' table of contents will include hyperlinks to each article, therefore a provider can choose an article(s) of particular interest to his/her medical practice.
- *Third-Party Web sites* – All third-party Web sites referenced within articles will include hyperlinks to the applicable information on that Web site.
- *References within the Contractor Web site*s – All additional resources or reference materials mentioned in the newsletter will include hyperlinks to that information within the FCSO Medicare Web sites (e.g., full-text versions of local medical review policies, prior publications, forms, online registration, etc.). Additionally, links to unique Web pages will allow access to information applicable to the user's specialty classification.

The enhanced electronic publications will be available at no charge through the FCSO Medicare Web sites and on CD-ROM at a minimal cost. In addition, you may sign up for the *FCSO eNews*, our free electronic mailing list. Subscribers receive an email notice when new publications are posted to our Web sites, plus frequent notification of other items of interest. Anyone with an email address may sign up for *eNews*; you don't have to be at the office.

Medicare A Bulletin Hardcopy Registration Form

To continue receiving the *Medicare A Bulletin* in hardcopy format, you must complete this registration form. Please complete and fax or mail it to the number or address listed at the bottom of this form. To receive a hardcopy of the Fourth Quarter 2003 *Bulletin* your form must be faxed or postmarked on or before June 30, 2003.

Please note that you are not obligated to complete this form to obtain information published in the *Medicare A Bulletin* – issues published beginning in 1997 are available free of charge on our provider education Web site *www.floridamedicare.com.*

Provider/Facility Name:

_____

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_____

Address:

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Contact Person/Title:

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or fax to 1 (904) 791-6292

Please let us know your concerns or questions regarding this initiative:

_____

_____

_____

Please do not contact our customer service call center regarding this initiative. Additional questions or concerns may be submitted via the Web site in the "contact us" section.

GENERAL INFORMATION

Additional Documentation Request Requirements for Ordering Providers of Laboratory Services

On November 23, 2001, CMS published in the *Federal Register* (66 FR 58788) a final rule regarding coverage and administrative policies for clinical diagnostic laboratory services under Medicare Part B. A committee of interested parties, including representatives from hospitals, physicians, laboratories, coding experts and CMS staff developed this rule under the Negotiated Rulemaking Act. A provision of the rule was that "if the documentation provided…does not demonstrate that the service is reasonable and necessary, CMS:

- provides the ordering physician or nonphysician practitioner information sufficient to identify the claim being reviewed,
- requests from the ordering physician or nonphysician practitioner those parts of a beneficiary's medical record that are relevant to the specific claim(s) being reviewed, and
- informs the entity submitting the claim(s) that the documentation has not been supplied and denies the claim if the ordering physician or nonphysician practitioner does not supply the documentation requested."

Policy Implementation

Effective July 1, 2003, Medicare will request any additional documentation needed for processing claims submitted for clinical diagnostic laboratory services from the billing provider, and under certain circumstances, from the ordering provider.

Laboratories may still ask the ordering physician or nonphysician practitioner for any appropriate documentation they need to respond to the initial additional documentation request. Thus, the ordering provider could, in some instances, receive requests for documentation from both the laboratory and Medicare.

Medicare will allow 45 days for the receipt of the additional documentation requested from the ordering physician or nonphysician practitioner prior to denying the claim, after the initial request for additional documentation to the billing provider, if Medicare needs that additional documentation to make a determination on the claim.

Laboratory billing providers are required to supply information sufficient to identify the ordering provider along with the claim. If this information is not present, contractors will adjudicate the claim based only on the documentation received and deny or down code the service as appropriate. ❖

Source: CMS Transmittal AB-03-021

Reporting Electrical Stimulation Claims with *CPT* Code *97014* and HCPCS Code G0283

With the implementation of the January 2003 HCPCS update, *CPT* code *97014* – Application of a modality to one or more areas; electrical stimulation (unattended) was discontinued without a grace period effective January 1, 2003. The replacement HCPCS code G0283 – Electrical stimulation (unattended), to one or more areas, for indication(s) other than wound care as part of a therapy plan of care, was also made effective January 1, 2003. However, in accordance with CMS' coverage determination policy, HCPCS code G0283 is effective for dates of service on or after April 1, 2003.

Action Required by Providers

The following billing instructions apply when billing for electrical stimulation service:

- Providers billing for this service furnished **on or after January 1, 2003 through March 31, 2003,** must report *CPT* code *97014*. Reimbursement for this service will be made at the 2002 payment rate.
- Providers billing for this service furnished **on or after April 1, 2003,** must report HCPCS code G0283.
- Providers that have already submitted a claim containing *CPT* code *97014* and other services for dates of service **on or after January 1, 2003 through March 31, 2003,** where the service for *CPT* code *97014* was rejected, may submit an adjustment claim in order to receive payment for *CPT* code *97014.*
- Claims that have been returned to the provider containing *CPT* code *97014* for date of services **on or after January 1, 2003 through March 31, 2003,** may be resubmitted for processing. ❖

Source: CMS Notification Dated April 4, 2003

Correction to Deported Medicare Beneficiary Article

In the Second Quarter 2003 *Medicare A Bulletin* (page 6), we published an article addressing Medicare policy implementation for deported beneficiaries. In that article, we indicated that Medicare contractors will deny claims for items and services furnished to deported beneficiaries using reason code 96 (noncovered charges) and remark code N126 – "Social Security records indicate that this individual has been deported. The payer does not cover items and services furnished to individuals who have been deported." **The correct implementation of this policy is effective for claims processed on or after April 1, 2003.** ❖

2003 Medicare Physician Fee Schedule Update

CMS published a final Medicare physician fee schedule (MPFS) rule for calendar year 2003 on December 31, 2002. This rule, which was based on a statutory formula, provided for an average reduction in payment rates for services of 4.4 percent. When Medicare published the rule, CMS Administrator Tom Scully, stated that CMS believed the statutory formula was flawed, and that the update should be 1.6 percent. However, CMS lacked the authority to depart from the statutory formula.

On February 13, Congress passed the Consolidated Appropriations Resolution, 2003 (CAR). CAR makes clear that Congress intends the Secretary to establish a 1.6 percent update to physician fee schedule rates on March 1, 2003. As a result, the update to the physician fee schedule will be based on an increase of 1.6 percent, rather than a negative 4.4 percent.

The increased payment for services paid under the 2003 MPFS is effective for dates of services **on or after March 1, 2003.**

The following new MPFS rates are available on our provider education Web site at *www.floridamedicare.com* under the fee schedule section:

- 2003 skilled nursing facility services
- 2003 outpatient rehabilitation services
- 2003 surgical dressing items
- 2003 orthotic/prosthetic devices
- 2003 mammography services

The 2003 fee schedules for clinical laboratory services and ambulance services were published in the January 2003 *Medicare A Bulletin* Special Issue. ❖

Source: CMS Transmittal AB-03-027, CR 2601

Appeal Time-Frame Extension Criteria

Under the BIPA provisions, CMS implemented the uniform 120-day timeframe for requesting an appeal (or redetermination) of an initial determination for Part A and Part B. Therefore, providers and beneficiaries have additional time to appeal a Part A claim (120 days versus 60 days), while physicians and other suppliers, as well as beneficiaries, have less time to request an appeal of a Part B claim (120 days versus 180 days).

The physician and supplier communities have argued that it is unfair for CMS to implement the shorter timeframe for Part B appeal requests. CMS recognizes that making the transition to the shorter filing timeframe may prove difficult in situations where appellants need to obtain documentation from other sources in order to file an appeal.

In order to alleviate any hardship associated with the possible need to gather documentation faster than in the past, Medicare may grant an extension of up to 60 days in the 120-day filing deadline for appeals of Part B claims, provided that the appeal request includes a credible explanation from the beneficiary, physician, or supplier that the time was needed to gather the necessary supporting records. Without a credible explanation the extension will not be granted and these appeals will be considered untimely.

Extension may be granted for appeals of initial determinations made on or after October 1, 2002. ❖

Source: CMS Transmittal AB-03-039, CR 2492

Holding Screening and Diagnostic Mammography Claims

CMS has requested from FIs to hold mammography claims containing *CPT* code *76085* or HCPCS code G0236. Instructions issued in the Medicare Intermediary Manual, transmittal 1864 (change request 2332), dated October 25, 2002, which were effective April 1, 2003, allow billing of CAD (computer-aided detention) *CPT* code *76085* in conjunction with film and digital screening mammography *CPT* code *76092* or HCPCS G0202 and CAD code G0236 to be billed in conjunction with film and digital diagnostic mammography codes *76090*, *76091*, G0204 or G0206.

The descriptors of CAD codes *76085* and G0236 have since been changed. These codes no longer identify screening versus diagnostic mammographies in the descriptors. As a result, future changes are required in the billing of these devices.

CMS is developing instructions to reflect this change in billing and will be issued at a future date.

Since CAD code combinations included in the Correct Coding Initiative (CCI) edits which are contained in the outpatient code editor (OCE) for April 2003 have not been updated to reflect the proper code combinations as indicated in transmittal 1864, claims containing CAD codes listed above will not process to payment. The CAD CCI edits will be removed from the July 2003 OCE so these claims can process to payment.

Claims containing *CPT* code *76085* and HCPCS G0236 will suspend to status location S/MCMS8 under reason code 75043 until the July OCE release is implemented. ❖

Source: CMS Notifications Dated April 4 and May 5, 2003

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 April 28, 2003, the interest rate applied to Medicare overpayments is **11.625 percent**, based on the revised PCR. This PCR will remain in effect until a new rate change is published. Interest rates for prior periods are available at *http://cms.hhs.gov/manuals/pm_trans/AB03019.pdf.* ❖

Source: Transmittal AB-03-051; CR 2431

Hospice Care Enhances Dignity and Peace as Life Nears Its End

This article published as a request from CMS addresses the issue of the Medicare hospice benefit and emphasizes the benefits of hospice care for beneficiaries. It advises physicians that they need not be concerned about CMS penalties when certifying an individual for hospice care. The article notes that CMS is aware that terminal illness does not always have a predictable course and can be extended beyond the initial six-month certification.

Much of the pain and sense of hopelessness that may accompany terminal illness can be eased by services specifically designed to address these needs. Hospice care, a fully reimbursable Medicare Part A benefits option for beneficiaries and providers since 1983, offers the services designed to address the physical and emotional pain through effective palliative treatment when cure is not possible. In the event that a beneficiary has been advised by his/her physician, that a cure for his/her illness is no longer possible, Medicare beneficiaries may discuss hospice care as an option. Physicians and other health care practitioners can be encouraged that the Medicare program includes a hospice benefit that provides coverage for a variety of services and products designed for those with terminal diagnoses. When properly certified and appropriately managed, hospice care is a supportive and valuable covered treatment option.

Physicians and health care providers in the community, skilled nursing facilities, and hospitals are urged to raise awareness among their patients about the hospice benefit and its availability. Further, a beneficiary may independently elect hospice care. The beneficiary may discuss this option in the event that he or she has a terminal diagnosis; however, in all such cases, a physician must certify that the beneficiary has a terminal diagnosis with a six-month prognosis, if the illness runs its usual course.

Hospice care that is covered by Medicare is chosen for specified amounts of time known as "election periods." Essentially, a physician may certify a patient for hospice care coverage for two initial 90-day election periods, followed by an unlimited number of 60-day election periods. Each election period requires that the physician certify a terminal illness. Payment is made for each day of the election period based on one of four per diem rates set by Medicare, commensurate with the level of care.

Generally speaking, the hospice benefit is intended primarily for use by patients whose prognosis is terminal, with six months or less of life expectancy. The Medicare program recognizes that terminal illnesses do not have entirely predictable courses; therefore, the benefit is available for extended periods of time beyond six months provided that proper certification is made at the start of each coverage period.

Recognizing that prognoses can be uncertain and may change, Medicare's benefit is not limited in terms of time. Hospice care is available as long as the patient's prognosis meets the law's six-month test.

This test is a general one. As the governing statute says: "The certification of terminal illness of an individual who elects hospice shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness."

CMS recognizes that making medical prognostication of life expectancy is not always an exact science. Thus, physicians need not be concerned. There is no risk to a physician about certifying an individual for hospice care that he or she believes to be terminally ill.

Many physicians appreciate the fact that hospice care enables family and loved ones to participate in the experience and to get help from the hospice in managing their own feelings and reactions to the illness. The value of hospice care is recognized and advanced by many physicians and other health professionals. One professional organization, the American Academy of Hospice and Palliative Medicine (formerly the Academy of Hospice Physicians) focuses its efforts on the "prevention and relief of suffering among patients and families" through palliative therapy, education and counseling. Among the Academy's objectives are to "bring the hospice approach into mainstream medicine and eliminate the dichotomy whereby patients receive either curative or palliative care."

This distinction is important because despite a growing appreciation for hospice care both as a philosophy and as a fully covered Medicare benefit, there appears to be two perceived barriers to its broader acceptance.

First is an understandable reticence to contemplate the end of life. A 1999 survey conducted by the National Hospice and Palliative Care Organization (NHPCO) found that Americans generally are reticent to discuss hospice care with their elderly parents. According to the survey, less than one in four of us have put into writing how we wish to be cared for at life's end. About one in five have not contemplated the subject at all, and a slightly smaller number told the surveyors they have thought about it but have not shared their thoughts with others.

The second perceived barrier is a lack of knowledge on the part of both patients and practitioners that the covered hospice benefits are both broad and readily available virtually everywhere in the country. As with other covered services, payments for hospice care generally are made to providers based on prospectively-set rates that are updated every year for inflation. Hospice care is primarily a specialized type of home health care, and as is the case with the home health care benefit, hospices are served by regional intermediaries for Medicare billings, payments, cost reports and audits.

Medicaid also covers hospice care in many states. Medicare covers a number of specific services as defined in regulation and in the Medicare Hospice Program Manual. Most of these services are familiar to health care professionals and other practitioners who have worked with skilled nursing facilities (SNFs) and home health services. Covered services include:

- Medical and nursing care
- Medical equipment (such as wheelchairs or walkers)
- Pharmaceutical therapy for pain relief and symptom control
- Home health aide and homemaker services
- Social work services
- Physical and occupational therapy
- Speech therapy
- Diet counseling
- Bereavement and other counseling services
- Case management

Hospice Care Enhances Dignity and Peace As Life Nears Its End (continued)

Hospice care also is covered by Medicaid in many states.

In 1999, 474,270 individuals received hospice care at 2,281 certified hospice programs in the United States. In 2000, there were 2,266 certified hospices. In 2001, approximately 580,000 individuals received hospice care at 2, 277 (as of August 2001) certified hospice programs.

The hospice setting also is appropriate for patients who suffer from terminal illnesses such as lung disease or end-stage heart ailments, cancer, Alzheimer's disease, and terminally ill AIDS patients. Hospice is not about death, but rather about the quality of life as it nears its end, for all concerned – the patient, family and friends, and the health professional community.

For more information: go online to the Medicare Learning Network at *www.cms.gov/medlearn/*; or see a related informational brochure on hospice care at: *www.medicare.gov/Publications/home.asp*. ❖

Source: CMS Transmittal AB-03-040, CR 2570

***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.*

Colorectal Cancer Screening Awareness for Health Care Providers

Editor's Note: This article is published as a request from the CMS. The Centers for Disease Control and Prevention Partners with CMS to increase colorectal cancer screening within the Medicare population and the general population aged 50 and above. Together, CDC and CMS have implemented the Screen for Life National CRC Action Campaign, which informs men and women aged 50 years and older about the importance of CRC screening for early detention and prevention of the disease.

Colorectal cancer (CRC) is the second leading cause of cancer-related death in the United States. The American Cancer Society (ACS) estimates that there will be 147,500 new cases and 57,100 deaths from CRC in 2003. However, CRC is one of the most preventable cancers, as well as one of the most curable when detected at an early stage. Screening can help prevent CRC by detecting polyps so they can be removed before they turn into cancer. According to the ACS, if the cancer is detected early and appropriately treated, the 5-year survival rate is approximately 90 percent. It has been estimated that widespread screening for CRC could save more than 20,000 lives each year.

The Importance of Screening

Despite the proven effectiveness and availability of various CRC screening tests, many Americans are not being screened for the disease. Screening for CRC lags far behind screening for other cancers. Only 21 percent of people aged 50 and older who responded to the Behavioral Risk Factor Surveillance System in 1999 reported having had a fecal occult blood test (FOBT) within the recommended timeframe of one year. Only 34 percent of respondents had undergone sigmoidoscopy or colonoscopy within the recommended timeframe of five years. These findings underscore the need to increase awareness and promote the use of colorectal cancer screening exams at regular intervals.

As a consequence of the low level of CRC screening, only 37 percent of cases are diagnosed when the disease is still localized. Later diagnosis results in a significantly lower 5-year relative survival rate than would occur if patients were diagnosed when the disease was localized. If the cancer is detected early, the 5-year survival rate is approximately 90 percent. When the cancer has spread regionally, the survival rate drops to 65 percent; and when it has metastasized, the rate lowers to only nine percent. These considerable differences in survival rates point to the importance of screening in preventing this disease and in detecting it at its earliest stage, when treatment is most effective.

According to the 2000 U.S. census, there are approximately 76.5 million Americans who are aged 50 and older, with an expected increase of 20 million Americans in this age group through 2005. By 2030, the number of Americans age 65 and older is expected to increase by over 200 percent. If prevention and early detection of CRC are not significantly improved, the increase in morbidity and mortality from CRC in the aging population will be even more pronounced than it is today.

Incidence and Mortality

CRC usually strikes men and women over the age of 50 (90 percent of cases). The incidence rate is similar among men and women until age 50. At that age, it becomes higher in men than in women. CRC incidence and mortality rates vary substantially by race and ethnicity, with both incidence and death rates being highest in African Americans and lowest in American Indian/Alaska Natives and Hispanics. Death rates for CRC began declining in women in 1950 and in men beginning in 1985. Despite this encouraging trend, the death rates for CRC are unacceptably high. It has been suggested that the incidence and mortality of CRC could be reduced by 60 and 80 percent, respectively, if compliance were 60 percent with initial testing and 80 percent with follow-up.

Screening Tests and Intervals

Several screening regimens have been proven to be effective (in various degrees) in reducing mortality from CRC: the FOBT, flexible sigmoidoscopy, double-contrast barium enema (DCBE), and colonoscopy. These allow detection of adenomatous polyps so they can be removed before they become cancerous and the removal of early-stage CRC when the disease is still highly curable. Each procedure differs in accuracy, cost and risk.

Regular CRC screening is recommended for all adults aged 50 or older who have no known risk factors. (Seventy-five percent of all new cases of CRC occur in individuals with no risk factors for the disease, and as stated above,

Colorectal Cancer Screening Awareness for Health Care Providers (continued)

more than 90 percent of cases of the disease occur in people over the age of 50.) Screening guidelines have been developed by several scientific agencies and organizations, including the U.S. Preventive Services Task Force; the ACS; and the Interdisciplinary Task Force, which is convened by the Agency for Healthcare Research and Quality (AHRQ) and supported by five major gastroenterology societies. All recommend the following screening procedures:

- Annual FOBT, or
- Flexible sigmoidoscopy every 5 years, or
- Annual FOBT plus flexible sigmoidoscopy every 5 years, or
- Total colon examination by colonoscopy every 10 years or by DCBE very 5-10 years.

These guidelines emphasize the key health benefit of CRC screening—finding precancerous polyps so they can be removed before they turn into cancer, and finding early stage CRC, so it can be treated. Currently, data are insufficient to determine the best single screening approach. Each option has advantages and disadvantages that may vary for individual patients and practice settings. AHRQ recommends developing a screening strategy based on patient preferences, medical contraindications, patient adherence, and available resources for testing and follow-up. AHRQ advises clinicians to speak with patients about the benefits and potential harms associated with each option before selecting a screening strategy.

Note: For the most up-to-date guidelines, refer to *www.guideline.gov*, the National Guidelines Clearinghouse.

The Role of the Health Care Professional in Increasing Screening Rates

Health care professionals should offer screening according to currently accepted guidelines to all individuals aged 50 and older who are at average risk for CRC. Those at higher than average risk should be counseled according to the accepted guidelines for those at increased risk. As with other screening tests, a recommendation by a health care professional is an important influence in determining whether or not individuals decide to be screened for CRC. Primary care providers play a very important direct role in facilitating compliance with screening. In general, when primary care providers recommend a screening procedure to patients, patients follow through.

The ACS reports that the low prevalence of CRC screening is due in part to limited communication between physicians and their patients. Patients may be unaware of the benefits of screening unless their health care professionals discuss them. However, physicians may be unlikely to suggest screening unless the patient asks about it. Clinicians should take advantage of every opportunity to recommend preventive care to patients (e.g., during visits for acute care). Reminders should be given at every visit.

Reminder systems have been shown to increase preventive services and screening rates in practices that use them. They are strongly recommended to ensure that cancer-screening programs are ongoing rather than a one-time event. Reminder systems are more efficient and effective when they include the participation of office staff. Reminders can be active (e.g., at point of service) or passive (e.g., receiving a postcard in the mail). Follow-up and surveillance should be built into reminder systems. At a minimum, health care professionals can use the *Put Prevention Into Practice* system (obtainable from AHRQ at 800-358-9295 or ahrqpubs@ahrq.gov).

Numerous educational materials are available on CRC and screening. See the order form for materials that have been developed as a part of the *Screen for Life:* National CRC Action Campaign. A description of the campaign and the order form follow. Most materials can be obtained from the Centers for Medicare & Medicaid Services (CMS) at no charge.

Who Should Be Tested

Patients with symptoms require immediate diagnostic testing. Symptoms include:

- Rectal bleeding
- Frequent abdominal discomfort or pain for no reason
- Bloating
- A change in bowel habits, such as having stools that are narrower than usual
- Iron deficiency anemia
- Unexplained weight loss.

For asymptomatic patients, routine screening is recommended for:

- Men and women aged 50 and older. As stated earlier, at least 75 percent of colorectal cancers occur in people with no personal or family history of CRC and no known risk factors.
- Patients at increased risk for developing CRC. These patients may need to be screened earlier and more frequently than other patients. Those considered at increased risk have:
  - A close relative (sibling, parent, or child) who has had CRC or an adenomatous polyp;
  - A personal or family history of familial adenomatous polyposis;
  - A personal or family history of hereditary nonpolyposis CRC;
  - A personal history of adenomatous polyps;
  - A personal history of CRC; or
  - Inflammatory bowel disease, including Crohn's disease and ulcerative colitis.

Colorectal Cancer Screening Awareness for Health Care Providers (continued)

Medicare covers the following tests/procedures:

Colorectal Cancer Screening Test/Procedure	HCPCS Code	Medicare Coverage
Colorectal cancer screening; fecal-occult blood t, 1-3 simultaneous determinations	G0107	Once every 12 months for patients age 50 and older.
Colorectal cancer screening; flexible sigmoidoscopy	G0104	Once every 48 months for patients age 50 and older when performed by a doctor of medicine or osteopathy, or a physician assistant, nurse practitioner, or clinical nurse specialist.
Colorectal cancer screening; colonoscopy on individual at high risk	G0105	Once every 24 months for patients at any age who are at high risk for colorectal cancer, when performed by a doctor of medicine or osteopathy.
Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	G0121	Once every 10 years but not within 48 months of a screening sigmoidoscopy for patients at any age who are not at high risk, when performed by a doctor of medicine or osteopathy.
Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema*	G0106	Physicians may substitute a barium enema examination for flexible sigmoidoscopy every four years for patients age 50 and older.
Colorectal cancer screening; alternative to G0105 (screening colonoscopy), barium enema*	G0120	Physicians may substitute a barium enema examination for colonoscopy every two years for high-risk patients.
Colorectal cancer screening; barium enema (not performed as an alternative to G0105 or G0104)	G0122	This service is denied as **noncovered,** because it fails to meet the requirements of the benefit. The beneficiary is liable for payment.

*****The screening barium enema must be ordered in writing after determining that the test is the appropriate screening test. The attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the screening potential estimated for a screening flexible sigmoidoscopy, or for a screening colonoscopy, as appropriate, for the patient.

Note: If during the course of a screening colonoscopy (or screening flexible sigmoidoscopy), a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy (or flexible sigmoidoscopy) with biopsy or removal should be billed and paid rather than G0121 (or G0104).

Note: For additional information on covered services, HCPCS Codes, and coverage criteria for colorectal cancer screening services:

– View CMS' Carrier Manual, Part 3, Chapter IV – Claims Review and Adjudication Procedures at**:** *http://cms.hhs.gov/manuals/14_car/3b4010.asp***.** See Section 4180 for CRC screening.

– Read *Medicare Resident & New Physician Training*, Screening for Colorectal Cancer, pp. 48-51. To obtain a hardcopy of this publication or a CD, send an e-mail note to Medlearn@cms.hhs.gov. Also visit CMS' Medlearn site, which was established for health care professionals, at: *http://www.cms.hhs.gov/medlearn/*.

Screen for Life National CRC Action Campaign and National CRC Awareness Month Campaign

CMS partners with the Centers for Disease Control and Prevention (CDC) to increase CRC screening within the Medicare population and the general population aged 50 and above. Together CDC and CMS develop and implement the *Screen for Life: National Colorectal Cancer Action Campaign* (SFL), which informs men and women aged 50 years and older about the importance of CRC screening for early detection and prevention of the disease. (For more information about SFL, visit: *www.cdc.gov/cancer/screenforlife*.) In addition, in March, CMS joins 50 agencies and organizations to carry out the National CRC Awareness Month Campaign, which generates widespread awareness about CRC and encourages people to learn more about how to reduce their risk of the disease through regular screening and a healthy lifestyle. The Cancer Research and Prevention Foundation (CRPF) leads this national campaign. (For more information on the NCCAM campaign, visit CRPF's Internet site at *www.preventcancer.org* or call 1-800-227-2732.) Medicare carriers, intermediaries, and quality improvement organizations join CMS and its partners in this effort by making people with Medicare aware of the importance of regular CRC screening and by encouraging health care professionals to: (1) educate themselves and their patients about the benefits of screening for prevention and early detection of colorectal cancer; (2) recruit patients for initial colorectal cancer screening; and (3) ensure patient compliance with current screening tests and appropriate follow-up. Both campaigns produce and distribute CRC materials for patients and health care professionals.

Colorectal Cancer Screening Awareness for Health Care Providers (continued)

Materials, Education and Training

Screen for Life has developed numerous materials (e.g., brochures, fact sheets, posters), which health care professionals can make available to patients and use to inform them about the importance of screening. The publications can be obtained free of charge from CMS or CDC. See the table entitled: "Materials on Colorectal Cancer Screening for Health Care Professionals" for information on available print materials and how they may be ordered or downloaded from the Internet.

In addition to the print materials, CDC has developed a slide presentation, *"A Call to Action: Prevention and Early Detection of Colorectal Cancer."* This was developed to generate awareness among primary care professionals of the importance of CRC screening in the prevention and early detection of CRC. CDC encourages health care professionals to download and present the slides to their colleagues. CDC also offers Web-based tools that health care professionals can use to help patients select screening options (e.g., suggestions for communicating effectively with patients about CRC). The slide presentation and online tools may be viewed, ordered, or downloaded at: *www.cdc.gov/cancer/colorctl/calltoaction/*.
Information for this article was taken from:

1. The American Cancer Society's *Cancer Facts & Figures 2002* (Special Section: Colorectal Cancer and Early Detection) and *Cancer Facts & Figures 2003.*
2. CDC's Cancer Prevention and Control, CRC Prevention and Control Initiatives Web site, including *Colorectal Cancer: The Importance of Prevention and Early Detection 2002 Fact Sheet.*
3. CDC's Cancer Prevention and Control, *Screen for Life: National CRC Action Campaign* Web site, including materials from the campaign.
4. CDC's *MMWR Weekly*, March 9, 2001/50(09); 162-6, "Trends in Screening for Colorectal Cancer—United States, 1997 and 1999.
5. Cancer Research and Prevention Foundation's (formerly the Cancer Research Foundation of America) *Confronting Colorectal Cancer: Action Steps for Change*, October 2002.
6. CMS' *Medicare Resident & New Physician Training, Sixth Edition, 2002*, Screening for Colorectal Cancer.
7. CMS' *Carrier Manual*, Part 3, Chapter IV – Claims Review and Adjudication Procedures, Section 4180. ❖

Source: CMS Transmittal AB-03-033, CR 2580

Colorectal Cancer Screening Publications

TO ORDER COPIES FROM CMS – FAX, E-MAIL, OR TELEPHONE:

Orders from CMS For 1 copy:

– Phone: 1-800-MEDICARE (1-800-633-4227)

Orders from CMS For 1-99 copies:

– Fax: 410-786-4786
– E-Mail: LBeasley@cms.hhs.gov
– Phone: If you have questions, or cannot fax or e-mail requests, call Larry Beasley (410-786-7843).

Orders for 100 or more copies:

– Fax: 410-786-1905
– E-Mail: STaylor@cms.hhs.gov
– Phone: If you have questions, or cannot fax or e-mail requests, call Susie Taylor (410-786-7849).

Note: Please order publications via fax or e-mail when possible. Because of the large volume of requests, you may not receive an acknowledgment return call for orders placed on voice mail.

TO ORDER OR DOWNLOAD PUBLICATIONS FROM CMS' INTERNET SITE:

– Internet: To download copies of *"Let's Break the Silence"* brochures (English and Spanish) from the CMS Internet site, visit: *www.medicare.gov*. Click "Health Information." Then click "Colorectal Cancer."

TO ORDER OR DOWNLOAD PUBLICATIONS FROM CDC:

– Internet: *http://www.cdc.gov/cancer/screenforlife*, To download slide presentation, visit: *www.cdc.gov/cancer/colorctl/calltoaction/index.htm.*
– Phone: 1-888-842-6355, or
– E-mail: cancerinfo@cdc.gov.

TO VIEW MATERIALS BEFORE ORDERING:

– Internet: Visit the CDC site at: *http://www.cdc.gov./cancer/screenforlife*

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.*

Materials on Colorectal Cancer Screening for Health Care Professionals

Campaign Material	Version	CMS – CDC Pub No.	Additional Information
Health Professionals' Fact Sheet *BEING UPDATED*	CRC Health Professionals' Facts on Screening	CDC # 099-6487 ORDER FROM CDC	To order or download copies: 1) visit *www.cdc.gov./cancer/screenforlife*; 2) e-mail to cancerinfo@cdc.gov; or phone 1-888-842-6355. Contains table with info on screening tests including scientific evidence supporting the tests, frequency, purpose, important considerations, insurance/ Medicare coverage; etc. Currently, may only be downloaded.
Slide Presentation for Health Professionals	"A Call to Action: Prevention and Early Detection of CRC"	ORDER FROM CDC. See "Additional Information."	Developed by CDC to generate a greater awareness among primary care providers of the importance of prevention and early detection of CRC. Visit: *www.cdc.gov/cancer/colorctl/calltoaction/index.htm*. Download and present slides to colleagues.
Poster (English/Span.)	"Medicare Good News" – Caucasian Audience – African-Amer. Audience – Asian-Amer. Audience – Hispanic Audience (Sp.)	CMS #10122 CMS #10124 CMS #10125 CMS #10142	Posterboard backing.
Poster	"No Symptoms"	CMS #10183 CDC #099-6478	Order version with posterboard backing from CMS. For version that folds, order from CDC (max 50 copies from CDC).
Poster	"True or False"	CMS #02256 (large) CMS #02255 (small)	Colorful poster with 4 questions about CRC & other info. Folds. Large - 17"x22". Small - ll"x17".
Basic Fact Sheet for Patients (low literacy version)	"CRC Basic Facts on Screening"	CMS#11011	8 ½ x 11", 2-sided sheet. Low literacy version of the detailed fact sheet (see below). Info provided is similar to brochure *CRC Screening Saves Lives.*
Detailed Fact Sheet for Patients	"CRC Facts on Screening"	CMS#11012	8 ½ x 11", 2-sided sheet. Includes a chart on the back, with information on frequency/cost estimate, purpose, important considerations, etc.
Brochure for Patients	"CRC Screening Saves Lives" (Eng.)	CMS#11010	8 ½ x 11" trifold. Information on types of tests, how screening saves lives, who is at high risk, symptoms, insurance coverage, etc.
Brochure for Patients (English/Span.)	"Let's Break the Silence"	CMS #95173 (Eng.) CMS #10158 (Sp.)	8 ½ x 11" trifold. Discusses terms related to CRC screening, who is at risk, steps to take, talking with the doctor, insurance, symptoms, preventing cancer, etc. Includes diagram of colon and rectum.
Pamphlet on Preventive Services Covered by Medicare (for Patients)	"Medicare Preventive Services . . . To Help Keep You Healthy"	CMS #10110 (Eng.)	Includes a chart that explains that preventive services are covered by Medicare, for whom they are covered, and what the beneficiary pays. Tear-off cards provide detailed information on some of the preventive benefits.

To view these materials, visit: http://*www.cdc.gov/cancer/screenforlife/preview.htm*.

Medicare Payments for Part B Mental Health Services

This article is published as a request from CMS to assist the provider community about requirements for payment of Part B mental health services.

The Office of Inspector General (OIG) recently studied the appropriateness of Medicare Part B payments for mental health services and recommended that we promote provider awareness of the requirements for payment of these services. OIG reports can be accessed at *http://www.oig.hhs.gov/oei/oeisearch.html*. This article explains Medicare's guidelines for payment of Part B mental health services including qualification requirements for mental health providers; incident to services; reasonable and necessary services; reasonable expectation of improvement; general principles of medical record documentation; documentation guidelines for evaluation and management (E/M) services involving a general psychiatric examination or the single system psychiatric examination; and documentation guidelines for psychiatric diagnostic or evaluative interview procedures, psychiatric therapeutic procedures, central nervous system assessment, and health and behavior assessment.

Qualification Requirements for Mental Health Providers

Providers of mental health services must be qualified to perform the specific mental health services that are billed to Medicare. In order for services to be covered, mental health professionals must be working within their State Scope of Practice Act and licensed or certified to perform mental health services by the state in which the services are performed. Qualification requirements for mental health professionals are listed below.

- **A qualified physician must:**
  1. Be legally authorized to practice by the state in which he/she performs the functions or actions, and
  2. Be acting within the scope of his/her license.
- **A clinical psychologist must**:
  1. Hold a doctoral degree in psychology; and
  2. Be licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he/she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

Refer to regulations found at 42 CFR section 410.71 and the Medicare Carriers Manual Part 3, Chapter II, section 2150 for the covered services of a clinical psychologist.

- **A clinical social worker must**:
  1. Possess a master's or doctor's degree in social work;
  2. After obtaining the degree, have performed at least two years of supervised clinical social work; and
  3. Be licensed or certified as a clinical social worker by the state in which the services are performed.

In states that do not provide for licensure or certification as a clinical social worker, the individual must:

1. Be licensed or certified at the highest level of practice provided by the laws of the state in which the services are performed; and
2. Have completed at least two years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's degree level social worker in an appropriate setting such as a hospital, skilled nursing facility, or clinic.

Refer to regulations found at 42 CFR section 410.73 and the Medicare Carriers Manual Part 3, Chapter II, section 2152 for the covered services of a clinical social worker.

- **A nurse practitioner must:**

1. Be a registered professional nurse who is authorized to practice as a nurse practitioner delivering mental health services by the laws of the state in which services are furnished; and
2. Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners, or be:
   - A registered professional nurse who is authorized to practice as a nurse practitioner by the laws of the State in which the services are furnished, and has been granted a Medicare billing number as a nurse practitioner by December 31, 2000;
   - A nurse practitioner who meets the above standards and applies for a Medicare billing number for the first time on or after January 1, 2001; or
   - A nurse practitioner who meets the above standards and applies for a Medicare billing number for the first time on or after January 1, 2003, and possesses a master's degree in nursing.

Refer to regulations found at 42 CFR section 410.75 and the Medicare Carriers Manual Part 3, Chapter II, section 2158 for the covered services of a nurse practitioner.

- **A clinical nurse specialist must**:

1. Be a registered nurse who is currently licensed to practice in the state where he/she practices and authorized to perform the services of a clinical nurse specialist in accordance with state law;
2. Have a master's degree in a defined clinical area of nursing from an accredited educational institution; and
3. Be certified as a clinical nurse specialist by the American Nurses Credentialing Center.

Refer to regulations found at 42 CFR section 410.76 and the Medicare Carriers Manual Part 3, Chapter II, section 2160 for the covered services of a certified nurse specialist.

- **A physician assistant must:**

1. Be a physician assistant who is licensed to practice

Medicare Payments for Part B Mental Health Services (continued)

as a physician assistant by the laws of the state in which services are furnished; and

2. Have graduated from a physician assistant educational program accredited by the Commission on Accreditation of Allied Health Education Programs, or passed the national certification examination administered by the National Commission on Certification of Physician Assistants.

Refer to regulations found at 42 CFR section 410.74 and the Medicare Carriers Manual Part 3, Chapter II, section 2156 for the covered services of a physician assistant.

Incident to Services

Certain nonphysician practitioners such as clinical psychologists, nurse practitioners, clinical nurse specialists, and physician assistants may have services furnished incident to their professional services. To the extent that they are licensed or authorized by the state to furnish mental health services, these practitioners could have others provide some services as an incident to overall mental health services. There is no national policy that specifies the qualifications for individuals who may furnish these incidental services. In the absence of national policy, contractors can implement local medical review policies that determine who can furnish mental health services incident to the professional services of these specific nonphysician practitioners. Therefore, inconsistencies may be found in policy in terms of billing and payment to nonphysician practitioners for incident to mental health services. The requirements found in the Medicare Carriers Manual Part 3, Chapter II, section 2050.1 are also applicable to services furnished incident to the professional services of certain nonphysician practitioners.

Refer to the following requirements found on the American Psychological Association's (APA) Web site at *http://www.apa.org/practice/medincident.html*:

- Qualifications of Ancillary Personnel.
- Graduate Medical Education (GME). (Current psychiatric residency programs require the teaching physician to be present during the "key portion" of **any** service in which a resident is involved. This would require **either direct observation of the service, or use of a one-way mirror or video equipment** (emphasis added). Thus, if psychiatry interns provide services, they must be observed.)

Reasonable and Necessary Services

Section 1862(a)(1)(A) of the Social Security Act states that all Medicare Part B services, including mental health services, must be "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." For every service billed, providers must indicate the specific sign, symptom, or patient complaint necessitating the service.

Partial hospitalization programs are structured to provide intensive psychiatric care through active treatment for patients who would otherwise require inpatient psychiatric care. These programs are used to prevent psychiatric hospitalization or shorten an inpatient stay and transition the patient to a less intensive level of care.

Reasonable Expectation of Improvement

Services must be for the purpose of diagnostic study or be reasonably expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization and improve or maintain level of functioning. The goal of a course of therapy is not necessarily restoration of the patient to the level of functioning exhibited prior to the onset of illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that a patient's condition would deteriorate, relapse further, or require hospitalization if treatment services are withdrawn, this criterion would be met.

General Principles of Medical Record Documentation

Medical record documentation is required to record pertinent facts, findings, and observations about a patient's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient, and is an important element contributing to high quality care. It also facilitates:

- The ability of providers to evaluate and plan the patient's immediate treatment and monitor his/her health care over time;
- Communication and continuity of care among providers involved in the patient's care;
- Accurate and timely claims review and payment;
- Appropriate utilization review and quality of care evaluations; and
- Collection of data that may be useful for research and education.

The general principles of medical record documentation for reporting of medical and surgical services for Medicare payments include the following, if applicable to the specific setting/encounter:

- Medical records should be complete and legible;
- Documentation of each patient encounter should include:
  - Reason for encounter and relevant history;
  - Physical examination findings and prior diagnostic test results;
  - Assessment, clinical impression, and diagnosis;
  - Plan for care; and
  - Date and legible identity of observer;

Medicare Payments for Part B Mental Health Services (continued)

- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;
- Past and present diagnoses should be accessible for treating and/or consulting physician;
- Appropriate health risk factors should be identified;
- Patient's progress, response to changes in treatment, and revision of diagnosis should be documented; and
- *CPT* and ICD-9-CM codes reported on health insurance claim form should be supported by documentation in the medical record.

Documentation Guidelines for E/M Services Involving a General Psychiatric Examination or the Single System Psychiatric Examination

Providers should **thoroughly** familiarize themselves with documentation guidelines for E/M services. These guidelines are available on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/medlearn/emdoc.asp*.

The *Medicare Resident & New Physician Training* manual, Chapter 6, (March 2002 edition) also contains the latest revisions to documentation guidelines for E/M services. Publication is available at *http://www.cms.hhs.gov/medlearn* or upon request from the Medicare Learning Network at *medlearn@cms.hhs.gov.*

Documentation Guidelines for Psychiatric Diagnostic or Evaluative Interview Procedures, Psychiatric Therapeutic Procedures, Central Nervous System Assessment, and Health and Behavior Assessment

Providers should follow the documentation guidance for psychiatric diagnostic or evaluative interview procedures and psychiatric therapeutic procedures (*CPT* codes *90801 – 90802, 90804 – 90899* under the Psychiatry Section), overview and definitions for central nervous system assessment (*CPT* codes *96100 – 96117*), and health and behavior assessment (*CPT* codes *96150 – 96155*) as described in the *Physicians' Current Procedural Terminology*, which is an annual publication developed by the American Medical Association (AMA). Available from the AMA at *http://www.ama-assn.org/ama/pub/category/3113.html*.

Refer to Program Memorandum A-02-129 dated January 3, 2003 for the 2003 update of the hospital outpatient prospective payment system (OPPS), which provides current revenue and HCPCS codes for the partial hospitalization program.

Providers should confer with the local carrier to determine if a local medical review policy has been written regarding documentation requirements. ❖

Source: CMS Transmittal AB-03-037, CR 2520

Appeal Form for Part A Claims is Now Available

First Coast Service Options, Inc. has developed a form titled "Request for Reconsideration or Appeal of Part A Medicare Claim" for providers and beneficiaries to request an appeal or reconsideration of a Part A claim. The form is now available for downloading from the provider education Web site at *www.floridamedicare.com*. If this form is appropriately and consistently used, it is expected to produce a number of benefits. They are as follows:

- Increase first contact resolution rate, meaning that the fiscal intermediary will be better able to process the appeal upon initial receipt, rather than returning the request to the provider or beneficiary for additional documentation or medical records.
- Reduce the costs associated with the re-work, second handling, postage, and additional review and research of the returned letter, as generated by the fiscal intermediary for either for lack of documentation, signature, or medical records.
- Expedite the adjudication of the claim through the appeals process.
- Decrease the risk of misrouted appeals.

A copy of this form may be found on page 73 of this publication. ❖

OUTPATIENT REHABILITATION SERVICES

Implementation of Financial Limitation for Outpatient Rehabilitation Services

Section 4541(a)(2) of the Balanced Budget Act (BBA) of 1997 (P.L. 105-33), which added section 1834(k)(5) to the Social Security Act (the Act), required payment under a prospective payment system (PPS) for outpatient rehabilitation services. Outpatient rehabilitation services include:

- Physical therapy (PT), which includes outpatient speech-language pathology.
- Occupational therapy (OT).

Section 4541(c) of the BBA required application of a financial limitation to all outpatient rehabilitation services (with the exception of outpatient departments of a hospital) of an annual per beneficiary limit of $1500 for all outpatient PT services (including speech-language pathology services) and a separate $1500 limit for all OT services. The $1500 limit is based on incurred expenses and includes applicable Part B deductible ($100) and coinsurance (20 percent). The annual limitation does not apply to services furnished directly or under arrangement by a hospital to an outpatient, or to a hospital inpatient who is not in a covered Part A stay. The BBA provided that the $1500 limits be indexed by the Medicare Economic Index (MEI) each year beginning in 2002. This indexed amount is $1590 for 2003.

The limitation is based on the services the Medicare beneficiary receives, not the type of practitioner who provides the service. Therefore, physical therapists, speech-language pathologists, occupational therapists, as well as physicians and nonphysicians practitioners could render a therapy service.

Moratorium on Application of Financial Limitation

Section 211 of the Balanced Budget Refinement Act of 1999 placed a two-year moratorium on the application of the financial limitation for claims for therapy services with dates of service January 1, 2000 through December 31, 2001. Section 421 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, extended the moratorium on application of the financial limitation to claims for outpatient rehabilitation services with dates of service January 1, 2002, through December 31, 2002. Therefore, the moratorium was for a three-year period and applied to outpatient rehabilitation claims with dates of service January 1, 2000, through December 31, 2002.

Application of Financial Limitation

The moratorium on the application of the financial limitation on outpatient rehabilitation services is no longer in effect. As a result, these instructions regarding financial limitation supersede current instructions in sections 3653.Q and 3653.R of the Medicare Intermediary Manual. Further, beginning with claims submitted for dates of service **on and after July 1, 2003,** Medicare contractors will apply the financial limitation for PT (including speech-language pathology) and OT services in a prospective manner, through December 31, 2003. For calendar year (CY) 2003, the financial limitation could not be implemented prior to July 1, 2003, because of system limitations. For each subsequent CY, the financial limitations will be effective for the entire year.

There are two separate $1590 limitations: one for PT (including speech-language pathology) services and the other for OT services. Effective July 1, 2003, for claims with dates of service on or after July 1, 2003, the common working file (CWF) system will track the $1590 PT (which includes speech language pathology services) and the $1590 OT financial limitation for outpatient rehabilitation services.

This financial limitation is an annual per beneficiary limitation. The $1590 limitation is on the allowed incurred expenses, which are defined as the Medicare physician fee schedule (MPFS) amount prior to any application of deductible ($100) and coinsurance (20 percent). If the beneficiary has already satisfied the Medicare Part B deductible, the maximum amount payable by the Medicare program is $1272; that is 80 percent of the $1590 for PT (including speech language pathology) and 80 percent of the $1590 for OT. The beneficiary is responsible for paying the remaining 20 percent coinsurance.

See the following examples:

Example I – Part B Deductible Previously Met:
$1590 (MPFS allowed amount) x 80 percent = $1272 (Medicare reimbursement).

The amount applied to the limitation in this example is $1590. The Medicare program pays $1272 and the beneficiary is responsible for $318 coinsurance.

Example II – Part B Deductible Not Met:
$1590 (MPFS allowed amount) – $100 (Part B deductible) = $1490 x 80 percent = $1192 (Medicare reimbursement).

The amount applied to the limitation in this example is $1590. The Medicare program pays $1192 and the beneficiary is responsible for $398, ($100 Part B deductible and $298 coinsurance).

Example III – Part B Deductible Previously Met:
$800 (MPFS allowed amount) x 80 percent = $640 (Medicare reimbursement).

The amount applied to the limitation in this example is $800. The Medicare program pays $640 and the beneficiary is responsible for $160 coinsurance.

Example IV – Part B Deductible Not Met:
$800 (MPFS allowed amount) – $100 (Part B deductible) = $700 x 80 percent = $560 (Medicare reimbursement).

Implementation of Financial Limitation for Outpatient Rehabilitation Services (continued)

The amount applied to the limitation in this example is $800. The Medicare program pays $560 and the beneficiary is responsible for $240, ($100 Part B deductible and $140 coinsurance).

Note: In the above examples the MPFS allowed amount is the lower of actual charges or the MPFS rate times the unit.

The CWF will be tracking the financial limitation based on presence of therapy modifiers GN, GO, and GP; therefore, providers/physicians/suppliers must continue to report one of these modifiers for any therapy service that is provided. The definitions of the therapy modifiers have been changed effective January 1, 2003; they are as follows:

GN Services delivered under an outpatient speech-language pathology plan of care
GO Services delivered under an outpatient OT plan of care
GP Services delivered under an outpatient PT plan of care

The fiscal intermediary will edit to ensure that the above listed therapy modifiers are present on a claim based on the presence of revenue codes 42x, 43x, or 44x. Claims containing revenue codes 42x, 43x, or 44x without a therapy modifier GN, GO, or GP will be returned to the provider.

The CWF will apply the financial limitation to types of bill 22x, 23x, 34x, 74x, and 75x, using the MPFS allowed amount (before adjustment for beneficiary liability). The reimbursement field portion of the CWF record will not be used by the CWF to track the financial limitation. The CWF will create a new "line-level" field entitled "Financial Limitation" to be used by standard systems to transmit to CWF the amount to be applied to the limitation. The CWF will also create a new line level override code value to be reported in situations where the MPFS allowed amount exceeds the limitation available. This override code can also be used for appeals.

For skilled nursing facilities (SNFs), this limitation will apply to outpatient rehabilitation services furnished to SNF residents not in a covered Part A stay and to SNF non-resident (outpatients) receiving these services at the SNF regardless of whether the services are furnished by the SNF itself or by an outside therapist.

For SNF residents in a covered Part A stay, rehabilitation services are included within the global Part A per diem payment that the SNF receives under the PPS for the covered stay. For SNF residents who have exhausted their Part A benefits, consolidated billing requires all outpatient rehabilitation services be billed to Part B by the SNF. Once a resident has reached the financial limitation, and remains in the SNF, no further payment will be made to the SNF or any other entity.

Once the financial limitation has been reached, SNF non-residents and beneficiaries receiving services at an outpatient rehabilitation facility (rehabilitation agency) or a comprehensive outpatient rehabilitation facility or by a home health agency to beneficiaries that are not homebound may receive outpatient rehabilitation services furnished directly by or under arrangement with a hospital.

Applicable Outpatient Rehabilitation *CPT*/ HCPCS Codes

The following codes apply to each financial limitation except as noted below. These codes supersede the codes listed in section 3653.D of the Medicare Intermediary Manual:

(Note: Listing of the following codes does not imply that services are covered.)

*29065**	*29075**	*29085**	*29086**	*29105**
*29125**	*29126**	*29130**	*29131**	*29200*
29220	*29240*	*29260*	*29280*	*29345**
*29355**	*29365**	*29405**	*29425**	*29445**
*29505**	*29515**	*29520*	*29530*	*29540*
29550	*29580*	*29590*	*64550*	*90901*
90911	*92506*	*92507*	*92508*	*92526*
*92601***	*92602***	*92603***	*92604***	*92607*
92608	*92609*	*92610*	*92611*	*92612*
92614	*92616*	*95831*	*95832*	*95833*
95834	*95851*	*95852*	*96000*	*96001*
96002	*96003*	*96105*	*96110*	*96111*
96115	*97001*	*97002*	*97003*	*97004*
97012	*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*
*97601**	*97703*	*97750*	*97799*	V5362
V5363	V5364	G0279	G0280	G0281
G0283	0020T	0029T		

Code 97504 should not be reported with code 97116. However, if code 97504 was performed on an upper extremity and code 97116 (gait training) was also performed, both codes may be billed with modifier 59 to denote a separate anatomic site.

***** These codes for casts and splints will not apply to the financial limitations when billed by physicians and non-physician practitioners, as appropriate. When these codes are billed by other providers (types of bill 22x, 23x, 34x, 74x, and 75x) or physical therapists or occupational therapists in private practice, specialty codes "65", "67", "73", or "74" they must be billed with modifier GO, or GP.

****** If an audiology procedure code is performed by an audiologist, the above modifiers should not be reported as these procedures are not subject to the financial limitation. When these *CPT* codes are billed under a speech language pathology plan of care, they must be reported with modifier GN and applied to the financial limitation.

Notification Requirements

Providers should notify beneficiaries of the therapy financial limitations, and that these limits are applied in all settings except hospital outpatient departments. Advance beneficiary notices (ABNs) cannot be used because of the statutory nature of the financial limitations. Therefore, providers should inform beneficiaries that beneficiaries are responsible for 100 percent of the costs of therapy services

Implementation of Financial Limitation for Outpatient Rehabilitation Services (continued)

above each respective therapy $1590 limit, unless this outpatient care is furnished directly or under arrangement by a hospital. It is the provider's responsibility to present each beneficiary with accurate information about the therapy limits and that, where necessary, appropriate care above the $1590 limit can be obtained at a hospital outpatient therapy department. Providers are to use the Notice of Exclusion from Medicare Benefits (NEMB) form to inform beneficiaries of the therapy financial limitation at their first therapy encounter with the beneficiary. When using the NEMB form, the practitioner checks box #1 and writes the reason for denial in the space provided at the top of the form. For CY 2003, provide the following: "Medicare will not pay for: PT and speech-language pathology services over $1590 (including dates of service from July 1, 2003 through December 31, 2003)." This same information is provided for OT services over the $1590 limit for the same time period, as appropriate. The NEMB form can be found at: *http://www.cms.hhs.gov/medlearn/refABN.asp*. Providers are reminded that a plan of care must be on file. ❖

Source: CMS Transmittal AB-03-018, CR 2183

AMBULANCE SERVICES

Ambulance Claims with Modifier QL

Medicare allows partial payment for an ambulance service where the ambulance begins its trip to pick up the beneficiary, but the beneficiary is pronounced dead before the pickup can be made. In such a circumstance, the allowed amount is the appropriate base rate. No amount shall be allowed for mileage or for a rural adjustment.

Until now, Medicare Part A providers were not required to report the charges for the noncovered miles in the noncovered charges field of the claim. However, this reporting is necessary to avoid overpayments.

Until clarifying instructions are issued, CMS is instructing Medicare fiscal intermediaries to hold all ambulance claims containing modifier QL – patient pronounced dead. CMS expects the instructions on billing noncovered miles to be issued as part of the October 2003 shared system release; at that point the affected claims will be released for processing.

Action Taken by the Fiscal Intermediary

Ambulance claims with modifier QL processed **on or after April 16, 2003,** will suspend to status location S/MCMS5 under reason code 75046 until the October 2003 shared system release is implemented.

If ambulance claims with modifier QL were processed **prior to April 16, 2003,** adjustments can be submitted and will suspend pending the Medicare Part A shared system correction.

Cases of death before arrival occur infrequently, and CMS is expecting to be few in number at this time. ❖

Source: CMS Notification Dated April 15, 2003

Noncovered Miles for Ambulance Services—Instruction Rescinded

CMS has advised fiscal intermediaries (FIs) that Program Memorandum A-02-113, Change Request (CR) 2331, issued on October 30, 2002, has been rescinded. Information from this CR was published in the Second Quarter 2003 *Medicare A Bulletin* (page 11). Claims containing noncovered ambulance miles and other covered outpatient services would have been denied effective April 1, 2003, had this CR taken effect as scheduled; therefore, this change will *not* be implemented. We apologize for any inconvenience this may have caused. ❖

Source: CMS Instruction to FIs dated March 17, 2003

Multiple Patient Ambulance Transport—Value Code 32

CMS has provided reimbursement policy and claim processing instructions for ambulance services when multiple patients are transported simultaneously in the same ambulance to the same destination.

The final regulation to establish an ambulance fee schedule contains a provision that clarifies the reimbursement policy for pricing a single ambulance vehicle transport of a Medicare beneficiary where more than one patient is onboard the ambulance.

Reimbursement Policy

Medicare ambulance service regulations provide payment policy and claim processing instructions for ambulance services when multiple patients are transported simultaneously in the same ambulance to the same destination, whether it is a ground transport or an air transport.

Effective for claims with dates of service on or after April 1, 2002, if **two** patients are transported to the same destination simultaneously, for each Medicare beneficiary, Medicare allows 75 percent of the payment allowance for the base rate applicable to the level of care furnished to that beneficiary plus 50 percent of the total mileage payment allowance for the entire trip.

If three or more patients are transported to the same destination simultaneously, the payment allowance for the Medicare beneficiary (or each of them) is equal to 60 percent of the base rate applicable to the level of care furnished to the beneficiary. However, a single payment allowance for mileage is prorated by the number of patients onboard. The applicable percentage is based on the total number of patients transported, including both Medicare beneficiaries and non-Medicare patients.

CMS has determined that the payment reduction should be applied to the **final payment amount for the base rate,** which is a combination of both the reasonable cost portion reduced by the transition percentage (80 percent for 2002, 60 percent for 2003) and the ambulance fee schedule portion reduced by the transition percentage (20 percent for 2002, 40 percent for 2003). This final payment amount should be reduced by 25 percent, to 75 percent, when there are two beneficiaries involved in the multiple patient transport. For three or more beneficiaries, this final payment amount should be reduced by 40 percent, to 60 percent.

In addition, **the mileage payment** under both the reasonable cost and the ambulance fee schedule should be reduced by the transition percentages, and then by 50 percent for each beneficiary in a multiple patient transport situation that involves two beneficiaries. For three or more beneficiaries, **the mileage payment** under both the reasonable cost and the ambulance fee schedule should be reduced by the transition percentages, then it should be prorated by the number of beneficiaries involved in the transport.

This policy applies to both ground and air transports.

Claim Billing Instructions

For claims with dates of service on or after April 1, 2002, providers must report value code 32 (multiple patient ambulance transport) when an ambulance transports more than one patient at a time to the same destination. Providers must report value code 32 and the number of patients transported in the amount field as a whole number to the left of the delimiter.

Providers may not report additional ambulance services on a claim that contains a multiple patient ambulance transport, even if the point of pick-up ZIP code is the same. A separate claim must be submitted for additional ambulance services.

Interim Billing Instructions

During a conference call with Medicare system maintainers, it was brought to the attention of CMS that there were some inconsistencies among the shared systems when applying the payment reduction for multiple patient transport.

Medicare Part A shared system maintainers must implement a correction to ensure the amount reported in the rate field and passed to the provider statistical and reimbursement report is correct. Until the systems are corrected, CMS is instructing fiscal intermediaries to hold all ambulance claims containing value code 32 – multiple patient transport. Once the shared systems are corrected, the affected ambulance claims will be released for processing.

Ambulance claims with value code 32 processed **on or after April 16, 2003,** will suspend to status location S/MCMS4 under reason code 75047 until the Medicare Part A shared systems are corrected.

If ambulance claims with valued code 32 were processed **prior to April 16, 2003,** adjustments can be submitted and will suspend pending the Medicare Part A shared system correction.

Cases of multiple patient transport occur infrequently, and CMS is expecting to be few in number at this time. ❖

Source: CMS Transmittal A-02-108, CR 2186
CMS Notification Dated April 15, 2003

MEDICARE SECONDARY PAYER

How to Submit Claims to Medicare When There Are Multiple Primary Payers

There are situations where there is more than one primary payer that pays on a Medicare Part A electronic claim and Medicare may still make a secondary payment on the claim. When there are multiple primary payers, you must do the following when sending the claim to Medicare for secondary payment.

- Comply with Section 1.4.2, titled "Coordination of Benefits," found in the 837 version 4010 Institutional Implementation Guide regarding the submission of Medicare beneficiary claims to multiple payers for payment. Follow model 1 in Section 1.4.2.1 that discusses "provider to payer to provider" methodology of submitting electronic claims.
- After you receive the electronic remittance advice from the primary payers, send the other payers' claim information to Medicare using the 837 version 4010 format. For Medicare secondary payer claims, place the primary payer paid amounts, in loop 2300, qualifier HIXX-1 = BE. Place the value codes in HIXX-2 and the (value code) monetary amounts in HIXX-5.

  Note: In regard to Value Code 44, Obligated to Accept as Payment in Full (OTAF) amount, indicate a value of "Y" in loop 2320, segment OI03. This will inform Medicare that an OTAF amount is present on the claim and the amount can be found in the 2300 loop HI segment.
- If, for any reason, you must send hardcopy MSP claims, you must place the MSP Value Codes and Value Code amounts in FL 39-41 of the Form UB 92-CMS-1450. ❖

Source: CMS Transmittal AB-03-011, CR 2050

Medicare Secondary Payer and the Debt Collection Improvement Act of 1996

MSP DCIA activities include all group health plan based debts, including those where a debtor is the provider, physician, other supplier, or beneficiary. MSP DCIA activities also now include liability and no-fault based debts of all types for all debtors, as well as workers' compensation based debts for all debtors.

The DCIA requires Federal agencies to refer eligible delinquent debt to a Treasury designated Debt Collection Center (DCC) for cross servicing and/or offset. The Centers for Medicare & Medicaid Services (CMS) is mandated to refer all eligible debt over 180 days delinquent, for cross-servicing, including the Treasury Offset Program (TOP).

For the purpose of DCIA debt selection/referred criteria, a debt becomes 'delinquent' if it has not been paid (in full) by the payment date specified in the agency's initial written notification (i.e., overpayment demand letter), unless other payment arrangements have been made, or if at any time thereafter the debtor defaults on a repayment agreement.

Further, specific to MSP, 'delinquent' is defined as a debt not being paid in full unless other arrangements have been made, no response from the debtor regarding the debt, and/or no valid documented defense to the debt.

Source: CMS Transmittal AB-02-102, CR 2145

MSP Recoveries/Debt-Related Issues—Frequently Asked Questions and Answers

Q1 How does a MSP debt arise?

A1 An MSP debt arises when Medicare learns that it made primary payment for services provided to a Medicare beneficiary that should have been the primary payment responsibility of another third party payer. The law requires Medicare to recover the payment from a party the law or regulations identify as responsible to repay Medicare.

Q2 Why didn't Medicare pay right in the first place?

A2 Medicare contractors make every effort to avoid mistaken primary payments. There are other cases where Medicare may not learn that the group health plan coverage existed until after some claims have been paid.

If a workers' compensation, no-fault or liability insurance does not pay a beneficiary's claim promptly, the law requires Medicare to make a "conditional" primary payment. Medicare recovers its "conditional" primary payments from the insurance proceeds once the beneficiary's claim is resolved.

Q3 What process does Medicare use to recover MSP debts?

A3 The recovery process begins with a "recovery demand letter" to an entity responsible for resolving the debt. The letter explains how the debt arose; provides detail about Medicare's recovery claim; and explains what must be done to resolve the matter. The matter may be resolved either through payment or presentation of a documented valid defense.

If the responsible entity does not resolve the matter timely, Medicare sends a second "recovery demand

MSP Recoveries/Debt-Related Issues—Frequently Asked Questions and Answers (continued)

letter." A copy of the original "recovery demand letter" is provided. This second letter explains that, if the matter is not resolved within 60 days, Medicare will refer the debt to the Department of Treasury for further collection action. This letter is often referred to as a "Notice of Intent to Refer" letter.

If the matter is still not resolved 60 days after the date of the "Notice of Intent to Refer" letter, Medicare refers the debt to the Department of Treasury for further collection actions. Treasury may collect the debt in a variety of ways, including offset of Federal payments to the responsible entity. Treasury may also ask the Department of Justice to take legal action to collect the debt.

Q4 Who is responsible for resolving group health plan-related MSP debts?

A4 The law makes all entities "responsible for payment under a group health plan" jointly and severally responsible for resolving these debts. These entities include the employer sponsoring or contributing to the plan; other plan sponsors (e.g., a union or other employee organization); the insurer or third party administrator (TPA) (TPAs administer plans for employers that self-insure); and the plan itself if it is a separate legal entity.

Q5 How do group health plan-related MSP debts occur?

A5 A provider bills Medicare for primary payment for services provided to a Medicare beneficiary for whom a group health plan should have been the primary payer and Medicare mistakenly pays.

Group health plans are primary payers for aged beneficiaries covered as a result of their own or a spouse's current employment status; disabled beneficiaries covered as a result of their own or a family member's current employment status; beneficiaries with end-stage renal disease for a 30-month coordination period) covered on any basis (including retirement).

Q6 How does Medicare pick whom to pursue for this type of MSP debt?

A6 Medicare law allows for the pursuit of recoupment of a Medicare mistaken payment to all entities who are individually or jointly liable for repayment. In 1997, Medicare began sending the recovery demand letters to the employer (if known) because some insurers/TPAs were routinely non-responsive and because a Circuit Court decision limited Medicare's ability to recover from TPAs. An employer is always responsible for the actions of any group health plan that it sponsors or to which it contributes.

Q7 How can Medicare hold an employer that purchased insurance responsible for resolving the debt? Why doesn't Medicare go after the insurer?

A7 An employer is always responsible for the conduct of any group health plan that it sponsors or to which it contributes. An employer cannot transfer legal obligations to a third party through a contract. This is explained in an enclosure to the initial recovery demand letter entitled, "Important Information for Employers."

An employer may direct its insurer to resolve the debt on the employer's behalf. However, if the insurer does not do so, the employer remains responsible for either paying the debt or documenting why it is not responsible.

Q8 What documentation does Medicare consider sufficient to demonstrate that a group health plan-related MSP debt is not owed?

A8 At the time the debt is being pursued, it has been reviewed several times to determine that it is valid. It is possible that the debtor has other information not available to Medicare that demonstrates that the debtor has no legal obligation to repay Medicare. Such information would include the following:

- The Medicare beneficiary was not covered by the group health plan or the group health plan was not obligated to be the primary payer when the services were provided (see prior question, "How do group health plan-related debts occur?");
- The services provided to the Medicare beneficiary were not covered under any circumstances by the group health plan;
- The group health plan had already made full primary payment to the provider of services or the Medicare beneficiary prior to the date of the initial recovery demand letter; and
- No entity responsible for payment under the plan had knowledge that the services had been provided to the Medicare beneficiary within the longer of the group health plan's timely filing requirements or the period during which the law authorizes Medicare to seek recovery.

These are explained below.

Q9 When is a "Medicare beneficiary not covered by the group health plan or the group health plan was not obligated to be the primary payer when the services were provided"? What would be proper documentation of this defense?

A9 It is possible that a beneficiary, entitled to Medicare on the basis of age or disability, did not have coverage under any employer plan based on their own or a spouse's or a family member's (for disability) current employment status at the time the services were provided, because the individual or his/her spouse or family member (for disability) had retired or left employment. Proper documentation would consist of **all** of the following:

1. A copy of the individual claim paid by Medicare and referenced in the original demand letter
2. Date of Medicare's original demand letter containing the claim
3. Associated reported identification numbers for that claim as provided in the demand letter

MSP Recoveries/Debt-Related Issues—Frequently Asked Questions and Answers (continued)

4. Identification of the individual through whom the beneficiary had coverage
5. Certification of the date of retirement or termination of that individual.

Failure to provide all the above information could result in Medicare not accepting the documentation or not applying it properly.

In the case of a beneficiary entitled to Medicare on the basis of end-stage renal disease, the debt is still valid if the beneficiary had coverage under any group health plan on any basis.

Q10 What exactly does the "coverage limitation" defense encompass? What would be proper documentation of this defense?

A10 A beneficiary, who has employer plan coverage that is obligated to be a primary payer, may have had services not covered by the employer's plan. This would mean that the services are not the responsibility of the employer's plan. If properly documented, this would be a valid defense to the debt associated with those services. Proper documentation would consist of the following:

- A copy of the individual claim with the non-covered services annotated
- Date of the original demand letter containing the claim
- Associated report identification number
- Copy of plan documents (e.g., Employee Services Handbook, Member Services Booklet, etc.) that establishes that the services are not covered under the plan with the applicable coverage terms annotated.

Q11 What should a responsible entity do if the group health plan paid primary for the services for which Medicare seeks to recover? What should a responsible entity do if the group health plan is an HMO and the services were covered by the HMO's capitation payment?

A11 It is possible that both Medicare and an employer plan made primary payment for the services identified on any unique MSP claim. If properly documented, an employer plan's full primary payment for the services on an MSP claim is a valid defense to the debt that had been associated with that claim. Proper documentation generally would consist of the following:

- A copy of the individual claim
- Date of the original demand letter containing the claim
- Associated report identification number for that claim as provided in the demand letter
- Explanation of how the prior primary payment was determined
- Proof of payment (e.g., copy of remittance advice).

If the employer plan is an HMO and the employer plan's full primary payment responsibility was resolved by a capitation payment to the provider, physician or other supplier that treated the Medicare beneficiary, proper documentation would consist of the following:

- A copy of the individual claim
- Date of the original demand letter containing the claim
- Associated report identification number for that claim as provided in the original demand letter
- Copy of the relevant portions of the HMO contract with the provider, physician or other supplier stipulating that the only payment obligation of the HMO was payment of a capitated amount; and proof that the capitated amount for the individual for the time period when the services were furnished was paid.

In these instances, Medicare will recover from the medical provider or supplier that received Medicare's payment.

Q12 What is a group health plan's timely filing defense? When is Medicare not bound by a group health plan's timely filing requirements? What documentation is needed?

A12 Most group health plans (GHPs) have established time limits during which claims must be submitted in order to qualify for payment. If a GHP or any entity responsible for payment under the plan (employer, insurer, third party administrator [TPA], or other plan sponsor ["responsible entities"]) does not receive a claim within those time limits, the plan is not obligated to make payment (even if it would be obligated to make payment if the claim had been submitted prior to the expiration of the time limit). These time limits are typically called "timely filing" requirements. Applicable Federal law limits the ability of any responsible entity (including the employer/insurer/TPA/GHP/other plan sponsor) that received a demand letter to assert a timely filing defense to an MSP-based debt.

As a first point, the date of Medicare's original demand letter is the date applicable to any defense that the recipient of the demand letter, or any entity acting on its behalf, may have to the debt or any portion of the debt. This is true regardless of which of these entities the original demand letter is issued to, and regardless of whether or not the demand is immediately shared among these entities. For example, the insurer may not establish a timely filing defense on behalf of an employer based upon the date the insurer received the demand letter from the employer. The insurer may only establish a timely defense for the employer based upon the date of the demand letter to the employer.

Additionally, two different rules are applicable to the MSP claims that comprise the Medicare debts. These rules are explained below.

The first rule applies to all services, regardless of the date those services were provided. The recipient of

MSP Recoveries/Debt-Related Issues—Frequently Asked Questions and Answers (continued)

the demand letter (regardless of whether it is the employer/insurer/TPA or other responsible entity) does not have a valid timely filing defense if either the employer, the insurer, the TPA, or other responsible entity had knowledge within the plan's timely filing period that the services were provided. This knowledge could come from a variety of sources, but is often due to the receipt of a claim from a provider, physician or other supplier (or the plan member), which included the services at issue.

The second rule applies to services provided on or after August 5, 1997, and further restricts the use of a timely filing defense. The Balanced Budget Act of 1997 eliminated timely filing defenses for at least 3 years from the date of the service. For services on or after August 5, 1997, there is no timely filing defense if Medicare's original demand letter is dated within 3 years of the date of the service. This rule applies even if the plan's timely filing period is less than 3 years. (If the services were on or after August 5, 1997, and Medicare's original *demand letter is not dated within 3 years from the date of the service, then the first rule applies*.)

Under the first rule, proper documentation of a timely filing defense would consist of the following:

- A copy of the individual Medicare claim supplied with the demand letter with the services for which the defense is offered annotated by the entity asserting the defense
- The date of the original Medicare demand letter containing the claim (and the associated report identification number for Data Match recoveries)
- A copy of plan documents that establish the timely filing period with the applicable provisions annotated
- A written statement by or on behalf of the recipient of the demand letter that claims records of all responsible entities exist for the time period when the services were provided, were searched, and no record of the services being provided to the beneficiary were found.

Remember that if a demand letter is sent to an employer and another responsible entity such as an insurer or TPA responds, the responding entity is assumed to be acting as the agent of the employer. In this situation, the date of the original demand letter to the employer is the date applicable to any asserted timely filing defense.

Q13 Is an employer still responsible for resolving a group health plan-related MSP debt if the employee became enrolled in a group health plan other than the one identified in the initial recovery demand letter?

A13 The health plan information that Medicare provided in the original demand letter was, in almost all cases, provided by the employer in response to Internal Revenue Service (IRS)/Social Security Administration (SSA)/CMS Data Match questionnaires. In other cases, the health plan information was obtained from the beneficiary, the insurer, or the provider/physician/other supplier that furnished services to the beneficiary. Thus, the information is presumed to be accurate as of the time it was provided. Many employers offer employees the opportunity periodically to choose among several available group health plans. Because CMS was not advised of changes in employees' group health plan choices, the group health plan Medicare identified as providing the health insurance may not be correct as of the date particular services were provided to an identified beneficiary.

The MSP debt is still valid as long as the Medicare beneficiary, entitled to Medicare on the basis of age or disability, had coverage under any employer plan based on his/her own or a spouse's or family member's (for disability) current employment status. In the case of a beneficiary entitled to Medicare on the basis of ESRD, the debt is still valid if the beneficiary had coverage under any employer plan on any basis. If you are unclear about your responsibility relative to ESRD, please call the Medicare contractor.

Q14 How does a responsible entity determine the proper amount to pay Medicare? How is interest determined? What documentation should be provided to assure proper crediting of the payment?

A14 The original demand letters explain that interest is due on any debt that is not resolved timely (60 days from the date of the original demand letter) and includes the applicable interest rate. Interest applies from the date of the demand letter for each 30-day period that the debt is unresolved. (Periods of less than 30 days are treated as a full 30-day period.) Accordingly, to resolve any MSP claim for which payment is due, the responsible entity (group health plan, employer, insurer, third party administrator [TPA], or other plan sponsor) must pay both the principal due and the applicable interest. To assist the responsible entity in determining the amount due on any individual unresolved MSP debt, the responsible entity should contact the Medicare contractor who issued the demand letter.

The responsible entity (employer, insurer, third party administrator [TPA], group health plan, or other plan sponsor) should contact the Medicare contractor with any question on the exact amount the responsible entity owes.

Q15 Can a responsible entity avoid the interest portion of the group health plan-related MSP debt by making a full primary payment to the provider of services following receipt of the original demand letter, Notice of Intent to Refer to Department of Treasury letter, or demand letter from the Department of Treasury or one of its collection agents?

A15 No. The law requires that the responsible payer pay Medicare, not some other party. Medicare will continue to look to the responsible entity for payment of all interest accrued to the date of payment to the

MSP Recoveries/Debt-Related Issues—Frequently Asked Questions and Answers (continued)

provider. Medicare will recover the principal from the party that the group health plan paid.

Q16 Is a responsible entity required to repay Medicare for a group health plan-related debt if it no longer has the records necessary to prove it is not responsible?

A16 Yes. A responsible entity's failure to maintain the records necessary to prove it is not responsible does not relieve the entity of responsibility to resolve the debt.

Q17 How long can Medicare pursue recovery of an MSP debt?

A17 The United States may undertake legal action to collect an MSP debt up to 6 years from the date of the original demand letter. In addition, these debts may be collected by offset of Federal government payments to the debtor for 10 years from the date of the original demand letter without undertaking legal action.

Q18 With whom should a responsible entity deal in resolving a group health plan-related MSP debt?

A18 Debtors should work with the entity that sent them the most recently dated recovery demand letter with respect to a particular debt. Prior to referral of a debt to the Department of Treasury, this would be the Medicare contractor. Once a debt has been referred to the Department of Treasury for collection action and a responsible entity has been contacted by either the Department of Treasury itself or a Treasury collection agent, the responsible entity should work with the Department of Treasury or its collection agent.

Q19 Where is Medicare sending the original recovery demand letter and the Notice of Intent to Refer letter for group health plan-related debts? Employer representatives responsible for resolving such issues often first learn of the debt when a copy of the demand letter from the Department of Treasury is forwarded to that official from elsewhere in the employer's organization.

A19 The original recovery demand letter and the Notice of Intent to Refer letter are sent via certified mail/return receipt to the address of the employer provided in the employer's response to the IRS/SSA/CMS Data Match questionnaire or the entity that identified the employer as responsible. Employers are encouraged to advise all components of the company that demand letters involving Medicare should be forwarded to a particular unit (e.g., Benefits Management) if the employer wishes that unit to respond.

Q20 What can an employer or other responsible entity do to minimize further collection activities related to group health plan MSP debts in the future?

A20 Recovery actions will be minimized if Medicare is aware that another payer is primary to Medicare when claims are presented to Medicare for payment. If Medicare is aware that another payer is a primary payer to Medicare, Medicare advises the entity that submitted the claim to Medicare that it should bill the other payer. The best way for employers and/or insurers to be sure that Medicare has such knowledge is through quarterly Voluntary Data Sharing Agreements with Medicare. Interested parties may contact the Coordination of Benefits Contractor at 1 (800) 999-1118 for more information or visit their Web site at *www.cms.gov/medicare/cob*.

Q21 Why are Medicare beneficiaries receiving a Notice of Medicare's Intent to Refer a debt to the Department of Treasury, as well as a recovery demand letter from Treasury?

A21 Generally, these letters are related to unresolved MSP debts arising from the failure of a beneficiary to pay a Medicare recovery claim arising from a judgment, settlement or award a beneficiary received from workers' compensation, liability or no-fault insurance. If the Medicare beneficiary does not resolve the debt, the Department of Treasury may collect through offset of Federal payments to the beneficiary. This could include offsets against the beneficiary's Social Security retirement checks.

Q22 What should a beneficiary do when in receipt of a Notice of Medicare's Intent to Refer letter?

A22 It is important that the beneficiary respond in order to avoid collection from the beneficiary's Social Security retirement check. The original demand letter attached to the Notice of Intent to Refer letter explains the actions the beneficiary can take.

Q23 What is a Voluntary Data Sharing Agreement?

A23 As an alternative to completing the annual IRS/SSA/CMS Data Match questionnaires, these agreements allow employers/insurers to provide plan coverage information to Medicare on a quarterly basis. CMS is able to update its internal records and immediately avoid making mistaken primary payments. In exchange, CMS provides the employer or insurer with Medicare eligibility information on employees who are no longer working. These are situations where Medicare is usually the primary payer. Savings to employers and insurers can be significant. Interested parties can contact the Coordination of Benefits Contractor at 1 (800) 999-1118 or visit their Web site at *www.cms.gov/medicare/cob*. ❖

Source: CMS FAQs, January 29, 2003

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GENERAL COVERAGE

Deep Brain Stimulation for Essential Tremor and Parkinson's Disease

Deep brain stimulation (DBS) refers to high-frequency electrical stimulation of anatomic regions deep within the brain utilizing neurosurgically implanted electrodes. These DBS electrodes are stereotactically placed within targeted nuclei on one (unilateral) or both (bilateral) sides of the brain. There are currently three targets for DBS – the thalamic ventralis intermedius nucleus (VIM), subthalamic nucleus (STN) and globus pallidus interna (GPi).

Essential tremor (ET) is a progressive, disabling tremor most often affecting the hands. ET may also affect the head, voice and legs. The precise pathogenesis of ET is unknown. While it may start at any age, ET usually peaks within the second and sixth decades. Beta-adrenergic blockers and anticonvulsant medications are usually the first line treatments for reducing the severity of tremor. Many patients, however, do not adequately respond or cannot tolerate these medications. In these medically refractory ET patients, thalamic VIM DBS may be helpful for symptomatic relief of tremor.

Parkinson's disease (PD) is an age-related progressive neurodegenerative disorder involving the loss of dopaminergic cells in the substantia nigra of the midbrain. The disease is characterized by tremor, rigidity, bradykinesia and progressive postural instability. Dopaminergic medication is typically used as a first line treatment for reducing the primary symptoms of PD. However, after prolonged use, medication can become less effective and can produce significant adverse events such as dyskinesias and other motor function complications. For patients who become unresponsive to medical treatments and/or have intolerable side effects from medications, DBS for symptom relief may be considered.

Effective on or after April 1, 2003, Medicare will cover *unilateral or bilateral thalamic VIM DBS* for the treatment of ET and/or Parkinsonian tremor and *unilateral or bilateral STN or GPi DBS* for the treatment of PD only under the following conditions:

1. Medicare will only consider DBS devices to be reasonable and necessary if they are Food and Drug Administration (FDA) approved devices for DBS or devices used in accordance with FDA approved protocols governing Category B Investigational Device Exemption (IDE) DBS clinical trials.
2. For thalamic VIM DBS to be considered reasonable and necessary, patients must meet all of the following criteria:
   a. Diagnosis of essential tremor (ET) based on postural or kinetic tremors of hand(s) without other neurologic signs, or diagnosis of idiopathic PD (presence of at least 2 cardinal PD features [tremor, rigidity or bradykinesia]) that is of a tremor-dominant form.
   b. Marked disabling tremor of at least level 3 or 4 on the Fahn-Tolosa-Marin Clinical Tremor Rating Scale (or equivalent scale) in the extremity intended for treatment, causing significant limitation in daily activities despite optimal medical therapy.
   c. Willingness and ability to cooperate during conscious operative procedure, as well as during post-surgical evaluations, adjustments of medications and stimulator settings.
3. For STN or GPi DBS to be considered reasonable and necessary, patients must meet all of the following criteria:
   a. Diagnosis of PD based on the presence of at least 2 cardinal PD features (tremor, rigidity or bradykinesia).
   b. Advanced idiopathic PD as determined by the use of Hoehn and Yahr stage or unified Parkinson's disease rating scale (UPDRS) part III motor subscale.
   c. L-dopa responsive with clearly defined "on" periods.
   d. Persistent disabling Parkinson's symptoms or drug side effects (e.g., dyskinesias, motor fluctuations, or disabling "off" periods) despite optimal medical therapy.
   e. Willingness and ability to cooperate during conscious operative procedure, as well as during post-surgical evaluations, adjustments of medications and stimulator settings.

DBS is not reasonable and necessary and is not covered for ET or PD patients with any of the following:

1. Non-idiopathic Parkinson's disease or "Parkinson's Plus" syndromes.
2. Cognitive impairment, dementia or depression that would be worsened by or would interfere with the patient's ability to benefit from DBS.
3. Current psychosis, alcohol abuse or other drug abuse.
4. Structural lesions such as basal ganglionic stroke, tumor or vascular malformation as etiology of the movement disorder.
5. Previous movement disorder surgery within the affected basal ganglion.
6. Significant medical, surgical, neurologic or orthopedic co-morbidities contraindicating DBS surgery or stimulation.

Patients who undergo DBS implantation should not be exposed to diathermy (deep heat treatment including shortwave diathermy, microwave diathermy and ultrasound diathermy) or any type of MRI that may adversely affect the DBS system or adversely affect the brain around the implanted electrodes.

DBS should be performed with extreme caution in patients with cardiac pacemakers or other electronically controlled implants that may adversely affect or be affected by the DBS system.

Deep Brain Stimulation for Essential Tremor and Parkinson's Disease (continued)

For DBS lead implantation to be considered reasonable and necessary, providers and facilities must meet all of the following criteria:

1. Neurosurgeons must: (a) be properly trained in the procedure; (b) have experience with the surgical management of movement disorders, including DBS therapy; and (c) have experience performing stereotactic neurosurgical procedures.
2. Operative teams must have training and experience with DBS systems, including knowledge of anatomical and neurophysiological characteristics for localizing the targeted nucleus, surgical and/or implantation techniques for the DBS system, and operational and functional characteristics of the device.
3. Physicians specializing in movement disorders must be involved in both patient selection and post-procedure care.
4. Hospital medical centers must have: (a) brain imaging equipment (MRI and/or CT) for pre-operative stereotactic localization and targeting of the surgical site(s); (b) operating rooms with all necessary equipment for stereotactic surgery; and (c) support services necessary for care of patients undergoing this procedure and any potential complications arising intraoperatively or postoperatively.

Billing Guidelines

This procedure can be two fold. Implantation of the electrodes is performed in a hospital inpatient setting. Implantation of the pulse generator can be performed in an outpatient department.

Applicable Bill Types

11x 12x 13x 83x 85x

Applicable Revenue Codes

Revenue codes for implementation can be performed in a number of revenue centers within a hospital such as operating room (360) or clinic (510). The revenue codes to report the pulse generator and/or electrodes are 270, 278, 279.

For CAHs that choose method II, use revenue code 98x for the professional component only.

Allowable Covered Diagnosis Codes

Deep Brain Stimulation is covered for the following ICD-9-CM diagnosis codes:

332.0 Parkinson's disease, with paralysis agitans
333.1 Essential and other specified forms of tremor

Allowable Covered Procedure Codes

The following procedure codes may be present:

02.93 Implantation of intracranial neurostimulator, encompasses the component parts of the surgery that include tunneling to protect the wiring and the initial creation of a pocket for the insertion of the electrical unit into the chest wall
86.09 Other incision of skin and subcutaneous tissue, to reflect the creation of a pocket for the battery device
86.99 Other operations on skin and subcutaneous tissue, for the tunneling of the wire connectors

CPT/HCPCS Coding

The following *CPT* and HCPCS codes are available for use when billing for covered deep brain stimulation:

E0752 Implantable neurostimulator electrode, each
E0756 Implantable neurostimulator pulse generator
61862 Twist drill, burr hole, craniectomy for stereotactic implantation of one neurostimulator array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray)
61880 Revision or removal of intracranial neurostimulator electrodes
61885 Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
61886 Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays
61888 Revision or removal of cranial neurstimulator pulse generator or receiver
95961 Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of physician attendance
95962 Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of physician attendance (List separately in addition to code for primary procedure) (Use 95962 in conjunction with code 95961)
95970 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (i.e., cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming
95971 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple brain, spinal cord, or peripheral (i.e., peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming
95972 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex brain,

Deep Brain Stimulation for Essential Tremor and Parkinson's Disease (continued)

spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour

95973 *Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex brain, spinal cord, or peripheral (except cranial nerve); complex brain, spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, additional 30 minutes after hour (List separately in addition to code for primary procedure) (Use 95973 in conjunction with code 95972)*

Payment Methodology

Payment for the inpatient procedure is under diagnostic related group (DRG). The outpatient procedure is outpatient prospective payment system. For critical access hospitals (CAH), the inpatient stay is on reasonable cost and the outpatient procedures are also based on reasonable cost. ❖

Source: CMS Transmittal AB-03-023, CR 2553

2003 April Update to the Laboratory National Coverage Determination Software

CMS implemented 23 national coverage determinations (NCDs) for clinical diagnostic laboratory services developed by the laboratory negotiated rulemaking committee and published as a final rule on November 23, 2001. A national uniform software was developed by Computer Sciences Corporation and incorporated into the Medicare shared maintainer systems so laboratory claims subject to one of the 23 NCDs would be processed uniformly throughout the nation, effective January 1, 2003. The laboratory edit module for the NCDs will be updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The purpose of this article is to announce the changes included in the April 2003 release of the edit module.

1. On January 28, 2003 CMS posted on the Internet a decision memorandum announcing the intent to add the following ICD-9-CM codes to the serum iron studies NCD: 282.60, 282.61, 282.62, 282.63, 282.69, and 285.21. These are codes for anemia in patients with end-stage renal disease and sickle cell anemia. CMS believes these codes flow from the existing narrative in the serum iron studies relating to abnormal blood count values. This NCD change is effective for dates of services **on or after November 25, 2002.** (See *http://cms.hhs.gov/ncdr/memo.asp?id=74* for additional information regarding this change.)

   The term "national coverage determination" means a determination by the Secretary of the Department of Health and Human Services with respect to whether or not a particular item or service is covered nationally under Medicare, but does not include a determination of what code, if any, is assigned to a particular item or service covered under Medicare or a determination with respect to the amount of payment made for a particular item or service so covered. Thus, the assignment of ICD-9-CM codes to given services will not be subject to review under section 1869(f).

2. Updates to the *CPT* coding system for 2003 included deletion of seven codes currently in the blood count NCD. CMS is eliminating the following *CPT* codes from the edit software: *85021, 85022, 85023, 85024, 85031, 85590, and 85595*, effective for dates of service **on or after April 1, 2003**. These codes remain in this NCD for dates of service November 25, 2002. The *CPT* also added new blood count codes for 2003. Therefore, CMS has undertaken an NCD review to add new codes to this policy. Readers may follow the progress of this NCD review on the Web site *http://cms.hhs.gov/ncdr/trackingsheet.asp?id=88*.

3. In PM AB-02-134, question and answer 4 noted that *CPT* codes *87184* and *87186*, the susceptibility studies for antimicrobial agents, were not specific to urine. Editing these codes for the diagnoses in the urine culture NCD could result in inappropriate denials when the code was being used for other identifications. CMS stated that the edit module would not edit for these *CPT* codes, but that contractors could develop local edits for them.

   CMS has learned that an error was made in developing the edit module and these codes were not removed as planned. Any inappropriate denials will be adjusted when brought to the contractor's attention.

4. In the serum iron studies NCD, there is a mismatch between the ICD-9-CM codes and the description of the codes in the list of ICD-9-CM codes covered by Medicare. The coding manual is being corrected to display the correct description of ICD-9-CM codes 562.02 and 562.03 to reflect that these codes indicate diverticulosis and diverticulitis of the small intestine with hemorrhage. No changes in the software are necessary for this change.

5. Several changes were made to the NCDs as produced in PM AB-02-110. These changes were incorporated in the January 1, 2003, edit module release, and in the Laboratory NCD Manual that may be found on the Web site *http://cms.hhs.gov/ncd/manual.pdf*. These changes do not reflect substantive changes to the policies, but rather

2003 April Update to the Laboratory National Coverage Determination Software (continued)

reflect correction of typographical errors and/or ministerial coding updates that have taken place prior to the January 2003 release. The changes to the NCDs are tracked in the NCD manual update section of the NCD Manual.

Below is a listing of changes that were made in the January release. CMS believes most of the typographical errors and ministerial coding update changes have been captured, and future changes of this nature will be limited.

- Expanded truncated code 780.9 to 780.99 in the urine culture and thyroid NCD
- Corrected code 99.8 to 099.8 in the HIV diagnostic NCD
- Corrected code 99.9 to 099.9 in the HIV diagnostic NCD
- Expanded the range of codes for coronary atherosclerosis to include new code 414.06 in the prothrombin time, blood glucose and lipid NCDs
- Added new code 414.12 to the range of codes for aneurysm and dissection of coronary artery in the blood glucose and lipid NCDs
- Expanded truncated code 459.1 to 459.10-459.13 and 459.19 in the prothrombin time NCD
- Expanded truncated code 633.9 to 633.90 and 633.91 in the human chorionic gonadotropin NCD
- Expanded truncated code 521.0 to 521.00 in the blood counts NCD
- Expanded truncated code V59.0 to V59.01, V59.02, and V59.09 in the blood count NCD
- Corrected last code in range 813.30-813.38 to 813.33 in the prothrombin time NCD
- Expanded truncated code 863.9 to 863.90 in the prothrombin time NCD
- Expanded truncated code 790.0 to 790.01 and 790.09 in the serum iron studies NCD
- Expanded truncated code 256.3 to 256.31 and 256.39 in the collagen crosslinks and thyroid NCDs
- Expanded truncated code 564.0 to 564.00-564.02, and 564.09 in the thyroid and fecal occult blood NCDs
- Expanded truncated code 200.0 to 200.00 in the serum iron studies NCD
- Deleted sentence 2 of Limitation #1 in the urine culture NCD as the reference was to a code that had been deleted from the CPT
- Added new code 277.03 to the alpha-fetoprotein NCD
- Added new code 537.84 to the partial thromboplastin time, serum iron studies, and fecal occult blood NCDs
- Added new code 569.86 to the serum iron studies and fecal occult blood NCDs
- Added new codes 771.81 - 771.83 to the urine culture NCD
- Added codes 634.00-634.02, 642.30-642.34, 642.40-642.74, 642.90-642.94 to the human chorionic gonadotropin NCD that were included in the final rule but inadvertently omitted from the PM AB-02-110
- Added code 216.0-216.9 to the blood counts NCD that were included in but were inadvertently omitted from PM AB-02-110
- Corrected typo in code 401.1 to make it 401.0 in the lipid NCD as originally stated in the final rule
- Corrected typo in code 780.2 to make it 780.02 in the urine culture NCD
- Expanded truncated code 780.9 to 780.99 in the thyroid NCD
- Expanded truncated code 733.1 to 733.10 in the prothombin time NCD
- Modified the codes description for the following codes: 85007, 85008, 85014, 85025, 85027, 85048, 780.99, 414.10, 214.0, 402.01, 402.11, 402.91, 428.0, 627.2, 627.4 in the NCD Manual.

The changes enumerated in the bullets above are already incorporated in the lab edit module software and the coding manual on the Internet. ❖

Source: CMS Transmittal AB-03-030, CR 2578

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New CLIA Waived Tests

Listed on the following page are the latest tests approved by the Food and Drug Administration as waived tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), effective December 17, 2002. The *Current Procedural Terminology* (*CPT*) codes for these new tests must have the modifier QW to be recognized as a waived test.

New CLIA Waived Tests (continued)

CPT Code	Test Name	Manufacturer	Effective Date	Use
80101QW	Phamatech QuickScreen One Step Amphetamine Test	Phamatech	8/23/02	Screening test for the presence/ detection of amphetamine in urine
80101QW	Phamatech QuickScreen One Step Cocaine Screening Test	Phamatech	8/23/02	Screening test for the presence/ detection of cocaine metabolites in urine.
80101QW	Phamatech QuickScreen One Step Methamphetamine Test	Phamatech	8/23/02	Screening test for the presence/ detection of methamphetamine in urine.
80101QW	Phamatech QuickScreen One Step Opiate Screening Test	Phamatech	8/23/02	Screening test for the presence/detection of opiates in urine.
80101QW	Phamatech QuickScreen One Step PCP Screening Test	Phamatech	8/23/02	Screening test for the presence/ detection of phencyclidine in urine.
81003QW	ThermoBiostar™ PocketChem™ UA	ThermoBiostar™	12/6/02	Screening of urine to monitor/ diagnose various diseases/ conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections.
82465QW 83718QW 84478QW 80061QW	Polymer Technology Systems CardioChek PA Analyzer {PTS Panels Lipid Panel Test Strips}	Polymer Technology Systems, Inc.	11/21/02	Measures total cholesterol, HDL cholesterol, and triglycerides in whole blood.
85610QW	Lifescan Harmony™ INR Monitoring System – Prescription Home Use and Professional Use	Lifescan, Inc.	12/2/02	Aid in screening for congenital deficiencies of Factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumadin or warfarin effect; screen for vitamin K deficiency.
86294QW	Matritech, Inc. NMP22_ BladderCheck_ Test for Professional and Prescription Home Use	Matritech, Inc.	8/12/02	Immunoassay for the qualitative detention of bladder cancer, and used as an aid in the management of bladder cancer patient.
86318QW	Meridian BioScience ImmunoCard STAT! *H.pylori* Whole Blood Test	Applied Biotech, Inc.	8/9/02	Immunoassay for rapid qualitative detention of IgG antibodies specific to *Helicobacter pylori* in whole blood.
87880QW	DE Healthcare Products, TruView Strep A Test	DE Healthcare Products	10/23/02	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection, which typically causes strep throat, tonsillitis and scarlet fever.
87880QW	Henry Schein Inc, One Step+ Strep A Test	Henry Schein, Inc.	10/23/02	Rapidly detects GAS antigen from throat swabs and used as an aid in the diagnosis of GAS infection, which typically causes strep throat, tonsillitis scarlet fever.

Information on CLIA services may be found in the:
Hospital Manual section 437.2
Skilled Nursing Facility Manual section 541.2
Rural Health Clinic Manual section 640
End Stage Renal Disease Manual section 322. ❖

Source: CMS Transmittal AB-03-013, CR 2533

Intestinal and Multi-Visceral Transplants

Effective for services on or after April 1, 2001, Medicare covers intestinal and multi-visceral transplantation for the purpose of restoring intestinal function in patients with irreversible intestinal failure. Intestinal failure is defined as the loss of absorptive capacity of the small bowel secondary to severe primary gastrointestinal disease or surgically induced short bowel syndrome. Intestinal failure prevents oral nutrition and may be associated with both mortality and profound morbidity. Multi-visceral transplantation includes organs in the digestive system (stomach, duodenum, liver, and intestine).

Medicare will cover intestinal transplantation if performed in an approved facility. The approved facilities are located at *http://cms.hhs.gov/providers/transplant/default.asp*.

For additional information on intestinal and multi-visceral transplants see Medicare Intermediary Manual section 3615.7 and Medicare Coverage Issues Manual section 35-103. ❖

Source: CMS Transmittal 1878, CR 2569

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INPATIENT HOSPITAL SERVICES

Three-Day Payment Window Under the Short-Term Hospital Inpatient Prospective Payment System

Section 1886(a)(4) of the Social Security Act defines the operating costs of inpatient hospital services under the prospective payment system to include certain preadmission services furnished by the hospital (or by an entity that is wholly owned or wholly operated by the hospital) to the patient up to **three** days before the date of the patient's admission to the hospital. The payment window for hospitals excluded from the short-term hospital inpatient prospective payment system includes only those services furnished during the **one** day before a patient's hospital admission. The term "day" refers to the calendar day immediately preceding the date of admission, not the 24-hour (or 72-hour) period that immediately precedes the hour of admission. Preadmission services that are subject to the payment window (covered under the inpatient payment) include diagnostic services (including clinical diagnostic laboratory tests) and nondiagnostic outpatient services that are related to a patient's hospital admission.

In the February 11, 1998, final rule (63 FR 6864), CMS made several refinements to the three-day payment window provisions. Effective March 13, 1998, Medicare defined nondiagnostic preadmission services as being related to the admission only when there is an exact match (for all digits) between the ICD-9-CM principal diagnosis code assigned for both the preadmission services and the inpatient stay. Additionally, Part A services furnished by skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions. Further, CMS revised the regulations at sections 412.2(c)(5) and 413.40(c)(2) to exclude maintenance renal dialysis services from services that are subject to the payment window.

Effective July 1, 2003, the Medicare shared maintenance and common working file claim processing systems will be updated to reflect the March 13, 1998 changes noted above. Additionally, the following manuals will be revised:

- Medicare Intermediary Manual Part 3, section 3610.3 – Outpatient Services Treated as Inpatient Services, and section 3670 – Detection of Duplicate Claims
- Medicare Hospital Manual, section 415.6 – Outpatient Services Treated as Inpatient Services
- Medicare Provider Reimbursement Manual, Part I – Chapter 27, section 2702.1.C – Outpatient Hospital Services that Become Inpatient Hospital Services
- Section 3610.3 of the MIM, and section 415.6 of the Hospital Manual will be revised to include the following revenue codes to report diagnostic services:

  51x – Clinic
  52x – Free-standing clinic
  61x – MRI
  71x – Recovery room
  75x – Gastrointestinal services.

In addition, revenue code 26x – IV Therapy, may be used to bill for therapeutic services. ❖

Source: CMS Transmittal A-03-013, CR 2573

Clarification of Three-Day Payment Window vs. One-Day Payment Window

Long-term care hospitals (LTCHs) and inpatient rehabilitation hospitals (IRFs) are **not** subject to the three-day payment window (72-hour rule) for pre-admission services. Hospitals excluded from inpatient prospective payment system are subject to the one-day payment window (24-hour rule) for pre-admission services, even though these types of facilities are now under their own prospective payment system (PPS). With the implementation of IRF PPS, it was mistakenly assumed that because they were coming under a PPS, the 72-hour rule would apply. In summary, only acute inpatient hospitals are subject to the three-day payment window. LTCHs and IRFs are only subject to the one-day payment window.

This information applies to type of bill 11x.

Source: CMS Transmittal A-03-008, CR 2537

Payment for Medicare+Choice Enrollees to Non-Inpatient Prospective Payment System Hospitals

Teaching hospitals that operate direct graduate medical education (DGME) programs and/or hospitals that operate approved nursing and allied health (N&AH) education programs must submit separate bills for payment for Medicare+Choice enrollees. The M+C inpatient days are to be recorded on the provider and statistics & reimbursement (PS&R) report type 118. For services provided to M+C enrollees by hospitals that do not have a contract with the enrollee's plan, non-IPPS hospitals and units are entitled to any applicable DGME and/or N&AH payments under these provisions. Therefore, such hospitals and units should submit bills to their intermediary for these cases in accordance with the instructions otherwise described in this notification. In addition to submitting the claims to the PS&R report type 118, hospitals must properly report M+C inpatient days on the Medicare cost report, Form 2552-96, on worksheet S-3, Part I, line 2 column 4, and worksheet E-3, Part IV, lines 6.02 and 6.06.

These instructions apply to the following hospitals and units excluded from the acute inpatient prospective payment system (IPPS):

- Rehabilitation units
- Psychiatric units
- Rehabilitation hospitals
- Psychiatric hospitals
- Long-term care hospitals
- Children's hospitals
- Cancer hospitals.

In addition, this notification also applies to all hospitals that operate an N&AH program and qualify for additional payments related to their M+C enrollees. These providers should similarly submit their M+C claims to their respective intermediaries to be processed as no-pay bills so that the M+C inpatient days can be accumulated on the PS&R (report type 118) for purposes of calculating the M+C N&AH payment through the cost report.

Billing Instructions

Non-IPPS hospitals, hospitals with rehabilitation and psychiatric units, and hospitals that operate an approved N&AH program must submit claims to their regular intermediary in UB-92 format, with condition codes 04 and 69 present on record type 41, fields 4-13, (form locator 24-30).

Condition code 69 has recently been modified by the National Uniform Billing Committee to indicate that the claims, in addition to being submitted for operating indirect medical education and DGME payment to IPPS hospitals, may now be submitted as no-pay bills to the PS&R report type 118 for M+C enrollees in non-IPPS hospitals and non-IPPS units to capture M+C inpatient days for purposes of calculating the DGME and/or N&AH payment through the cost report.

If Medicare enrollment records do not indicate that the beneficiary is a M+C enrollee, the claim will be rejected and the hospital will be notified of this reason. The hospital may resubmit the claim after 30 days to see if the enrollment data has been updated. ❖

Source: CMS Transmittal A-03-007, CR 2476

For regulations on DGME programs see 42 CFR section 413.86. For regulations on N&AH education programs see 42 CFR section 413.87 and 42 CFR section 413.87(e).

Interim Billing of Part A Claims and Timely Filing Impacts to PIP Providers

CMS mandates that all claims be filed on or before December 31st of the calendar year following the year in which the services were furnished unless the service is rendered in the months of October, November, and December. The timely filing limitation for services rendered in those three months is extended to December 31st of calendar year two years following the year in which the services were furnished. In cases of extended inpatient stays, CMS allows Part A providers to submit interim bills. The following guidelines should be used to correctly file interim claims to Medicare.

PPS Providers (Non-PIP)

Inpatient billing for providers under a PPS is normally done after the patient is discharged from the facility. If providers are not receiving PIPs (periodic interim payments) they may bill sixty days after the admission and every sixty days thereafter in the sequence in which services occurred. **The initial billing must be an interim bill (type of bill xx2) with each subsequent claim billed as an adjustment (type of bill xx7) of the previous interim bill.** Each bill must include all diagnoses, procedures and services from admission to the "through" date. Charges that were on the prior bill must also be included on each subsequent adjustment bill. The initial PPS interim claim must have a patient status of 30 (still patient) and a TOB 112 (interim first claim). When a subsequent PPS interim bill is sent, it is submitted as an adjustment (TOB 117) with a valid patient status code, (i.e., patient status 30) unless the patient is being discharged or transferred).

Example – First Interim Bill

A Medicare beneficiary is admitted for inpatient hospital services on August 1, 2002. On September 30th the PPS provider decides to submit an interim bill.

TOB = 112
From Date = 08/01/02
Through Date = 09/30/02
Admit Date = 08/01/02
Patient Status = 30

Interim Billing of Part A Claims and Timely Filing Impacts to PIP Providers (continued)

Example – Second Interim Bill

On November 30, 2002, the beneficiary is still a patient and the PPS hospital needs to submit another bill for the period ending November 30, 2002. This will be the second interim bill.

TOB = 117
From Date = 08/01/02
Through Date = 11/30/02
Admit Date = 08/01/02
Patient Status = 30

Note: All the billing data from the previous claim must be on this adjustment as well as the additional charges for this period.

Example – Final Bill

The beneficiary is discharged from this facility on December 27, 2002, requiring that a final bill be submitted.

TOB = 117
From Date = 08/01/02
Through Date = 12/27/02
Admit Date = 08/01/02
Patient Status = Appropriate patient status

Note: The adjustment bill must repeat charges included on all prior bills and all diagnoses, procedures and services from admission to discharge date.

Non-PPS (Non-PIP) Providers/Skilled Nursing Facilities

Non-PPS providers not receiving PIP, and SNFs must bill upon discharge or 30 days after an admission. Each 30-day billing must be billed as an interim bill reflecting the "from" date as the day after the "through" date of the earlier bill. Each interim bill should include all diagnoses, procedures and services applicable to the admission. However, charges billed on prior interim bills must not be included on the subsequent bills. The initial interim claim must have a patient status of 30 using TOB xx2 for the first bill. When the second interim bill is sent, it is submitted as a TOB xx3 or xx4 depending on if the patient is discharged at this time, and the appropriate patient status code.

Example – First Interim Bill

A Medicare beneficiary is admitted for inpatient services on August 1, 2002 and the patient is discharged on January 31, 2003. The non-PPS (non-PIP) provider/SNF needs to submit the first interim bill for the period ending August 31, 2002.

TOB = 112
From Date = 08/01/02
Through Date = 08/31/02
Admit Date = 08/01/02
Patient Status = 30

Example – Second Interim Bill

On September 30, 2002, the beneficiary is still a patient and the non-PPS (non-PIP) provider/SNF must submit an interim bill for the period ending September 30, 2002. Interim bills will continue to be submitted with TOB 113 until such time the patient is discharged.

TOB = 113
From Date = 09/01/02
Through Date = 09/30/02
Admit Date = 08/01/02
Patient Status = 30

Note: This interim bill must repeat all diagnoses, procedures and services from admission to the "through" date. However, the charges submitted on the previous bill(s) must not be included.

Example Final Bill:

The beneficiary is discharged from this facility on January 31, 2003 requiring a final bill to be submitted.

TOB = 114
From Date = 01/01/03
Through Date = 01/31/03
Admit Date = 08/01/02
Patient Status = Appropriate patient status

Note: This interim bill must repeat all diagnoses, procedures and services from admission to the "through" date. However, the charges submitted on the previous bill(s) must not be included.

PIP Providers

Hospitals who are reimbursed on the PIP method can only submit a claim from admit to discharge.

Because PIP providers are not allowed to bill until after the patient's discharge, the potential exists that the claim will be filed beyond the normal timely filing limit. Even though the PIP provider has received reimbursement by this time, the claim must still be submitted to Medicare because of utilization implications.

Billing Example

A Medicare beneficiary was admitted for inpatient hospital services on March 1, 2002 and discharged from this facility on January 31, 2003. The PIP provider will submit one admit through discharge bill after January 31, 2003.

TOB = 111
From Date = 03/01/02
Through Date = 01/31/03
Admit Date = 03/01/02
Patient Status = Appropriate patient status

Additionally, as long as PIP providers submit the claim prior to the end of the year in which the patient was discharged, the claim will be considered timely. ❖

Temporary Equalization of Urban and Rural Standardized Payment Implementation

CMS has established the new fiscal year 2003 operating standardized amounts for IPPS hospitals not in large urban areas effective April 1, 2003, as required by section 402(b) of Public Law 108-7.

The standardized amounts for large urban areas are revised slightly because of the recalculation of the budget neutrality factors as a result of wage index corrections in Program Memorandum A-02-92. In conjunction with the new standardized amounts, CMS has also announced new capital rates to be effective April 1, 2003. The following standardized amounts and capital rates are effective for discharges occurring **on or after April 1, 2003, and before October 1, 2003.**

Revised FY 2003 National Operating Rates

Large Urban Areas

National labor-related	$3,022.31
National nonlabor-related	$1,228.48

Other Areas

National labor-related	$3,022.31
National nonlabor-related	$1,228.48

Revised FY 2003 Capital Rates

National	$406.93

As a result of the behaviors described in the March 5, 2003 proposed rule (68 FR 10420), and based upon preliminary data regarding outlier payments for the first quarter of FY 2003, CMS believes it is likely that Medicare has continued to overpay for outliers during the first quarter of FY 2003. Accordingly, the outlier threshold is unchanged at $33,560.

CMS expects to publish a final rule establishing these new payment rates very soon. ❖

Source: CMS Transmittal A-03-023, CR 2661

OUTPATIENT HOSPITAL SERVICES

Observation Claims—Codes G0263 and G0264

CMS has advised fiscal intermediaries (FIs) that the January 2003 outpatient code editor (OCE) software is applying an edit to observation HCPCS codes G0263 and G0264 when billed with revenue code 762. This edit is causing claims with these codes to be returned to the provider incorrectly.

In the interim, CMS has instructed FIs to temporarily turn this edit off to allow these claims to process correctly. The edit will be reactivated upon successful implementation of the April 2003 OCE release to allow HCPCS codes G0263 and G0264 to be reported with revenue code 762.

Action Required by Providers

Providers may resubmit claims for observation codes G0263 and G0264 billed with revenue code 762 that have been returned to the provider with reason code W7044. ❖

Source: CMS Notification Dated January 27, 2003

Reactivation of Outpatient Code Editor Edit 15

CMS issued a notification in April 2002 to discontinue the application of the OPPS OCE edit 15 – Service Unit Out of Range for Procedure, until further notice.

CMS is lifting the moratorium on application of the OPPS OCE edit 15. Therefore, Medicare Part A system maintainers will reactivate OPPS OCE edit 15 for claims with dates of service **on or after April 1, 2003.** The units of service edit will not be applied to all services at this time; instead, there will be limited edits applied to certain services for this quarter. However subsequent modifications to this edit will be made in upcoming OPPS OCE releases. CMS' goal is to eventually allow OCE edit 15 to operate the way it was fully intended, and to avoid any additional inconsistencies with required units. ❖

Source: CMS Transmittal A-03-19, CR 2612

Billing for Low Osmolar Contrast Material

Effective with services furnished **on or after April 1, 2003,** hospitals billing under the outpatient PPS may use HCPCS codes A4644, A4645, or A4646 when billing for low osmolar contrast material (LOCM) services.

Non-OPPS hospitals must continue to follow the billing instructions in sections 443.C.3f and 443.C.3g of the Medicare Hospital Manual and sections 3631.C.3f and 3631.C.3g of the Part A Medicare Intermediary Manual. Those instructions continue to be applicable to non-OPPS hospitals. ❖

Source: CMS Transmittal A-03-19, CR 2612

LOCAL MEDICAL REVIEW POLICIES

In accordance with publications specified by CMS, Medicare contractors no longer distribute full-text local medical review policies (LMRPs) to providers in hardcopy format. Providers may obtain full-text LMRPs from 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 comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the fiscal intermediary's medical policies and review guidelines are consistent with accepted standards of medical practice.

Effective and Notice Dates

Effective dates are provided in each policy, and are based on the date 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 provider education 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* maling list. It is very easy to do; simply sign on to the provider education Web site, *www.floridamedicare.com*; click on the "Join our electronic mailing list FCSO *eNews*" bar and follow the prompts.

More Information

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

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

Medical Policy Table of Contents

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

29540: Strapping—Addition to Policy

The LMRP for Strapping – *29540* was published in the First Quarter 2002 *Medicare A Bulletin* (pages 31-32). Since that time, revenue code 761 has been considered an appropriate revenue code when the services are furnished in an outpatient setting not related to a rehabilitation plan of care. Therefore, revenue code 761 has been added to the policy to be used with types of bill 13x and 85x.

Effective Date

This addition is effective for claims processed **on or after April 11, 2003**. ❖

Correction to Previous Article

The LMRP for Strapping – *29540* was published in the Second Quarter 2003 *Medicare A Bulletin!* (page 22). The effective date for the addition of diagnosis range 707.10-707.19 (ulcers of lower limbs, except decubitus) and revenue code changes is for claims processed **on or after December 19, 2002.** Additionally, the effective date for the removal of diagnosis 734 (flat foot) from the "ICD-9-CM Codes that Support Medical Necessity" section of the policy is for claims processed **on or after January 23, 2003.** We apologize for any inconvenience this may have caused. ❖

64550: Application of Surface (Transcutaneous) Neurostimulator—Revision to Policy

The LMRP for Application of Surface (Transcutaneous) Neurostimulator – *64550* was implemented on March 24, 2003. Since that time, types of bill 74x – Outpatient Rehabilitation Facility, and 75x – Comprehensive Outpatient Facilities have been added to the "Type of Bill" section of the policy.

In addition, revenue codes 429 – Other Physical Therapy, and 439 – Other Occupational Therapy were removed from the "Revenue Codes" section of the policy.

Effective Date

This revision is effective for claims processed **on or after March 24, 2003**. ❖

78300: Bone and/or Joint Imaging—Implementation of New Policy

CPT code *78306* was chosen for focused medical review for fiscal year 2001 based on the January through June 2000 data revealing a carrier national ratio of allowed dollars of $1.93. Based on the conclusion of the findings, the performance of this service was considered a widespread problem; therefore, a probe was conducted to determine the medical conditions for which the service was being performed. Using the results of the widespread probe, a local medical review policy to include bone scan CPT codes *78300*, *78305*, *78315*, and *78320* was developed to address the indications for coverage and define the criteria for performing the different bone scan techniques (e.g., limited versus whole body, three-phase study).

The complete local medical review policy can be found at *www.floridamedicare.com*.

Effective Date

Implementation of this policy is effective for claims processed **on or after June 30, 2003**. ❖

36515: Protein A Column Apheresis (Prosorba®)—Revision to Policy and Title Change

The LMRP for Protein A Column Apheresis (Prosorba®) – *36515* was recently updated to include low-density lipoprotein apheresis as an accepted therapy for patients who have familial hypercholesterolemia (FH) for which strict diet and medication management has not been effective. The LMRP title was also revised and will be referred to as Therapeutic Apheresis Using Adsorption Columns.

Effective for dates of service on or after February 20, 2003, Florida Medicare will consider LDL Apheresis medically necessary for the treatment of the following patients with FH:

- LDL is greater than 300 mg/dL despite a six-month trial of diet therapy and maximum tolerated combination drug therapy***** or
- LDL is greater than 200 mg/dL and documented coronary artery disease.******

*****These LDL levels for the indicated patient populations are baseline LDL levels obtained after the patient has had, at a minimum, a 6-month trial of an AMA Step II diet (or equivalent) and a maximum tolerated combination drug therapy designed to reduce LDL. A maximum tolerated trial includes drugs from at least 2 separate classes of hypolipidemic agents such as, bile acid sequesterants, HMG-CoA reductase inhibitors, fibric acid derivatives, Niacin/ Nicotinic Acid, etc. Baseline lipid levels are to be determined after stabilization on diet and drug therapy by making two measurements during a two to four week period. (Note the two values should be within 10 percent of each other, indicating a stable condition.)

******Documented CHD includes documentation of CAD by angiography or a history of MI, CABG, PTCA or alternative revascularization procedure (stent), or progressive angina documented by exercise or non-exercise stress test.

LDL Apheresis requires careful patient selection and long-term commitment to therapy. Additionally, patients should simultaneously be treated with diet and drug therapy as tolerated.

The complete LMRP for more information and important coverage guidelines for this therapy can be found on the provider education Web site *www.floridamedicare.com*.

Effective Date

This revision is effective for dates of service furnished **on or after February 20, 2003**. ❖

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

93922: Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries—Revision to Policy

The LMRP for Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries – *93922* was published in the April/May 2000 *Medicare A Bulletin* (pages 22-24). Since that time, revenue code 460 and type of bill 85x have been added to this policy. Type of bill 71x has been deleted from this policy.

Effective Date

These revisions are effective for services processed **on or after February 21, 2003**. ❖

97010: Physical Medicine and Rehabilitation—Revision to Policy

The LMRP for Physical Medicine and Rehabilitation – *97010* was published in the Second Quarter 2002 *Medicare B Bulletin* (pages 47-59). Based on transmittal AB-02-161, CR 2313, changes have been made to reflect the coverage and billing requirements for electrical stimulation for the treatment of wounds.

In addition, the policy has been revised to reflect the coverage requirements for neuromuscular electrical stimulation (NMES) to enhance walking for spinal cord injury (SCI) patients, based on coverage guidelines issued in Transmittal AB-02-156, CR 2314.

Effective Date

This revision is effective for services furnished **on or after April 1, 2003**. ❖

A0430: Air Ambulance Services—Revision to Policy

The LMRP for Air Ambulance Services – A0430 has been revised to provide limitation for services rendered based on a standing order. In addition, language has been added to provide clarification for cancellations of air ambulance services due to death prior to transport, or aborted transport due to bad weather or circumstances beyond the pilot's control. This revision is based on transmittal AB-03-007, CR 2470.

Effective Date

This revision is effective for claims processed **on or after January 24, 2003**. ❖

95934: H-Reflex Study—Revision to Policy

The LMRP for H-Reflex Study – *95934* was published in the October/November 2000 *Medicare A Bulletin.* Since that time, the following diagnosis codes have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy:

724.2	Lumbago
728.2	Muscular wasting and disuse atrophy, not elsewhere classified
728.85	Spasm of muscle
736.79	Other acquired deformities of ankle and foot (drop foot)
780.79	Other malaise and fatigue (weakness, generalized)
781.3	Lack of coordination

In addition, type of bill code 85x – Critical Access Hospital was added to the policy and types of bill 71x – Rural Health Clinic and 72x – End Stage Renal Disease were removed from the policy.

Effective Date

This revision is effective for claims processed **on or after March 27, 2003**. ❖

A0425: Ground Ambulance Services—Revision to Policy

The Medicare program includes an ambulance benefit for services provided by a free standing ambulance supplier or a participating Part A provider. Three basic requirements must be met for ambulance services to be covered:

- The ambulance and crew must meet specific requirements
- The transportation must be medically reasonable and necessary
- The origin and destination requirement must be met.

The coding and definition of these services has evolved over the past two years, with new HCPCS codes in 2001 and 2002. In addition, CMS implemented the ambulance fee schedule payment methodology on April 1, 2002. Based on these changes, this policy was revised to further define and provide clarification on a basic life support (BLS) and advance life support (ALS) assessment and intervention. Examples of a BLS and ALS level of transport were also added. Services for specialty care transport, HCPCS code A0434, have been removed from this LMRP and further defined in a separate LMRP, Specialty Care Transport – A0434.

Effective Date

This revision is effective for services processed **on or after June 30, 2003**. ❖

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

A0434: Specialty Care Transport—Implementation of New Policy

Specialty care transport (SCT), HCPCS code A0434, is a hospital to hospital transport of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies or services, at a level beyond the scope of the emergency medical technician (EMT)-paramedic. Since the inception of this level of transport in January 2001, all Florida Medicare claims have suspended for 100 percent prepayment medical review. In keeping with Florida Medicare's long-term goal to eliminate prepayment medical review for all ground ambulance services, this policy was developed to communicate the requirements for SCT and to identify the indications and limitations of coverage.

The complete LMRP can be found at *www.floridamedicare.com*.

Effective Date

Implementation of this policy is effective for claims processed **on or after June 30, 2003**. ❖

C1300: Hyperbaric Oxygen Therapy (HBO Therapy)—Revision to Policy

Effective April 01, 2003, a national coverage decision expanded the use of hyperbaric oxygen therapy (HBO) to include coverage for the treatment of diabetic wounds of the lower extremities, and clarify the special supervision and credentialing requirements for physicians who perform HBO therapy. The LMRP for Hyperbaric Oxygen Therapy – C1300 has been revised to reflect these changes based on transmittal AB-02-183, CR 2388.

Effective Date

This revision is effective for dates of service **on or after April 1, 2003**. ❖

C9119: Pegfilgrastim (Neulasta™)—Implementation of New Policy

Pegfilgrastim (Neulasta™) is a colony stimulating factor (CSF) that acts on hematopoietic cells by binding to specific cell surface receptors thereby stimulating proliferation, differentiation, commitment, and end cell functional activation. This drug was FDA-approved on January 31, 2002 to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe febrile neutropenia. Current Medicare coverage is for the FDA-approved indication only. The drug is billed using HCPCS code C9119 and requires a dual diagnosis. An ICD-9-CM code from List I and one from List II is required.

ICD-9-CM LIST I

140.0-149.9	Malignant neoplasm of lip, oral cavity, and pharynx
150.0-159.9	Malignant neoplasm of digestive organs and peritoneum
160.0-165.9	Malignant neoplasm of respiratory and intrathoracic organs
170.0-176.9	Malignant neoplasm of bone, connective tissue, skin and breast
179-189.9	Malignant neoplasm of genitourinary organs
190.0-199.1	Malignant neoplasm of other and unspecified sites
200.00-202.88	Malignant neoplasm of lymphatic and hematopoietic tissue
203.00-204.81	Multiple myeloma and immunoproliferative neoplasms
204.00-204.81	Lymphoid leukemia
273.3	Waldenström's macroglobulinemia

ICD-9-CM LIST II

995.2	Unspecified adverse effect of drug, medicinal and biological substance
V58.1	Encounter for chemotherapy
V66.2	Convalescence and palliative care following chemotherapy

The complete LMRP can be found at *www.floridamedicare.com.*

Effective Date

Implementation of this policy is effective for services furnished **on or after January 31, 2002** and claims processed **on or after June 30, 2003**. ❖

DYSPHRT: Dysphagia/Swallowing Diagnosis and Therapy—Revision to Policy

The LMRP for Dysphagia/Swallowing Diagnosis and Therapy was published in the Second Quarter 2003 *Medicare A Bulletin!* (page 27). Since that time language has been removed from the "Coding Guidelines" section of the policy. The full-text of this LMRP may be found on the provider education Web site *www.floridamedicare.com*. ❖

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

G0108: Diabetes Outpatient Self-Management Training—Revision to Policy

The LMRP for Diabetes Outpatient Self-Management Training – G0108 was published in the Fourth Quarter 2001 *Medicare A Bulletin* (pages 68-70). Since that time, transmittal AB-02-151, dated October 25, 2002 was issued to add language for clarification of billing instructions and to clarify the differences between the benefits of this policy and the LMRP for Medical Nutrition Therapy – 97802.

Effective Date

This revision is not affected by an effective date. ❖

J0585: Botulinum Toxin Type A (Botox®)—Revision to Policy

The LMRP for Botulinum Toxin Type A (Botox®) – J0585 was recently updated to include the following statement to the "Coding Guidelines" section of the policy:

> When using Botulinum toxin type A (Botox) for the treatment of bilateral blepharospasm, *CPT* code *64612* may be billed once for each eye with the appropriate modifier. However, procedure code *64612* is allowed at 150 percent when performed bilaterally.

Effective Date

This revision is effective for claims processed **on or after March 20, 2003**. ❖

J0001: Self-Administered Drugs—Retirement of Policy

The LMRP for Self-Administered Drugs – J0001 will be retired **effective June 30, 2003.** Self- administered drugs will be defined according to instructions issued in change requests 2200 and 2311. Providers may view guidelines and the self-administered drug list on the provider education Web site at *www.floridamedicare.com*. ❖

J0636: Vitamin D Analogs in Chronic Renal Disease—Revision to Policy

The LMRP for Vitamin D Analogs in Chronic Renal Disease was published in the Third Quarter 2002 *Medicare A Bulletin!* (pages 31-33). Due to policy contenting language related to least costly alternative, which has **not** become effective, the following statement has been added to the policy. **Once CMS communicates the effective date of the "Least Costly Alternative Pricing for Vitamin D Analogs", the Florida intermediary will implement the following statement per CMS direction.**

All three vitamin D derivatives treat the patient with secondary hyperparathyroidism associated with chronic renal failure by directly suppressing the synthesis and secretion of PTH. Because calcitriol, paricalcitol, and doxercalciferol produce the same clinical effects, reimbursement will be based on the drug that is the least costly when given for patients with secondary hyperparathyroidism (diagnosis code 588.8).

The full-text of this LMRP may be found on the provider education Web site *www.floridamedicare.com*. ❖

J0640: Leucovorin (Wellcovorin®)—Implementation of New Policy

Leucovorin (Wellcovorin®) is a reduced form of folic acid, which is readily converted to other reduced folic acid derivatives. It is used as an antidote, antianemic and as a chemotherapeutic adjunct. Florida Medicare will consider leucovorin medically reasonable and necessary when used for any of the following FDA approved indications:

- as an antidote for the toxic affects of the folic acid antagonists such as methotrexate, pyrimethamine, or trimethoprim;
- as a rescue agent after high-dose methotrexate therapy;
- as an adjunct to fuorouracil in the palliative treatment of advanced colorectal cancer; *and*
- as a treatment for megaloblastic anemias associated with sprue, nutritional deficiency, pregnancy, and infancy when oral folic acid therapy is not feasible.

Note: Leucovorin is not recommended for use in the treatment of pernicious anemia or other megaloblastic anemias secondary to lack of Vitamin B12, since it may produce hematologic remissions while neurologic manifestations continue to progress.

Florida Medicare will cover leucovorin for the FDA-approved indications as well as for the treatment of the following off-labeled indications:

- Head and neck squamous cell carcinoma, when used in combination with agents such as fluorouracil or high-dose methotrexate
- Ewing's sarcoma when used in combination with high-dose methotrexate
- Non-Hodgkin's lymphoma when used in combination with high-dose methotrexate
- Gestational trophoblastic tumors when used in combination with high-dose methotrexate
- Breast carcinoma when used in combination with fluorouracil
- Gastric carcinoma when used in combination with fluorouracil
- Pancreatic carcinoma when used in combination with fluorouracil
- Bladder carcinoma when used in combination with fluorouracil
- Prostate carcinoma when used in combination with fluorouracil
- Ovarian carcinoma when used in combination with fluorouracil

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

J0640: Leucovorin (Wellcovorin®) (continued)

- Cervical carcinoma when used in combination with fluorouracil
- Endometrial carcinoma when used in combination with fluorouracil
- Malignant neoplasm of the small intestine
- Esophageal carcinoma when used in combination with fluorouracil
- Liver carcinoma when used in combination with fluorouracil
- Gallbladder and extrahepatic bile duct carcinoma when used in combination with fluorouracil
- Cancer of unknown primary site (CUPs)
- Adrenal cortex carcinoma when used in combination with fluorouracil
- Vulvar carcinoma when used in combination with fluorouracil
- Penile carcinoma when used in combination with fluorouracil

Leucovorin is used as an antineoplastic agent as well as an antidote and an antianemic and is administered in a variety of ways depending on the clinical situation. Therefore, the appropriate chemotherapy administration codes are to be used when this drug is being used as an antineoplastic therapy. Appropriate therapeutic infusion and injection codes are to be used when leucovorin is being used as an antidote or an antianemic**.**

The complete LMRP can be found at *www.floridamedicare.com*.

Effective Date

Implementation of this policy is effective for claims processed **on or after June 30, 2003**. ❖

J1440: G-CSF (Filgrastim, Neupogen®)—Revision to Policy

The local medical review policy G-CSF (Filgrastim , Neupogen®) – J1440 was published in the October/ November 2000 *Medicare A Bulletin* (pages 47-49). Since that time, ICD-9-CM code 238.7 – myelodysplastic syndrome has been 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 April 10, 2003**. ❖

J9212: Interferon—Revision to Policy

The LMRP for Interferon – J9212 was published in the Fourth Quarter 2001 *Medicare A Bulletin* (page 79). This revision is to remove all reference to LMRP Self-Administered Drugs – J0001 since this policy will be retired effective June 30, 2003.

Effective Date

This revision is effective for claims processed **on or after June 30, 2003**. ❖

Clarification on Epoetin Billing Issues

First Coast Service Options, Inc. (FCSO) is aware of several issues impacting adjudication of Part A outpatient EPO claims billed with procedure codes Q0136 and C1774 (Aranesp®). The following provides a brief description of each of these issues and the corrective action we are taking:

- **Claim denials of Q0136 for non-ESRD patients that met diagnosis and value code criteria identified as appropriate in the LMRP for Q0136 – Non-ESRD Epoetin (Procrit®).**
  System logic for Q0136 was incorrectly applying automated rules, and caused inappropriate denials. This situation has been corrected and claims for Q0136 are now adjudicating appropriately. In addition, a mass adjustment will be performed within the next 45-60 days to reprocess claims denied in error. **Therefore, it is not necessary to resubmit claims for payment.**
- **Transmittal A-01-106, CR 1839, regarding Q0136 for chronic renal failure in outpatient hospitals.**
  There has been some confusion around the effective date of this transmittal. A request for clarification has been submitted to CMS; however, until a response is received, the contractor considers the effective date of this PM to be August 24, 2001. A mass adjustment will be performed within the next 45-60 days to reprocess claims received on or after August 24, 2001, that met the requirements in this transmittal. In addition, a revision to the Q0136 – Non-ESRD Epoetin (Procrit) LMRP is in progress to incorporate the instructions in this PM.
- **Diagnosis criterion for the new code for C1774 – Aranesp was inadvertently implemented in error prior to finalization and implementation of the draft LMRP C1774.**
  This application has been removed from automated editing and a mass adjustment will be performed within the next 45-60 days to reprocess claims denied in error. **Therefore, it is not necessary to resubmit claims for payment.**

If you have any further questions or issues after the mass adjustments occur, please contact Part A Customer Service at 1-877-602-8816. ❖

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

Clarification on Certain Pathology Codes

We are aware of an issue impacting adjudication of Part A claims billed with certain pathology codes. The following provides a brief description of these issues and the corrective action we are taking:

- A national coverage determination policy for certain pathology codes was implemented nationally effective November 25, 2002. With the implementation of the NCD policy, certain LMRPs were retired. In addition to retirement of the LMRP, any local policy system editing (i.e., procedure-to-diagnosis and utilization screens) was also discontinued.
- The LMRP on nine procedure codes were discontinued effective November 25, 2002. However, the procedure-to-diagnosis edit associated with these codes was not removed from the system. Therefore, system logic was inappropriately applying automated rules for certain codes, and caused inappropriate denial. The applicable *CPT* procedures are: *85009, 84437, 84480, 84481, 84482, 83719, 84703, 86294,* and *82274.* This situation has been corrected and claims for these *CPT* codes are now adjudicating appropriately.

In addition, a mass claim adjustment is being performed to reprocess claims denied in error. **Therefore, it is not necessary to resubmit claims for payment.**

For questions or issues after the mass adjustments occur, please contact Part A Customer Service toll free at 1-877-602-8816. ❖

Retirement of Local Medical Review Policies for Certain Clinical Diagnostic Laboratory Services

The LMRPs listed here relating to clinical laboratory services have been retired, effective for services furnished **on or after November 25, 2002.** Indications and limitations for these services are included in the administrated policies for the Negotiated Rulemaking for Clinical Diagnostic Laboratory Services published in the *Federal Register* on November 23, 2001.

For more information regarding the national coverage decisions that replace these LMRPs, please refer to the First Quarter 2003 *Medicare B Bulletin!* (pages 5-7), and CMS Web site at *http://cms.hhs.gov/ncd/default.asp.*

A80061	Lipid Profile/Cholesterol Testing
A80162	Digoxin
A82105	Tumor Markers
A82270	Fecal Occult Blood
A82378	Carcinoembryonic Antigen(CEA)
A82728	Serum Ferritin
A82947	Blood Glucose Testing
A82985	Glycated Protein
A83036	Glycated Hemoglobin
A83540	Iron
A84153	Prostate Specific Antigen
A84436	Thyroid Function Test
A85007	Complete Blood Count
A85610	Prothrombin Time
A87086	Urine Bacterial Culture
A87536	HIV-1 Viral Load Testing ❖

***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.*

Self-Administered Injectable Drugs

CMS has issued instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provided contractors a process for determining if an injectable drug is *usually self-administered* and therefore, not covered by Medicare.

Contractors are also required to establish a self-administered drug (SAD) list on their Web site listing drugs that have been evaluated and determined to be usually self-administered. This list may be viewed on the provider education Web site at *www.floridamedicare.com.* Currently, the injectable drugs on the Florida Medicare A SAD list are as follows:

J0270	Alprostadil, 1.25 mcg
J1438	Etanercept, 25 mg (Enbrel®)
J1815	Insulin, 5 units (formerly J1820)
J1830	Interferon beta-1b, 0.25mg (Betaseron®)
J2940	**S**omatrem, 1mg
J2941	**S**omatropin, 1 mg
J3030	Sumatriptan succinate, 6mg (Imitrex®)
J3490	Kineret™, per 100mg
J3490	Ribef®
J9218	Leuprolide acetate, per 1 mg
Q2010	Compaxone® per 20 mg

Medicare exclusion is clear for oral drugs, suppositories and topical medications. The 2003 outpatient prospective payment system regulations define pass-through drugs, biologicals and radiopharmaceuticals. Part A providers may refer to transmittal A-02-129, CR 2503 for a listing of these drugs. Instructions regarding Medicare payment for drugs and biologicals incident to a physician's service were issued in transmittal AB-02-072, CR 2200, and transmittal AB 02-139, CR 2311. ❖

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

Zevalin: Ibritumomab Tiuxetan (Zevalin™)—Implementation of New Policy

Ibritumomab tiuxetan (Zevalin™), as part of a specific therapeutic regimen, was FDA-approved on February 19, 2002 for the treatment of patients with relapsed or refractory low-grade, follicular, or transformed B-cell non-Hodgkin's lymphoma, including patients with rituximab (Rituxan®) refractory follicular non-Hodgkin's lymphoma. The regime includes rituximab, In-111 Zevalin, and Y-90 Zevalin. Ibritumomab tiuxetan (Zevalin™) therapy is a two-step process, which includes both a diagnostic and therapeutic portion. Zevalin is a radiolabeled monoclonal antibody that targets the CD20 antigen, which is found on the surface of normal and malignant B-lymphocytes. Its mechanism of action is twofold. When Zevalin binds to malignant cells, it activates a direct immune response, while the attached radioactive isotope emits radiation to the cell.

The therapy begins with the administration of rituximab (Rituxan®), J9310, followed by the administration of one dose of Zevalin, a monoclonal antibody that is linked to the radioisotope, indium-111 (In-111 Zevalin). Imaging studies are then performed within two to 24-four hours post infusion to assess the biodistribution of the In-111 Zevalin. Assessment of biodistribution may involve a second scan performed 48 to 72 hours after the initial infusion of In-111 Zevalin. In some rare instances, a third scan may be required which should be performed 90 to 120 hours after the initial infusion. If the biodistribution is not acceptable, then the therapy is stopped.

If biodistribution is acceptable, another infusion of rituximab is administered once during days seven through nine. Within four hours of this infusion, Zevalin linked to the radioisotope yttrium-90 (Y-90 Zevalin) is administered.

Ibritumomab tiuxetan (Zevalin™) therapy is intended and considered to be a single course treatment regime. The efficacy, safety, and toxicity of multiple courses of the therapy have not been established and more than one course of treatment is considered not reasonable and necessary. In addition, doses of Y-90 Zevalin greater than 32 mCi are considered excessive and are, therefore, not medically necessary. This therapy is contraindicated in patients with platelet counts <100,000/mm^3.

We have received numerous inquiries regarding the appropriate codes to use when billing for these services. On October 1, 2002, pass-through codes C9117, and C9118 were assigned for this therapy. These codes were deleted as of January 1, 2003 and two new codes for the service, G0273, and G0274 were implemented on January 1, 2003.

For claims submitted to the FI for dates of service **on or after October 1, 2002, and until December 31, 2002,** use the following the guidelines:

Diagnostic Portion

For the diagnostic (In-111 Zevalin) component of the therapy, providers should use the appropriate procedure codes from the following list, which is **not** an inclusive list:

78800 *Radiopharmaceutical localization of tumor; limited area*
78801 *Radiopharmaceutical localization of tumor; multiple areas*
78802 *Radiopharmaceutical localization of tumor; whole body*
C9118 Injection, indium 111 ibritumomab tiuxetan, per mCi

The diagnostic nuclear scans used to assess distribution of the radiopharmaceutical should be coded using only one of the following CPT codes: *78800, 78801* or *78802*. The scan should be billed with a unit of service of one. All scans for this service are considered part of a single tumor scan regardless of the number of scans performed or the number of days on which the scans were obtained. The diagnostic dose of In-111 Zevalin should be coded using HCPCS code C9118. The administration of In-111 Zevalin, which includes the intravenous access, is included in the imaging service and should not be separately coded.

Therapeutic Portion

For the therapeutic (Y-90 Zevalin) component of the therapy, providers should use the appropriate procedure codes from the following list, which is not an inclusive list:

79400 *Radiopharmaceutical therapy, nonthyroid, nonhematologic (administration of Y-90 Zevalin)*
C9117 Injection, yttrium 90 ibritumomab tiuxetan, per mCi

The administration of Y-90 Zevalin, which includes the intravenous access, should be billed using *CPT* code *79400.* The provision of the therapeutic dose of Y-90 Zevalin should be coded using the HCPCS code C9117 with a unit of service equal to the dose of Y-90 Zevalin, in mCi, administered to the patient.

The infusion of the radiopharmaceutical; supervision, handling and loading of radiation source; basic dosimetry calculation; and special radiation physics consultation are included in the therapeutic treatment *CPT* code, *79400,* and may not be billed separately.

For claims submitted to both the carrier and FI for dates of service **on or after January 1, 2003,** use the following the guidelines:

Diagnostic Portion

For the diagnostic (In-111 Zevalin) component of the therapy, providers should use the appropriate procedure codes from the following list, which is not an inclusive list:

G0273 Radiopharmaceutical biodistribution, single or multiple scans on one or more days, pre-treatment planning for radiopharmaceutical therapy of non-Hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies)

Therapeutic Portion

For the therapeutic (Y-90 Zevalin) component of the therapy, providers should use the appropriate procedure codes from the following list, which is **not** an inclusive list:

G0274 Radiopharmaceutical therapy, non-Hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies)

The complete LMRP can be policy can be found at *www.floridamedicare.com*.

Effective Date

Implementation of this policy is effective for services furnished **on or after February 19, 2002** and claims processed **on or after June 30, 2003**. ❖

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

COMPREHENSIVE DATA ANALYSIS

36245: Extracardiac Arteriography Associated and Billed with Primary Cardiac Catheterizations

A recent study was performed by the New York peer review organization (PRO) in conjunction with CMS PRO staff in response to a carrier referral related to payments for potential medically unnecessary diagnostic procedures performed in conjunction with primary cardiac catheterizations. The study focused on a review of Medicare beneficiaries who underwent renal arteriogram during inpatient admission for cardiac catheterization. The NY carrier medical director, through claims data, determined a number of physicians were billing for both cardiac catheterization and a 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 Part A and B data were extracted to identify if there were any significant billing/performing patterns visible. The study focused on more than 1,000 inpatient medical records of Medicare beneficiaries admitted to the top 30 hospitals for cardiac catheterization, who, based on analysis of the data, also underwent extracardiac arteriography, particularly renal arteriograms. The study focused on the following:

- Were cardiologists performing the renal arteriograms?
- Were the renal arteriograms carried out at the same time as the cardiac catheterization?
- Were the renal studies medically necessary?
- Did this pattern of performance constitute poor quality of care?

Preliminary findings demonstrated that 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 medically unnecessary invasive procedure associated with high risk.

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

The Medicare data analysis staff noted the following upon their initial review:

- A total of $2,875,603 was paid to all performing providers in Florida, from January through September 2001, who billed a renal arteriogram procedure on the same day/session as a primary cardiac catheterization. A total of 8953 renal arteriograms, by 261 providers, were billed for the same time frame.

We will be performing a widespread medical review across Florida, which may result in specific medical necessity guidelines, PRO referrals and/or provider education. Please assure that when billing these services (*CPT 36245* with *CPT 93512* or *93526*), the renal arteriogram is both medically necessary and performed in accordance with the intention of the *CPT* Editorial Panel. ❖

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES

Changes in Payment for Certain Services Provided by Outpatient Physical Therapy Providers

Outpatient rehabilitation services, (physical therapy, including outpatient speech-language pathology services and occupational therapy services) furnished by an outpatient physical therapy (OPT) provider are paid under the Medicare physician fee schedule (MPFS) as required by section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33). All other outpatient services are currently paid on a reasonable cost basis with the exception of orthotic devices, which are paid under the orthotic fee schedule. The following information identifies services that may be provided in an outpatient rehabilitation facility (ORF), and provides the appropriate payment methodology for those services.

Outpatient Rehabilitation *CPT*/HCPCS Codes

ORFs may bill for the following outpatient rehabilitation *CPT*/HCPCS codes. Payment is made under the MPFS methodology.

29065	*29075*	*29085*	*29086*	*29105*	*29125*	*29126*
29130	*29131*	*29200*	*29220*	*29240*	*29260*	*29280*
29345	*29355*	*29365*	*29405*	*29425*	*29445*	*29505*
29515	*29520*	*29530*	*29540*	*29550*	*29580*	*29590*
64550	*90901*	*90911*	*92506*	*92507*	*92508*	*92526*
92601	*92602*	*92603*	*92604*	*92607*	*92608*	*92609*
92610	*92611*	*92612*	*92614*	*92616*	*95831*	*95832*
95833	*95834*	*95851*	*95852*	*96000*	*96001*	*96002*
96003	*96105*	*96110*	*96111*	*96115*	*97001*	*97002*
97003	*97004*	*97012*	*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*	*97601*	*97703*	*97750*
97799	*0020T*	*0029T*	G0279	G0280	G0281	
G0283	V5362	V5363	V5364			

Note: Code *97504* should not be reported with code *97116.* However, if code *97504* was performed on an upper extremity and code *97116* (gait training) was also performed, both codes may be billed with modifier 59 to denote a separate anatomic site.

The above list of outpatient rehabilitation *CPT*/HCPCS codes **supercede** those codes listed in section 3653 of the Medicare Intermediary Manual. CMS will update section 3653 in the future to reflect the above list of *CPT*/HCPCS codes.

Additional HCPCS Codes

ORFs may also bill for the following nonoutpatient rehabilitation *CPT*/HCPCS codes:

95860	*95861*	*95863*	*95864*
95867	*95869*	*95870*	*95900*
95903	*95904*	*95934*	G0237
G0238	G0239		

Note: The above list of codes is not intended to be a list of all covered OPT services and does not assure coverage of these services.

New Payment Requirement

Effective with claims with dates of service **on or after July 1, 2003,** ORFs, (type of bill 74x) are required to report all their services utilizing *CPT*/HCPCS. Payment for these services will be made under the MPFS unless the item or service is currently being paid under the orthotic fee schedule or the item is a drug, biological, supply or vaccine (see below for an explanation of these services).

Drugs and Biologicals

Drugs and biologicals do not apply in an ORF setting. Therefore, ORFs must not bill for these services.

Supplies

Some ORFs are currently being reimbursed for supplies on the basis of reasonable cost. However, since supplies are part of the practice expense, under the MPFS these expenses are already taken into account in the practice expense relative values. Therefore, ORFs should not bill for the supplies they furnish.

Vaccines

OPTs must not provide influenza, pneumococcal pneumonia and hepatitis B vaccines and their administration. This **supercedes** current instructions in section 3660.7 of the MIM, which indicates payment is on a reasonable cost basis. ❖

Source: CMS Transmittal A-03-011, CR 2366

SKILLED NURSING FACILITY SERVICES

Correction to Edits Affecting Audiologic Function Tests

An article titled "Billing for Audiologic Function Tests for Beneficiaries that Are Patients of a Skilled Nursing Facility (SNF)" was published in the Fourth Quarter 2001 *Medicare A Bulletin* (page 14) based on Program Memorandum AB-01-71. Those instructions were intended to correct an earlier error in which audiologic function tests provided to SNF beneficiaries **not** in a covered Part A stay were included with speech therapy services and subject to SNF consolidated billing. Audiologic function tests are bundled into the PPS amount for beneficiaries in a covered Part A stay.

However, at the end of calendar year 2002, some fiscal intermediaries reported to CMS that these services, paid under Part B to non-SNF providers, were still being subject to SNF consolidated billing editing. As a result, CMS released an emergency fix of these edits to the common working file hosts, and these new edits were put into production on February 3, 2003.

The audiologic function test procedure codes are listed below. All codes listed have a technical component. Only the two codes identified with an asterisk have a professional component.

Audiologic Function Tests

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

Action Required by Providers

Claims for audiologic function tests furnished **on or after April 1, 2001**, incorrectly rejected under SNF consolidated billing editing may be resubmitted for correct processing. Adjustments for audiologic function tests for dates of service April 1, 2001, through September 30, 2001, will not be subject to timeliness edits, provided the adjustments are submitted by the end of the sixth month from the date of this notification (September 30, 2003). Providers must indicate in the remark section they are resubmitting for audiologic function tests. ❖

Source: CMS Notification Dated February 14, 2003

Restating the Three-Day Window Requirement

In accordance with the Code of Federal Regulations (CFR) section 409.30, a SNF claim generally qualifies for Medicare reimbursement only if the SNF admission was preceded by an inpatient hospital stay of at least three consecutive calendar days, not counting the date of discharge, and was within 30 calendar days after the date of discharge from a hospital.

Some SNFs may not understand that a particular day in a beneficiary's hospital stay may not be considered an inpatient day under the Medicare regulations. The OIG review has concluded that occasionally a beneficiary's hospital stay of three consecutive days will include a day of outpatient services, such as emergency room or observation care preceding the actual inpatient services. When this situation occurs, outpatient services, furnished during the hospital visit, are treated as inpatient services for billing purpose only. However, the first day of inpatient hospital services is the day that the patient is formally admitted as an inpatient, which is subsequent to the patient's release from the emergency room or from observational care. A SNF misunderstanding of these Medicare regulations will result in an incorrect claim of a three consecutive day hospital stay. The hospital's related inpatient claim will appropriately reflect two days of inpatient care.

The legislative authority for coverage of SNF claims is contained in Section 1861 of the Social Security Act. The governing regulations are found in Title 42 of the Code of Federal Regulations. CMS coverage guidelines are found in both the Medicare Intermediary and Skilled Nursing Facility manuals. ❖

CRITICAL ACCESS HOSPITAL SERVICES

January 2003 Update to the Medicare Outpatient Code Editor

The Medicare outpatient code editor (OCE) specifications (version 18.1R1) have been updated with new additions, changes, and deletions to the *CPT*/HCPCS codes.

This OCE update is used to process bills from hospitals that are not paid under the outpatient prospective payment system. Below are the additional changes that were not reflected in previous communications:

Changes Retroactive to January 1, 2001

Nonreportable List Changes

The following HCPCS code were **added** to the list of nonreportable procedures effective January 1, 2001:

G0179 G0180 G0181 G0182

Changes Retroactive to January 1, 2002

Noncovered List Changes

- The following HCPCS code was **added** to the list of noncovered procedures effective January 1, 2002:

  L3677

- The following *CPT* codes were **removed** from the list of noncovered procedures effective January 1, 2002:

  97802 97803 97804

Changes Retroactive to January 1, 2003

HCPCS Code Changes

The following HCPCS codes were **deleted** from the list of valid HCPCS codes effective January 1, 2003:

G0281 G0282 G0283 G0296

Nonreportable List Changes

- The following *CPT*/HCPCS codes were **added** to the list of nonreportable procedures effective January 1, 2003:

  36416 99026 G0256 G0257 G0259
  G0260 G0261 G0263 G0264 G0290
  G0291 G0292 G0293 G0294 J1825
  Q3021 Q3022 Q3023 Q3026

- The following *CPT*/HCPCS codes were **removed** from the list of nonreportable procedures effective January 1, 2003:

  90740 90743 90744 90746 90747 P9011

Changes Effective April 1, 2003

HCPCS Code Changes

- The following HCPCS codes have been **added** to the list of valid HCPCS codes effective April 1, 2003:

  C1207 C9202 C9203 C9204 G0281
  G0282 G0283 K0552 K0560 K0600
  K0601 K0602 K0603 K0604 K0605

- The following HCPCS codes have been **deleted** from the list of valid HCPCS effective April 1, 2003:

  G0258 K0571

Noncovered List Changes

The following *CPT*/HCPCS code were **added** to the list of noncovered procedures effective January 1, 2003:

90871 97014 G0282

Questionable Covered List Changes

The following CPT code was **removed** from the list of questionable covered procedures effective January 1, 2003:

90846

Nonreportable List Changes

The following *CPT*/HCPCS code were **added** to the list of nonreportable procedures effective January 1, 2003:

0019T A4632 A4632 C1207 C9202
C9203 C9204 K0552. ❖

Source: CMS Transmittal A-03-028, CR 2676

RURAL HEALTH CLINIC SERVICES

Guidelines for Signature and Documentation of Medical Records

The current requirements for patient health records for rural health clinics (RHCs) and federally qualified health centers (FQHCs) state that for each patient receiving health care services, the clinic or center maintains a record that includes the following documentation, as applicable:

1. Identification and social data, evidence of consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient.
2. Reports of physical examinations, diagnostic and laboratory test results, and consultative findings.
3. All physician's orders, reports of treatments and medications, and other pertinent information necessary to monitor the patient's progress.
4. Signatures of the physician or other health care professional.

The current interpretive guidelines for signature and documentation of medical records in RHCs and FQHCs do not expand on the above stated policy. However, since the RHC/FQHC regulations and guidelines were published in 1978, medical professionals have been using advances in technology to assist in the development of medical record documentation. CMS has adopted the hospital guidelines for electronic medical records and electronic signatures for other providers. These guidelines are now applicable to RHCs/FQHCs. These guidelines state the following:

1. Only individuals specified in hospital and medical staff policies may make entries in the medical record. All entries in the medical record must be dated and authenticated, and a method established to identify the author. The identification may include written signatures, initials, computer key, or other code.
2. When rubber stamps are authorized, the individual whose signature the stamp represents shall place in the administrative offices of the hospital a signed statement to the effect that he/she is the only one who has the stamp and uses it. There shall be no delegation to another individual. A list of computer or other codes and written signatures must be readily available and maintained under adequate safeguards. There shall be sanctions for improper or unauthorized use of stamp, computer key, or other code signatures.
3. The physician must authenticate the parts of the medical record that are the responsibility of the physician. When nonphysicians have been approved for such duties as taking medical histories or documenting aspects of physician examination, such information shall be appropriately authenticated by the responsible physician. Any entries in the medical record by house staff or nonphysicians that require counter signing by a supervisory or attending medical staff members shall be defined in the medical staff rules and regulations.
4. There must be a specific action by the author to indicate that the entry is verified and accurate. Any system that would meet the authentication requirements are as follows:
   - Computerized systems that require the physician to review the document on-line and indicate that it has been approved by entering a computer code.
   - A system in which the physician signs off against a list of entries that must be verified in the individual record.
   - A mail system in which transcripts are sent to the physician for review, then he/she signs and returns a postcard identifying the record and verifying their accuracy.

A system of auto-authentication in which a physician or other practitioner authenticates a report before transcription is not consistent with these requirements. There must be a method of determining that the practitioner did, in fact, authenticate the document after it was transcribed.

CMS does not expect RHCs/FQHCs to conform to signature guidelines that are more stringent than those stated for hospitals. For example, stamped signature need not be countersigned or initialed by the provider. This would negate the expediency of using a stamped signature. Neither should unsigned dictations be accepted as an acceptable practice. ❖

Source: CMS Transmittal A-03-021, CR 2511

Payment Rate Increase for Rural Health Clinics

CMS has announced a rate increase for calendar year 2003 to upper payment limit per visit for rural health clinics (RHCs). The payment rate increase is as follows:

- For services rendered **January 1, 2003 through February 28, 2003,** the RHC upper payment limit is increased to $66.46, which reflects a 2.6 percent increase over the 2002 upper payment limit in accordance with the rate of increase in the Medicare economic index (MEI) as authorized by section 1833(f) of the Social Security Act. CMS is required to use the 2002 rate of increase in the MEI for this period due to the delayed effective date of the 2003 MEI.
- For services rendered **March 1, 2003 through December 31, 2003,** the RHC upper payment limit is increased to $66.72. The 2003 rate reflects a 3.0 percent increase over the 2002 upper payment limit in accordance with the rate of increase in the MEI as authorized by section 1833(f) of the Social Security Act.

The fiscal intermediary does, however, retain the discretion to make adjustments to the interim payment rate or a lump sum adjustment to total payments already made to take into account any excess or deficiency in payments to date. ❖

Source: CMS Transmittal A-03-021, CR 2511

Payment for Diabetes Self-Management Training and Medical Nutrition Therapy Services

Diabetes self-management training services and medical nutrition therapy services rendered by registered dietitians or nutrition professionals are included under the RHC and FQHC benefit, if all relevant program requirements are met.

Separate payment under Part B to RHCs and FQHCs for these services provided by these practitioners is precluded as set forth in regulations at section 414.63 and 64 as well as in Medicare manuals.

However, RHCs and FQHCs are permitted to become certified providers of diabetes self-management training and medical nutrition therapy services and bundle the cost of such services into their clinic/center payment rates. Please note that the provision of these services would not generate an RHC or FQHC visit. However, the costs of these services can be claimed on the RHC/FQHC cost report and bundled into the all-inclusive payment rate. ❖

Source: CMS Transmittal A-03-021, CR 2511

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

April 2003 Update to the Hospital Outpatient Prospective Payment System

CMS has issued changes to the hospital outpatient PPS for April 2003. The April 2003 update to the outpatient code editor (OCE) and the PRICER software systems reflects HCPCS and ambulatory payment classification addition, changes and revisions, identified in this notification. This article also includes correction of errors that were brought up to CMS attention subsequent to the publication of the January 2003 update, which was published in the electronic version of the 2003 January *Medicare A Bulletin* Special Issue (pages 31-43). Unless otherwise noted, all changes discussed in this notification are effective for services furnished **on or after April 1, 2003.**

New HCPCS Codes Under the Hospital OPPS

The following HCPCS codes are effective for services furnished on or after April 1, 2003:

G0281 Electrical stimulation, (unattended), to one or more areas, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous statsis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care

G0282 Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281

G0283 Electrical stimulation, (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

K0560 Metacarpal phalangeal joint replacement, two pieces, metal (e.g., stainless steel or cobalt chrome), ceramic-like material (e.g., pyrocarbon), for surgical implantation (all sizes, includes entire system)

K0600 Functional neuromuscular stimulator, transcutaneous stimulation of muscles of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program

K0601 Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each

K0602 Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each

K0603 Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each

K0604 Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each

K0605 Replacement battery for external infusion pump owned by patient, lithium, 4.5 Volt, each

Changes Affecting Drugs and Biologicals Eligible for Pass-Through Payments

The following drugs have been designated as eligible for pass-through payment under the OPPS effective April 1, 2003:

C9202 Injection, suspension of microspheres of human serum albumin with octafluoropropane, per 3 ml
Assigned APC: 9202

C9203 Injection, perflexane lipid microsheres, per single use vial
Assigned APC: 9203

C9204 Injection, ziprasidone mesylate, per 20 mg
Assigned APC: 9204

The descriptor for the following pass-through drugs has been corrected. These pass-through drugs are effective January 1, 2003:

J2324 Nesiritide, per 0.5 mg vial

J3487 Injection, zoledronic acid, per 1 mg

Pass-Through Device Category Codes in Effect as of April 1, 2003

Device Categories Eligible for Pass-Through Payment

Below is a complete listing of the device categories that are eligible for pass-through payment under the OPPS, including one new category added effective April 1, 2003. If a device is described by one of the existing device categories but is packaged as a component of a system, only the device that meets the pass-through criteria would be eligible for pass-through payment under the appropriate category.

HCPCS Codes	Descriptor	Effective Date
C1765	Adhesion barrier	July 1, 2001
C1783	Ocular implant, aqueous drainage assist device	July 1, 2002
C1814*	Retinal tamponade device, silicone oil	April 1, 2003
C1884	Embolization protective system	January 1, 2003
C1888	Catheter, ablation, non-cardiac, endovascular (implantable)	July 1, 2002
C1900	Lead, left ventricular coronary venous system	July 1, 2002
C2614	Probe, percutaneous lumbar discectomy	January 1, 2003
C2618	Probe, cryoablation	April 1, 2001
C2632	Brachytherapy solution, iodine – 125, per mCi	January 1, 2003

***New pass-through device category code **effective April 1, 2003.**

April 2003 Update of the Hospital Outpatient Prospective Payment System (continued)

Explanation of Terms/Definitions for Specific Category Codes

Adhesion barrier (C1765) – A bioresorbable substance placed on and around the neural structures, which inhibits cell migration (fibroblasts) and minimizes scar tissue formation. It is principally used in spine surgeries, such as laminectomies and diskectomies.

Catheter, ablation, non-cardiac, endovascular (C1888) – a radiofrequency catheter designed to occlude or obliterate blood vessels (e.g., veins).

Embolization protective system (C1884) – A system designed and marketed for use to trap, pulverize, and remove atheromatous or thrombotic debris from the vascular system during an angioplasty, atherectomy, or stenting procedure.

Left ventricular coronary venous system lead (C1900) – Designed for left heart placement in a cardiac vein via the coronary sinus and is intended to treat the symptoms associated with heart failure.

Retinal tamponade device, silicone oil (C1814) – A device used as a permanent/prolonged retinal tamponade in the treatment of complex retinal detachments. This is used as a post-operative retinal tamponade following vitreoretinal surgery.

Correction to Ambulatory Payment Classifications

The following APC for these *CPT*/HCPCS codes have been corrected effective for services furnished on or after January 1, 2003:

***CPT*/HCPCS Code**	**APC**
76070	0288
G0267	0110
C1207*****	1207
A9518	1348
J1327	1607
C9111	9111

*****HCPCS code C1207 was erroneously designated as a deleted code, however HCPCS code C1207 is **not** deleted.

Changes to Some APCs

The following APC for these *CPT*/HCPCS codes have been changed for services furnished on or after January 1, 2003:

***CPT*/HCPCS Code**	**APC**	***CPT*/HCPCS Code**	**APC**
20910	0027	20912	0027
20920*****	0027	20922	0027
20926	0027	78459	0285
77523	0712	77525	0712
90740	0356	90743	0356
90744	0356	90746	0356
90747	0356	G0237	0706
G0238	0706	G0239	0706
J1327	1607	J1563	0905

Deleted Ambulatory Payment Clasifications

APCs 0026, 0650 and 0916 have been deleted effective January 1, 2003.

Correction to Billing for Radiation Therapy (*CPT* Codes *77401* through *77416*)

The instructions for billing for radiation therapy have been revised to read as follows:

> "*CPT* Codes *77401* through *77416* may be reported more than once per date of service only when radiation treatment is provided during completely different sessions. Only one of these codes may be reported for each treatment session no matter how many areas are treated or no matter how much radiation is delivered**.** *CPT* codes *77402* through *77406* describe treatment delivery for a single treatment area. *CPT* codes *77407* through *77411* describe treatment delivery to two treatment areas. *CPT* codes *77412* through *77416* describe treatment delivery to three **or more** treatment areas. In the cases of *CPT* codes *77407* through *77416*, the number of distinct treatment areas and complexity of the treatment determine which code series to report, which is then modified by the selection of energy (i.e. MV). For example, if three treatment areas are each treated with 11 MV, then the proper code to bill is 77414. It is incorrect to report *77404 – 77414* (for "11-19 MeV") three times. However, if there is a distinct break and the same region or regions are treated again the same day then a second charge describing the energy and level of complexity is appropriate."

Correction to Payment Policy When a Surgical Procedure on the Inpatient List Is Performed on an Emergency Basis or When a Patient Whose Status is Outpatient Dies

Hospital must report patient status code 20 in form locator 22 on a claim for a service billed with modifier CA for services furnished on or after January 1, 2003.

Revision to Partial Hospitalization Program (PHP)

Coding Partial Hospitalization Services

CPT codes *90875* and *90875* are not covered by Medicare and should not be billed for partial hospitalization program patients.

Correction to Changes to Pass-Through Drugs, Biologicals and Radiopharmaceuticals

HCPCS Replacement Codes for Retiring Pass-Through Drugs

Effective for services furnished on or after January 1, 2003, hospital should use HCPCS code A9520, to replace deleted HCPCS code C1202. The crosswalk of HCPCS code C1202 to HCPCS code A9519 indicated previously was an error.

April 2003 Update of the Hospital Outpatient Prospective Payment System (continued)

Charges for Packaged Drug, Contrast Medium, or Radiopharmaceutical Agent Billed Separately and in Addition to Charges for the Procedure with which They Are Associated

Hospitals that bill for a drug, contrast medium, or a radiopharmaceutical agent using revenue code 025x or 062x, either with or without a HCPCS code, must exclude that charge from the charge for the associated procedure for which the drug, contrast, or radiopharmaceutical agent is used.

Example Hospitals may bill G0273 and G0274 using the revenue code that designates where the procedures were performed and include the charge for Zevalin™ within the charge for the appropriate G-code. However, hospitals that bill for Zevalin separately, using HCPCS codes A9522 and A9523, must report A9522 and A9523 using revenue codes 621 and 622. Hospitals that bill for Zevalin separately using HCPCS codes A9522 and A9523 and revenue codes 621 and 622 must report the charge for G0273 and G0274, using the revenue code that designates where the service was furnished, and must exclude the charge for Zevalin from the charge for HCPCS G0273 and G0274.

New Code for Optison

Effective for services furnished **on or after April 1, 2003** hospitals may use new HCPCS code C9202 instead of A9700 to bill for Microspheres with octafluoropropane (Optison).

Billing for Octreotide Acetate Depot

Hospitals must continue to use HCPCS code C1207 to bill for Octreotide acetate depot, 1 mg. This code has not been deleted effective on April 1, 2003. HCPCS code C1207 will continue to be paid under APC 1207 for services furnished on or after April 1, 2003.

Billing for Intravenous Immune Globulin

Hospitals should use HCPCS codes J1563 (Immune globulin, 1 g) and J1564 (Immune globulin, 10 mg) to bill for intravenous immune globulin (IVIG). Hospitals should report J1563 when billing for multiple units of 1-gram quantities of IVIG that they furnish to beneficiaries. One additional unit of J1563 can be reported for residual quantities greater than 0.75 gram. HCPCS J1564 should be reported rarely and only during instances when patients receive residual quantities of IVIG less than 0.75 gram.

Example 1: If a beneficiary receives 40.50 grams of IVIG, the hospital should report 40 service units of J1563 and 50 service units of J1564 using revenue code 636, and the appropriate administration code.

Example 2: If a beneficiary receives 30.80 grams of IVIG, the hospital should report 31 service units of J1563 using revenue code 636, and the appropriate administration code. ❖

Source: CMS Transmittal A-03-020, CR 2671

Further Guidance Regarding Billing Under Outpatient Prospective Payment System

CMS has reissued guidelines to reinstate previous instructions regarding the billing of blood surgical procedures and inpatient Part B services under the outpatient prospective payment system (OPPS).

Proper Billing for Blood Products and Blood Storage and Processing

When a hospital purchases blood or blood products from a community blood bank, or runs its own blood bank and assesses a charge for the blood or blood product, the hospital reports blood and blood products under revenue code series 38x – Blood, along with the appropriate blood HCPCS code. The amount billed should reflect the hospital's charge.

When a hospital does not pay for the blood or blood product, it often incurs an administrative cost from a community blood bank for the bank's processing, storage and related expenses. In this situation, the hospital bills the charge associated with the blood bank storage and processing costs under revenue code 390 – Blood Storage/Processing, and reports the HCPCS code assigned to the blood or blood product and the number of units transfused. Payment is based on the ambulatory payment classification (APC) to which the HCPCS code is assigned, times the number of units transfused.

If a hospital purchases blood, or blood products, or runs its own blood bank, it is **not** appropriate to bill both the blood or blood product under revenue code series 38x and an additional blood bank storage and processing charge under revenue code 390.

A transfusion APC will be paid to the hospital for transfusing blood once per day, regardless of the number of units transfused. Hospitals should bill for transfusion services using revenue code 391 – Blood Administration, and *CPT* code *36430* through *36460***.** The hospital may also bill the laboratory revenue codes (30x or 31x) along with the *CPT*/HCPCS codes for blood typing and cross matching and other laboratory services related to the patient who receives the blood.

Proper Billing of Outpatient Surgical Procedures

When multiple surgical procedures are performed at the same session, it is not necessary to bill separate charges for each procedure. It is acceptable to bill a single charge under the revenue code that describes where the

Further Guidance Regarding Billing Under the Outpatient Prospective Payment System (continued)

procedure was performed (e.g., operating room, treatment room, etc.) on the same line as one of the surgical procedure *CPT*/HCPCS codes and bill the other procedures using the appropriate *CPT*/HCPCS code and the same revenue code, but with "0" charges in the charge field.

In the past, some hospitals billed a single ER visit charge, which included charges for any surgical procedures that were performed in the ER at the time of the ER visit. Under the OPPS, CMS requires hospitals to bill a separate charge for ER visits and surgical procedures effective with claims with dates of service on or after July 1, 2001. If a surgical procedure is performed in the ER, the charge for the procedure must be billed with the emergency room revenue code. If an ER visit occurs on the same day, a charge should be billed for the ER visit and a separate charge should be billed for the surgical procedure(s) performed. As described above, a single charge may be billed for all surgical procedures if more than one is performed in the ER during the same session.

The following is an example of how a claim should be completed under these new reporting requirements:

42 REV. CD.	44 HCPCS/RATES	45 SERV. DATE	47 TOTAL CHARGES
450	*99283*/25	7/5/2001	$150
450	*12011*	7/5/2001	$300
450	*12035*	7/5/2001	
250		7/5/2001	$70
270		7/5/2001	$85

The charge for both surgical procedures in this example is reflected in the $300 charge shown on the line with procedure code *12011*.

Note: This instruction was previously posted on the CMS Web Site as a question and answer with an effective date of January 1, 2001. Since many hospitals did not change their reporting requirements based on the question and answer, this notification reflects a new prospective date of July 1, 2001.

Inpatient Part B Services

Inpatient Part B services paid under OPPS include:

- X-rays and other diagnostic tests (excluding clinical diagnostic laboratory tests)
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians
- Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations (include dental splints) applied during an encounter at the hospital
- Implantable prosthetic devices
- Pneumococcal or hepatitis B vaccine and its administration
- Certain preventive screening services (pelvic exams, screening sigmoidoscopies, screening colonoscopies, bone mass measurements, and prostate screening).

  Note: Payment for some of these services is packaged into the payment rate of other separately payable services.

Inpatient Part B services paid under other payment methods include:

- Clinical diagnostic laboratory tests, prosthetic devices other than implantable ones and other than dental which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.
- Leg, arm, back and neck braces, trusses, and artificial legs, arms, and eyes, including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.
- Take home surgical dressings, outpatient physical therapy, outpatient occupational therapy, and outpatient speech pathology services.
- Ambulance services.
- Screening pap smears, screening fecal occult blood tests, and screening mammography.

HCPCS/Revenue Code Edits

Standard system maintainer will **not** edit for HCPCS and revenue codes relationship for services payable under OPPS with the exception of editing for revenue codes required to be billed with pass-through and nonpass-through medical devices. ❖

Source: CMS Transmittal A-03-014, CR 1585

Holding Outpatient Rehabilitation Claims for *CPT* Code *92597*

CMS has advised fiscal intermediaries of the need to hold claims containing *CPT* code *92597* – Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech. Prior to January 1, 2003, this service was billed using HCPCS code G0200. Through an inadvertent error, the status indicator in the Medicare physician fee schedule database was not changed to reflect *CPT* code *92597* as "active" and payable under the fee schedule. As a result of this error, the April 2003 outpatient code editor (OCE) software did not get updated timely to reflect this change and claims containing this code will not process for payment until the July 2003 OCE software update implementation.

Fiscal Intermediary Action

Claims containing *CPT* code *92597* will suspend to status location S/MCMS1 under reason code 75041 until the July OCE release is implemented.

In addition, claims containing HCPCS code G0200 with dates of service on or after April 1, 2003 will be returned to the provider with reason code 75042 advising them to resubmit evaluation for use and/or fitting of voice prosthetic device to supplement oral speech service using *CPT* code *92597*. ❖

Source: CMS Notification Dated April 4, 2003

FRAUD AND ABUSE

The article originally published on this page has been removed at the request of the Centers for Medicare & Medicad Services

Source: CMS Joint Signature Memorandum 05190, February 8, 2005

The Health Insurance Portability and Accountability Act (HIPAA)

HIPAA Makes Electronic Claims Submission the Best Choice

The following article is a reprint of a narrative written by Cathy Benoit, CMS Atlanta Regional Office HIPAA Coordinator.

Today, a health care provider may do business with a number of health plans, each with its own version of forms, code sets, or identifiers required for payment. The Health Insurance Portability and Accountability Act (HIPAA) sets out to change that. Under HIPAA, all health plans are required to use the standards set forth in this regulation.

The standards established by HIPAA will enable administrative efficiency all across the health care industry. Physicians' offices will have more time for patients and spend less time on paperwork. We will have standard data, which will yield better data; and better data will yield better information. This, in turn, will yield better health outcomes for all of us.

All covered entities must comply with the HIPAA privacy regulations. It is true that if you are a 100 percent paper office, you are not a 'covered entity' and, thus, do not have to comply with the HIPAA rules. But, is that a good business decision? We live in a competitive market. The organizations that embrace HIPAA as a business opportunity and prepare their organization for the future of health care will be able to realize the benefits.

Other industries have gone through their own standardization processes. For example, the banking and grocery industries have embraced technology and standardization to streamline their costs. There was a time when we had to wait in line for a bank teller to process all of our transactions, but now we can use the telephone, computer, or ATM for access to our accounts 24 hours a day, 7 days a week. We are also capable of processing transactions from any banking institution, not just the one where we first opened our account.

Do you recall when the stock clerks worked all night to fill the grocery shelves with priced items, and the cashier had to type in the price of each item into a cash register? Then, when we checked-out, we received a generic receipt. Now, every item is identified by a bar code and is scanned for an itemized receipt. In fact, the grocery stores have streamlined the process to the point that we can checkout ourselves via the U-SCAN-it stations. These changes have proved to provide customers greater benefits while saving the industry's service providers money in the long run.

In both of these industries and many more, the use of electronic standards have revolutionized the way business is conducted. Implementing HIPAA will require the health care industry to change many long used and familiar business processes. Change is difficult for most people, and HIPAA is about change. A change of this magnitude will not happen overnight. It will take time, hard work, communication and possibly investment capital.

HIPAA is the first step in an e-commerce platform for the health care industry. Once the standards are in place, more and more products will be developed that will provide greater benefits to providers and to patients.

Over the past few decades, we have seen health care costs continue to rise. HIPAA will result in more efficient business processes, which should make more money available for health care delivery. We are at a turning point in the health care industry.

It is important for all health care providers to realize that HIPAA is about the future of health care. HIPAA is a long-term benefit rather than a short-term cost or inconvenience. The providers that embrace HIPAA as an opportunity will be in a better position to adjust to changes and take advantage of the EDI [Electronic Data Interchange] benefits. I urge you to consider the following questions.

- Where are the banks that have not embraced ATMs?
- Where are the companies that have not embraced personal computers (or cell phones)?
- Where are the grocery stores that have not embraced checkout scanners?
- If given the choice between Dr. A and Dr. B where the services are equal, and if Dr. A is obligated by federal law to protect your health records and Dr. B is not, whom would you choose?

It is a fact that we live in a competitive market, so I encourage you to consider HIPAA as the first step in preparing your organization for the future of health care.

Can you afford not to? ❖

Benefits of Electronic Claim Filing under HIPAA-AS

The following article was prepared by CMS to promote a consistent message within the provider community.

The April 14, 2003, HIPAA privacy deadline and the April 16, 2003, testing deadline have passed, and the October 16, 2003, deadline for compliance with the HIPAA electronic transactions and code set standards is approaching quickly. Many providers are only now starting to think about what they need to do to become HIPAA compliant. To avoid being a HIPAA-covered entity, some consultants are suggesting that providers consider switching from electronic transmission to paper claims. This advice is extremely shortsighted and certainly not a panacea, especially for Medicare providers. Consider the following:

Requirement to Go to Electronic Claims

Medicare will **not** accept paper claims, effective October 16, 2003. There will be exceptions for small providers and under other limited situations. Regulations are expected soon.

Negative Fiscal Impact of Paper Claims

Processing paper claims takes longer than electronic claims, and has an increased rate of error. Faster payment can be made for electronic claims submitted to Medicare. Electronic Medicare claims can be paid 14 days after they are received, while paper claims cannot be paid before 28 days after receipt. In addition, processing paper claims has increased administrative, postage, and handling costs.

Changes to Business Processes

Switching from electronic transmission to paper claims would have numerous repercussions on the business processes of your office. Remember that HIPAA transactions include more than just claims submission. Providers often conduct eligibility queries, claim status queries, and referral transmission electronically. All of these would have to be done on paper to avoid being a HIPAA covered entity, ultimately leaving less time for patient care and more time devoted to administration. However, you could decide to do some paper transactions and some electronic transactions, but remember that the electronic transactions must be HIPAA compliant.

General HIPAA Information

What is HIPAA?

Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996. There are four main areas that comprise administrative simplification:

1. Electronic Transactions and Code Sets
2. Unique Identifiers
3. Privacy
4. Security

What are the HIPAA Transactions?

Electronic Transaction Standards have been developed for the following exchanges of information that providers conduct:

1. Health care claims or electronic encounter information
2. Health care payment and remittance advice
3. Health care claims status
4. Eligibility inquiry
5. Referral certification and authorization
6. Claims attachment (standards forthcoming)
7. First report of injury (standards forthcoming)

What is a HIPAA Covered Entity?

Under HIPAA, all health care clearinghouses, all health plans, and those health care providers that conduct certain transactions in electronic form or who use a billing service to conduct transactions on their behalf are considered covered entities.

What Is "Electronic?"

The term "electronic" is used to describe moving health care data via the Internet, and extranet, leased lines, dial-up lines such as for "direct data entry" (DDE), private networks, points of service, and health care data that is physically moved from one location to another using magnetic tape, disk, or CD media. For example, if a provider transmits information electronically by transmitting claims, , conducting eligibility queries, conducting claim status queries or referrals, they would be considered a covered entity under HIPAA.

A Benefit to Consider

HIPAA efficiencies include using the same format for all payers rather than separate formats for each payer, as is often done today.

HIPAA Deadlines

April 14, 2003	Privacy – all covered entities except small health plans.
April 16, 2003	Electronic Health Care Transactions and Code Sets – all covered entities must have started internal software and systems testing.
October 16, 2003	Electronic Health Care Transactions and Code Sets – all covered entities that filed for an extension and small health plans.
April 14, 2004	Privacy – small health plans.
April 21, 2005	Security – all covered entities except small health plans.
April 21, 2006	Security – small health plans.

Where To Go For Help:

CMS Web site: *http://www.cms.hhs.gov/hipaa/hipaa2*
HIPAA hotline: 1-866-282-0659
AskHIPAA mailbox, send an email to *askhipaa@cms.hhs.gov*
For more information on privacy, visit *http://www.hhs.gov/ocr/hipaa*
For privacy questions, call 1-866-627-7748? ❖

Source: CMS Notification Dated April 25

HIPAA Resources

Updated March 27, 2003

CMS

Products/Resources

- **Web Site** – *http://www.cms.hhs.gov/hipaa/hipaa2/* – Answers to Frequently Asked Questions, links to other HIPAA sites, and information on the law, regulations, and enforcement are located here.
- **New Regulations** – HHS recently published two rules, the Modifications Rule (modifies the Electronic Transactions and Code Sets Rule) and the final Security Rule. You can find both rules at *http://www.cms.hhs.gov/hipaa/hipaa2/*.
- **Small Provider Checklist Tool** – Use this to help you determine first steps you should be taking to prepare for HIPAA. *http://www.cms.hhs.gov/hipaa/hipaa2/education/ReadinessChkLst.pdf*. Also available in Spanish version: *http://www.cms.hhs.gov/hipaa/hipaa2/education/ReadinessChkLstEsp.pdf*.
- **CMS HIPAA 101 Paper for Providers** – This short paper gets straight to the point describing HIPAA and what it means to providers. This is part of a larger series being developed that walk providers through what they need to know about the electronic transactions and code sets. Stay tuned for more information on the remainder of the series. *http://www.cms.hhs.gov/hipaa/hipaa2/education/HIPAAPaper101–1of1.pdf*. Spanish version: *http://www.cms.hhs.gov/hipaa/hipaa2/education/ReadinessChkLstEsp.pdf*.
- **Covered Entity Decision Tool** – Need help determining if you are covered by HIPAA? Try using this tool found at: *http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/default.asp*.
- **FREE HIPAA Roundtable Conference Call** – This is a good source of information and a forum to get answers to your questions on HIPAA Administrative Simplification. Check the CMS Web site at *http://www.cms.hhs.gov/hipaa/hipaa2/* for future call information.
- **FREE Video and CD–ROM** – Coming Soon! CMS' HIPAA 101 Video and CD-ROM are packed with tips for preparing your office for HIPAA. Stay tuned to our Web site for information.
- **FREE Listserves** – Both listserves are operated by the U.S. Department of Health & Human Services
  Regulations – *http://www.cms.hhs.gov/hipaa/hipaa2/regulations/lsnotify.asp* – Sign up to receive notification when proposed or final rules on HIPAA have been published in the *Federal Register* (The *Federal Register* is the place where the government, upon passing a law, tells the public how the law will be implemented).
  ***New!* Outreach** – *http://list.nih.gov/archives/hipaa–outreach–l.html* – Sign up here to receive free notices on HIPAA announcements, new tools and educational material, and related information.
- **CMS Medicaid HIPAA Web Address** – *http://www.cms.hhs.gov/medicaid/hipaa/adminsim/*
- **Medicare Free/Low Cost Billing Software** – *http://cms.hhs.gov/providers/edi/* – If you bill Medicare, there is software available to you free or for a small charge. This software is designed only for Medicare claims. Check the above link for the appropriate contact in your state for more information.
- **White Paper**: Am I A Covered Entity Provider? *http://www.wedi.org/snip/public/articles/coveredEntitiy.pdf*
- **White Paper**: How HIPAA Is Reshaping The Way We Do Business *http://www.wedi.org/snip/public/articles/centMedicarencaid.pdf*

Contact information for CMS

- **CMS E–Mailbox** – *askhipaa@cms.hhs.gov*. Send HIPAA administrative simplification questions here.
- **CMS HIPAA Hotline** – 1-866-282-0659 – This hotline has been established to help answer your HIPAA administrative simplification questions.

Other Resources

- **HHS' Office for Civil Rights (Privacy) –** *http://www.hhs.gov/ocr/hipaa/* – The U.S. Department of Health & Human Services' Office for Civil Rights oversees the privacy requirements.
  - ***New!* OCR Posts Frequently Asked Questions** to their Web Site at: *http://www.hhs.gov/ocr/hipaa/whatsnew.html*.
  - Model "Business Associate Agreement" at: *http://www.hhs.gov/ocr/hipaa/contractprov.html*
  - "Guidance Explaining Significant Aspects of the Privacy Rule" at: *http://www.hhs.gov/ocr/hipaa/privacy.html*.

  Contact information
  - *OCRPrivacy@hhs.gov* or
  - Call 1-866-627-7748.
- **WEDI SNIP Web site** –*http://www.wedi.org/snip/* – WEDI is an organization working to foster widespread support for the adoption of electronic commerce within healthcare and SNIP is a collaborative healthcare industry–wide process resulting in the implementation of standards and furthering the development and implementation of future standards. This Web site contains various resources on HIPAA administrative simplification.
  - Materials from CMS HIPAA Workshop for Small / Rural Health Care Providers – *http://www.wedi.org/snip/public/articles/details%7E56.htm*
  - Find out if your state has a local WEDI SNIP affiliate – Go to *http://www.wedi.org/snip/public/articles/index%7E8.htm.* ❖

Source: CMS Region IV HIPAA Coordinator

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.*

HIPAA-AS Transactions and Code Sets: Testing and Updates

HIPAA-AS requires each electronic submitter to submit all of their electronic claims, claim status inquiries, and eligibility inquiries in compliance with the X12N version 4010A1 requirements, **by October 16, 2003.** If you have successfully tested the 837-claim version 4010 with Medicare, you do **not** need to be retested on 4010A1.

The Administrative Simplification Compliance Act (ASCA) requires entities that requested a one-year extension to start testing their systems no later than April 16, 2003 (this requirement relates to the entities own internal testing, not testing with Medicare).

Providers who use clearinghouses, billing services or vendor software are urged to follow up with these associates to ensure they are testing with payers well in advance of the deadline. Our provider education Web site (*www.floridamedicare.com.*) has a list of electronic billing vendors who have passed testing with First Coast Service Options, Inc. (FCSO).

To schedule testing of the 4010A1 Inbound 837 Claim with Medicare, call:

1-904-791-6865

HIPAA noncompliant (but previously approved version) submissions **will not be rejected prior to October 16, 2003,** regardless of whether the provider applied for an ASCA extension prior to October 16, 2002. Medicare will **not** charge for processing paper claims.

There is a host of Internet sites available to learn more about HIPAA-AS and to obtain up-to-date information. Please visit our provider education Web site for more information and links to other sites.

Support Continues for Low Cost HIPAA Billing Software

The Centers for Medicare & Medicaid Services will continue support of low cost HIPAA Medicare billing software through fiscal year 2004 and beyond.

FCSO supports the PC-ACE Pro32® software. To learn more about using this software, call 1-904-791-8767, extension 1. ❖

Source: CMS Notification March 26,2003

HIPAA Information Series

The first edition to CMS HIPAA Information Series was reproduced in the Second Quarter 2003 *Medicare A Bulletin* (pages 37-40). That edition, called "HIPAA 101," has now been supplemented with editions two and three. To access this information, visit the CMS Web site at *www.cms.hhs.gov/hipaa/hipaa2/education/infoserie/* for "Are you a covered entity?" and "Key HIPAA dates and tips for getting ready." Seven additional installments are coming soon. You can also visit *www.cms.hhs.gov/hipaa/hipaa2/* for CMS's all-in-one reference site for HIPAA–AS including a countdown for upcoming compliance deadlines. ❖

Provider HIPAA Readiness Checklist

CMS has developed a checklist to help you determine your office's readiness for HIPAA compliance. We published this checklist in the Second Quarter 2003 *Medicare A Bulletin* (pages 35-36), and the list is also available on the CMS Web site at *www.cms.hhs.gov/hipaa/hipaa2/education/readinesschklst.doc*. ❖

ELECTRONIC DATA INTERCHANGE

Medicare A of Florida to Begin Testing and Support of HIPAA-AS Addenda Transactions

Effective April 7, 2003, First Coast Service Options, Inc. (FCSO) begun supporting the Addenda version (4010A1) for the following transactions:

- X12N 837 Inbound Claims Transaction
- X12N 835 Remittance Advice
- X12N 276/277 Claim Status Inquiry/Response

All current health care claim and remittance advice formats will be supported through October 16, 2003. ***As of October 16, 2003, only the 4010 Addenda version of the transactions noted above will be supported.***

Important: *If you do not contact us to schedule your test before July 2003, it may not be possible to guarantee a testing date before the October 16, 2003 compliance deadline. We therefore strongly encourage you to call early to schedule your testing.*

837 – Inbound Claims Transaction

Effective October 16, 2003, Medicare will *only* accept the Addenda version of the ANSI 837 claims transaction. **Between April 7 and October 15, 2003,** Medicare will support both the 4010 and 4010 Addenda versions of the 837 Inbound Claims Transaction.

Senders and vendors who have not previously been approved to send Medicare A claim files in ANSI version 4010 must schedule testing for the 4010 Addenda. Those currently approved to transmit electronic files in ANSI version 4010 are not required to re-test. Also, if your vendor has supplied you with 4010 Addenda software, you are not required to re-test.

Testing of the Addenda version is anticipated to begin April 7, 2003. To schedule testing, or for additional information about the 837 transaction, please call Audrey Lipinski at 1-904-791-6865, or via email at *Audrey.Lipinski@fcso.com*.

835 – Remittance Advice Transaction

Effective October 16, 2003, Medicare will ***only*** generate the 4010 Addenda version of the ANSI 835 remittance advice. Between April 7 and October 15, 2003, Medicare will generate both the 4010 and 4010 Addenda versions of the 835-remittance advice.

Testing of the 4010 Addenda version of the remittance advice is anticipated to begin April 7, 2003. Users who have successfully tested the 4010 remittance advice transaction are not required to re-test the 4010 Addenda transaction.

We encourage testing of the outbound remittance advice in either version 4010 or 4010 Addenda for users who have not tested version 4010.

To schedule testing or for additional information about the 835 transaction, please call Cynthia Moore at 1-904-791-8254, or via email at *Cynthia.Moore@fcso.com*.

276/277 – Claim Status Request and Response

Effective April 7, 2003, only the 4010 Addenda version of the 276/277 transaction will be accepted; version 4010 will not be accepted at any time. Testing is anticipated to begin at that time.

To schedule testing or for additional information about the 276/277 transactions, please call Peggy Kelly at 1-904-791-0912, or via email at *Peggy.Kelly@fcso.com*.

How To Obtain Addenda Information

The final updated Designated Standards Maintenance Organizations (DSMO) Addenda pages for all transactions are available at *http://hipaa.wpc-edi.com/HIPAAAddenda_40.asp*.

Additional information regarding the ANSI version 4010 Addenda transactions will be provided to senders, vendors, and clearinghouses as information becomes available.

Special Information for PC-ACE Pro32® Customers

PC-ACE Pro32® anticipates the addenda version (4010A1) will be available to all existing PC-ACE Pro32® users April 1, 2003. Senders who have elected to download the program will be notified via email by April 1, 2003. All other senders will receive a CD upgrade scheduled to be distributed between April 7 – 9, 2003. If you wish to switch from receiving a CD to start downloading updates, please contact Technical Support at 1-904-355-0313. ❖

Source: CMS Transmittal AB-03-026, CR 2385

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.*

ASC X12N 270/271 Eligibility Benefit Inquiry and Response Transaction—Real-Time Access

The ASC X12N 270/271 Eligibility Benefit Inquiry and Response Transaction is a "paired" transaction (270 is an inbound eligibility inquiry; 271 is an outbound eligibility response). The 270/271 (004010X092A1) Implementation Guide may be downloaded without charge from *www.wpc-edi.com/HIPAA*.

Florida fiscal intermediary (FI) will support provider access to real-time eligibility information via the ASC X12N 270/271, using TCP/IP (transition control protocol/internet protocol) connectivity **on or about July 1, 2003.** The FI will build upon existing network connectivity to provide a TCP/IP port connecting to the common working file (CWF) system supplied eligibility module. The interface runs in a CICS (customer interactive control service) mainframe environment. Providers will be able to dial in and connect directly to the CWF module through an IP socket. Billing services, clearinghouses, network service vendors and providers that want to use this connectivity are required to have supporting software and technical expertise to implement this communication method.

Providers that prefer to obtain eligibility data in an EDI (electronic data interchange) format but not use the ASC X12N 270/271 Eligibility Benefit Inquiry and Response Transaction may contract with a clearinghouse to translate the information on their behalf; however, that providers will be liable for any clearinghouse costs.

Detailed information pertaining to the Addenda version of the ASC X12N 270/271 and related connectivity requirements is available on the provider education Web site *www.floridamedicare.com*. If you do not have access to the Internet, please contact us at 1-904-791-8131 to request a hard copy of this information.

To help providers make educated and timely decisions, Medicare will furnish basic information on the HIPAA-AS standard transaction requirements (such as the 270/271). However, Medicare will **not** furnish in-depth training on the use and interpretation of the standards' Implementation Guides. Providers who need in-dept training for their staff are expected to seek it from commercial vendors, their clearinghouse, or through standards development organizations.

Thank you for your continued support of the eligibility transaction. ❖

Source: CMS Transmittal AB-03-036, CR 2576

Health Care Claim Status Request and Response ASC X12N 276/277

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers must use health care claims status category codes and health care claim status codes approved by the Health Care Code Maintenance Committee.

These codes can be found at *http://www.wpc-edi.com/StatusCategory_40.asp and http://www.wpc-edi.com/ClaimStatus_40.asp*. Included in the code lists are specific details such as the date when a code was added, changed or deleted.

We will provide information in future issues of the *Medicare A Bulletin* regarding implementation of the update to the claims status category codes and health care claim status codes for use with the Health Care Claim Status Request and Response, ASC X12N 276/277. In addition, we will inform providers of any new codes that may be seen in ASC X12N 277 responses. ❖

Source: CMS Transmittal AB-03-029, CR 2555

ELECTRONIC CLAIM SUBMISSION

Remittance Advice Remark and Reason Code Update

CMS is the national maintainer of the remittance advice remark code list that is one of the code lists mentioned in ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010 Implementation Guide (IG). Under the Insurance Portability and Accountability Act (HIPAA), all payers have to use reason and remark codes approved by X12-recognized maintainers instead of proprietary codes to explain any adjustment in the payment. As a result, CMS received a significant number of requests for new remark codes and modifications in existing remark codes from non-Medicare entities. These additions and modifications may not impact Medicare. Traditionally, Medicare staff in conjunction with a policy change request remark code changes that impact the Medicare program. Contractors are notified of those new/modified codes in the corresponding implementation instructions in the form of a program memorandum (PM) or manual instruction implementing the policy change, in addition to the regular code update PM. The code changes initiated by Medicare have been identified in this article to single out codes implemented by contractors effective April 1, 2003.

Remittance Advice Remark and Reason Code Update (comtinued)

The list of remark codes is available at *http://www.cms.gov/providers/edi/hipaadoc.asp* and *http://www.wpc-edi.com/hipaa/*, and the list is updated each March, July, and November. The following list summarizes changes made through October 31, 2002.

New Remark Codes

Code	Current Narrative
N117*	This service is paid only once in a lifetime per beneficiary.
N118*	This service is not paid if billed more than once every 28 days.
N119*	This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive days in any inpatient or SNF (Part B) facility within those 28 days.
N120*	Payment is subject to home health prospective payment system partial episode payment adjustment. Beneficiary transferred or was discharged/ readmitted during payment episode.
N121*	Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered skilled nursing facility stay.
N122*	Mammography add-on code cannot be billed by itself.
N123*	This is a split service and represents a portion of the units from the originally submitted service.
N124*	Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/ item was furnished that we would not pay for it, and the patient agreed to pay.
N125*	Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to this refund requirement in two cases: • If you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service/ item; or • If you notified the beneficiary in writing before providing it that Medicare likely would deny the service/item, and the beneficiary signed a statement agreeing to pay. If an exception applies to you, or you believe the carrier was wrong in denying payment, you should request review of this determination by the carrier within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30 days, you may delay refunding to the beneficiary until you receive the results of the review. If the review determination is favorable to you, you do not have to make any refund. If the review is unfavorable, you must make the refund within 15 days of receiving the unfavorable review decision. You may request review of the determination at any time within 120 days of receiving this notice. A review requested after the 30-day period 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 or she may be entitled to a refund of any amounts paid, if you should have known that Medicare would not pay and did not tell him or her. It also instructs the patient to contact your office if he or she does not hear anything about a refund within 30 days. The requirements for refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact this office.
N126*	Social Security Records indicate that this individual has been deported. This payer does not cover items and services furnished to individuals who have been deported.
N127*	This is a misdirected claim/service for a United Mine Workers of America beneficiary. Submit paper claims to: UMWA Health and Retirement Funds, PO Box 389, Ephraim, UT 84627-0361. Call Envoy at 1-800-215-4730 for information on electronic claims submission.
N128	This amount represents the prior to coverage portion of the allowance.
N129	This amount represents the dollar amount not eligible due to the patient's age.
N130	Consult plan benefit documents for information about Restrictions for this service.
N131	Total payments under multiple contracts cannot exceed the allowance for this service.
N132	Payments will cease for services rendered by this US Government debarred or excluded provider

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Remittance Advice Remark and Reason Code Update (comtinued)

Code	Current Narrative
	after the 30 day grace period as previously notified.
N133	Services for predetermination and services requesting payment are being processed separately.
N134	This represents your scheduled payment for this service. If treatment has been discontinued, please contact Customer Service.
N135	Record fees are the patient's responsibility and limited to the specified co-payment.
N136	To obtain information on the process to file an Appeal in Arizona, call the Department's Consumer Assistance Office at (602) 912-8444 or (800) 325-2548.
N137	You, the provider, acting on the Member's behalf, may file an appeal with our Company. You, the provider, acting on the Member's behalf, may file a complaint with the Commissioner in the state of Maryland without first first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The Commissioner's address: Commissioner Steven B. Larsen, Maryland Insurance Administration, 525 St. Paul Place, Baltimore, MD 21202 - (410) 468-2000.
N138	In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review.
N139	Under the Code of Federal Regulations, Chapter 32, Section 199.13 a non-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.
N140	You have not been designated as an authorized OCONUS provider, therefore, are not considered an appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.
N141	The patient was not residing in a long-term care facility during all or part of the service dates billed.
N142	The original claim was denied. Resubmit a new claim, not a replacement claim.
N143	The patient was not in a hospice program during all or part of the service dates billed.
N144	The rate changed during the dates of service billed.
N145	Missing/incomplete/invalid provider identifier for this place of service.
N146	Missing/incomplete/invalid/not approved screening document.
N147	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.
N148	Missing/incomplete/invalid date of last menstrual period.
N149	Rebill all applicable services on a single claim.
N150	Missing/incomplete/invalid model number.
N151	Telephone contact services will not be paid until the face-to-face contact requirement has been met.
N152	Missing/incomplete/invalid replacement claim information.
N153	Missing/incomplete/invalid room and board rate.
N154	This payment was delayed for correction of provider's mailing address.
N155	Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.
N156	The patient is responsible for the difference between the approved treatment and the elective treatment.

Modified Remark Codes

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 within 120 days of the date of this notice. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from

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Remittance Advice Remark and Reason Code Update (comtinued)

Code	Current Narrative
	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 of the date of this notice. 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 120 days of the date of this notice. 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. 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 120 days of the date of this notice (or, for a medical insurance review, within 120 days of the date of this notice). You may make the request through any Social Security office or through this office.
M80	Not covered when performed during the same session/date as a previously processed service for the patient.
MA0*	(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 120 days of the date of this notice, 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 reasonable and necessary 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. If your carrier issues telephone review decisions, a professional provider should phone the carrier's office for a telephone review if the criteria for a telephone review are met.
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 reconsideration within 120 days of the date of

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Remittance Advice Remark and Reason Code Update (comtinued)

Code	Current Narrative
	this notice. Decisions made by a Quality Improvement Organization (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 reasonable and necessary denial, a SNF non-certified 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.
MA03*	(Medicare Hearing) – If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you received a

Code	Current Narrative
	revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence, which could affect our decision. An institutional provider, e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a reasonable and necessary 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.
N22*	This procedure code was changed because it more accurately describes the services rendered.
N104*	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS Web site at *www.cms.hhs.gov.*

X12 N 835 Health Care Claim Adjustment Reason Codes

The Health Care Code Maintenance Committee maintains the health care claim adjustment reason codes. An updated list is posted three times a year after each X12 trimester meeting at *http://www.wpcedi.com/hipaa/*. All reason code changes from July 2002 to October 2002 are listed here. The current reason code set was installed April 1, 2003.

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 PM. 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 periodically issue a PM to provide a summary of changes in the reason and remark codes introduced since the last update PM, and will establish the deadline for Medicare contractors to implement the reason and remark code changes applicable to Medicare that may not already have been implemented as part of a previous Medicare policy change instruction.

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

New Reason Codes

149* Lifetime benefit maximum has been reached for this service/benefit category.

150* Payment adjusted because the payer deems the information submitted does not support this level of service.

151* Payment adjusted because the payer deems the information submitted does not support this many services.

152* Payment adjusted because the payer deems the information submitted does not support this length of service.

153* Payment adjusted because the payer deems the information submitted does not support this dosage.

154* Payment adjusted because the payer deems the information submitted does not support this day's supply.

Modified Reason Codes

35 Lifetime benefit maximum has been reached.

Retired Reason Codes

57* Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply. (Inactive for version 4050)

88 Adjustment amount represents collection against receivable created in prior overpayment. (Inactive for version 4050)

Source: CMS Transmittal AB-03-012, CR 2546

*Medicare Initiated

EDUCATIONAL RESOURCES

Web Cast Schedule and Registration Information

As communicated in the Second Quarter 2003 *Medicare A Bulletin*, FCSO is offering live online instructor-led educational sessions, called Web casts, at no cost, through our Florida provider education Web site (*www.floridamedicare.com*).

FCSO will be facilitating the following Web casts at the dates and times indicated below:

Date	Time	Topic
Thursday, May 8, 2003*	3:30 – 5:00 EST 2:30 – 4:00 CST	How to Get Paid Under HIPAA
Tuesday, July 1, 2003	3:30 – 5:00 EST 2:30 – 4:00 CST	Procedure Code to Diagnosis or Other Current Major Issue
Thursday, July 31, 2003	3:30 – 5:00 EST 2:30 – 4:00 CST	Medicare Fee Schedule and Overpayment or Other Current Major Issue
Thursday, September 4, 2003	3:30 – 5:00 EST 2:30 – 4:00 CST	HIPAA from a FCSO EDI Perspective

***** If you were unable to attend this "live" session, you may view the recorded session by accessing our Web site.

The following frequently asked questions (FAQs) have been developed to give you further details on how to register and attend these Web casts:

Web Cast Frecuent Asked Questions

1Q. What is a Web cast?

1A. A Web cast, also known as a Webinar or Web conference, is an interactive, Internet-based educational delivery method that allows the user to attend at a time and location convenient to his/her schedule. An Internet browser is used to view presentation slides, tour Web sites displayed by the presenter, submit questions through the chat room feature, respond to questions asked by the presenter, and to complete course evaluation forms. The audio portion of the presentation is delivered through a sound card in the user's personal computer (PC) or telephone.

2Q. What are the system requirements needed to participate?

2A. ***Browser:*** Netscape Navigator 4.0 or higher, Microsoft Internet Explorer 4.01 or higher, Java™ and JavaScript™ and cookies-enabled browser

Computer: Pentium-based PC with Windows 95, 98, 2000, XP, or NT 4.0, Mac OS 9.x or later, PowerPC Macintosh G3, Solaris 7, or Solaris 8

Internet Connection: 56 Kbps or faster

Display: 800 X 600 resolution or higher; optimal viewing at 1024 X 768 resolution

3Q. Is there a cost to participate in a Web cast?

3A. There are no costs associated with participating in a Web cast, other than those associated with traveling to a registered host site in your local area.

4Q. Why is registration being conducted through host sites?

4A. In order to reach the maximum number of providers through this medium, FCSO has developed a host site registration process. FCSO is partnering with various hospital and medical facilities throughout Florida, including places not typically reached through traditional training methods, to provide you with a variety of host sites for these events. The host site list has been posted to our provider education Web site. The list of host sites may change periodically; so continue to monitor our Web site for the most current information. As an additional feature, you will have the ability to register online or print a registration form and fax it directly to the host site of your choice!

5Q. How can I locate a registered host site in my area?

5A. To access a list of registered host sites in your area, perform the following steps:

- Go to *www.floridamedicare.com*
- Click on the *e-Learning* link on the *What's New* or *Education-Training* page
- Click on the *Host Site Information* link at the top of the FCSO E-Learning page
- On the Florida map, locate and click on the city where your office is located
- Choose a host site at a convenient location

6Q. Once I find a host site in my area, how do I register to participate in the Web cast?

6A. Once you have located a registered host site with an *open* status at a convenient location, you may:

- Register online by clicking the *Online Registration* link at the top of the page, or

Web Cast Schedule and Registration Information (continued)

- Print a registration form and fax it to the number indicated. To access the Faxable Registration Form, click on the link at the top of the page, or
- Call the contact person indicated

Note: If status indicates full, then look for another host site in your area.

7Q. How often is the host site information updated?
7A. The host site information is updated frequently, so check our Web site for the most current information!

8Q. If I cannot attend the *live* event, can I view a recording?
8A Yes. FCSO will record each session and place a link to the archived video and audio recording on our provider education Web site. The session can be accessed up to 90 days from the date of the event. Your PC must possess a sound card to hear the audio recording.

9Q. How can I access the archived event?
9A. Approximately two days after the event, a link to the archived event will be posted on our provider education Web site.

10Q. Can I obtain a CD-ROM containing the recorded event and materials?
10A. Yes. CD-ROMs containing the recorded event and materials will be available at a nominal cost that includes development, shipping, and handling. Ordering information will be posted to the provider education Web site. ❖

Medicare A Bulletin Reader Survey

A customer satisfaction survey was included in the Second Quarter 2003 issue of the *Medicare A Bulletin.* We would like to take this opportunity to thank all of you for sharing your opinions, comments and recommendations. Overall, the results were favorable although the participation was low.

One reader indicated, "sometimes the same item is discussed in different sections." Although this may appear to be true, articles contained in some sections of our publication are intended to inform all Medicare Part A providers of new initiatives, coverage and guidelines. On the other hand, the information included in specific sections is targeted to specific providers or facility settings since the same billing guidelines and reimbursement methods may not apply to all the facilities.

We will continue to solicit input from our readers and we are always open to your suggestions and ideas. Our next reader survey is scheduled to coincide with the publication of the Fourth Quarter 2003 *Medicare A Bulletin.* In addition, we will provide an enhanced online version to make your participation as easy as possible.

You may always provide feedback concerning this publication at any time by writing to the Medicare Communication and Education department at the address on page 2 of this publication. Listening to our customers is one of our organization's values.

We appreciate your time and support in assisting us to improve your *Medicare A Bulletin.* ❖

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

www.FloridaMedicare.com —
Florida Medicare's Provider Education Web Site

The following outlines the types of information available on the First Coast Service Options, Inc. (FCSO) Florida Medicare provider education Web site.

New Releases

Pages within the site containing information of immediate interest.

- ***What's New*** - Recent additions to specific areas within the site as well as other pertinent Medicare program change headlines and highlights.
- ***HIPAA*** - Information about the Health Insurance Portability and Accountability Act.

Content–Part A and B

Both areas contain the following:

- ***Special Release Articles*** - Articles of immediate interest that will also be published in the next regularly scheduled quarterly publication.
- ***Bulletins/Publications*** - FCSO Medicare quarterly and special issue publications (*Medicare A Bulletin* and *Medicare B Update!*).
- ***CMS/DHHS Publications*** - Publications issued by the Centers for Medicare & Medicaid Services (CMS), and Department of Health and Human Services (DHHS).
- ***Medical Policy*** - FCSO Medicare final and draft local medical review policies (LMRP), FCSO's list of self-administered drugs, links to CMS national coverage files, and more.
- ***Fraud, Abuse, and Waste*** - Articles and resources relative to Medicare providers.
- ***Self-Administered Drugs*** - Medicare payment for drugs and biologicals furnished incident to a physician's service.

Part A

Additional information found within the Part A area of the site (not inclusive).

- ***PPS*** - Prospective payment systems.
- ***Issues*** - Document containing a status of the most commonly reported Part A claim and system issues.
- ***Reason Codes*** - Part A reason codes.

Part B

Additional information found within the Part B area of the site (not inclusive).

- ***Crossovers/Medigap*** - A listing of Medigap insurers and supplemental insurers (automatic crossover), and other helpful information.

MCS

- Contains publications relative to FCSO's conversion to the Multi-Carrier System (MCS). Also includes the Part B System Issues Log.

Shared Content

Provides information shared by Part A and Part B providers.

- ***Education & Training*** - Educational resources and calendar of events featuring online registration capabilities.
- ***Electronic Data Interchange (EDI)*** - Publications/news, forms/ applications, specification manuals for programmers and guidelines relevant to electronic transactions.
- ***FAQs*** - Providers' most frequently asked questions and answers.
- ***Fee Schedules*** - Medicare physicians fee schedule files and links to CMS files for download for Medicare payment systems.
- ***Forms*** - Various FCSO and CMS enrollment applications and forms.
- ***General Info*** - Information about other Medicare topics (not inclusive):
  - ***COB/MSP*** - Coordination of Benefits/Medicare Secondary Payer.
- ***Medicare Enrollment*** - Medicare provider enrollment applications and forms with instructions, which include paper and electronic versions of the CMS-855s.
- ***MEDPARD*** - Medicare Participating Physician and Supplier Directory.
- ***UPIN*** - Access to FCSO and national UPIN (unique physician identification number) directories.

Extras

- ***eNews*** - FCSO electronic mailing list. Sign up to receive automatic email notification when new or updated information is posted to Florida Medicare's provider education Web site.
- ***Search*** - Enables visitors to search the entire site or individual areas within the site for specific topics or subjects.
- ***Links*** - Valuable links to resources on other Web sites.
- ***Contact Us*** - Important telephone numbers and addresses.

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).

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
_____	***Medicare A Bulletin* Subscriptions** - One subscription of the *Medicare A Bulletin* is sent free of charge to all providers with an active status with the Medicare Part A program. Non-providers (e.g., billing agencies, consultants, software vendors, etc.) or providers who need additional copies at other office facility locations may purchase an annual subscription. This subscription includes all Medicare bulletins published during calendar year 2003 (back issues sent upon receipt of the order). Please check here if this will be a: [ ] Subscription Renewal or [ ] New Subscription	700284	$65.00

Subtotal $ _____

Tax **(add % for your area)** $ _____

Total $ _____

Mail this form with payment to:

First Coast Service Options, Inc.

Medicare Publications - ROC 10T

P.O. Box 45280

Jacksonville, FL 32232-5280

Facility Name:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Attention:_____ Area Code/Telephone Number:_____

Please make check/money order payable to: BCBSFL- FCSO Account #700284

(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)

ALL ORDERS MUST BE PREPAID -

DO NOT FAX - PLEASE PRINT

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

REQUEST FOR RECONSIDERATION or APPEAL OF *PART A* MEDICARE CLAIM

First Coast Service Options, Inc.
Medicare Part A Appeals
P.O. Box 45053
Jacksonville, FL. 32232-5053

☐ Part A Reconsideration (Inpatient SNF services / i.e. TOB 21X)

☐ Part B (of A) Appeal (Hospital Outpatient and Outpatient SNF services. TOB 131,141,74,75,)

This form can be downloaded at *www.FloridaMedicare.com*.

1. Provider's Name and Number

Address

City, State, and Zip Code

2. Beneficiary's Name

Address

City, State, and Zip Code

3. Health Insurance (Medicare) Claim Number of the Beneficiary

4. I do not agree with the determination made on the claim as described on the Explanation of Medicare Benefits dated: ____/____/____

5. The reason that I do not agree with the determination made is as follows: (attach additional documentation if necessary)

6. Please accept this as a request for an appeal for payment on the denied services, which are indicated on this form.
Signature (required)

Relationship to beneficiary

Address

City, State, and Zip Code

Name of Intermediary

7. Attachments
Please attach and submit any evidence (i.e. medical records) to support a reversal of the denial**. If medical records are not attached, then a medical determination for payment may not be made. For all technical denials, an SSA1696U4* (appointment of representative) form must be attached.**

☐ The medical records are attached.

☐ The appointment of representative form is attached.

8. Description of services being appealed	9. Dates of service	10. Claim Amount ($ in dispute)	11. **Initial Denial Date
a.	a.	a.	a.
b.	b.	b.	b.
c.	c.	c.	c.
d.	d.	d.	d.
e.	e.	e.	e.

****The appeal must be submitted within 120 days of the initial denial.**

* The SSA1696U4 form is required in the event that the provider does not have appeal rights and the beneficiary is liable. This most often occurs when Medicare services are rendered without a physician's order. The beneficiary may appoint the provider to represent him in an appeals process by submitting this form to the Medicare intermediary. The form may be downloaded at ***www.ssa.gov/online/forms.html***.

The following is for internal usage by the intermediary only:

Number of Cases _____ Number of Claims _____ Focus Code _____ Review Decision _____

Reason for Decision (65i) _____ DCN _____ Type of Bill ____ Total Amount Awarded ($) _____

Analyst _____ Received JD ____ Set-up JD _____ Completion JD _____ Denial Code _____ Requestor Type _____

MR Analyst ____ Dx Code _____ Services Received _____Set-up by _____ SNF # days paid _____ From __

A

B

C

D

D (continued)

E

F

G

H

Diagnostic Tests, 70100-89399 (continued)

Medicine, 90281-99199

Medicine 90281-99199 (continued)

HCPCS Codes

Addresses

CLAIMS STATUS

Coverage Guidelines
Billing Issues Regarding
Outpatient Services, CORF, ORF, PHP
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

APPEAL RECONSIDERATIONS

Claim Denials (outpatient services only)
Medicare Fair Hearings (Part A)
P. O. Box 45203
Jacksonville, FL 32232-5203

MEDICARE SECONDARY PAYER (MSP)

Information on Hospital Protocols
Admission Questionnaires
Audits
Medicare Secondary Payer
Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

General MSP Information
Completion of UB-92 (MSP Related)
Conditional Payment
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Automobile Accident Cases
Settlements/Lawsuits
Other Liabilities
Medicare Secondary Payer Subrogation
P. O. Box 44179
Jacksonville, FL 32231-4179

PROVIDER EDUCATION

Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Seminar Registration Hotline
1-904-791-8103

ELECTRONIC CLAIM FILING

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

FRAUD AND ABUSE

Medicare Anti-fraud Branch
P. O. Box 45087
Jacksonville, FL 32232-5087

REVIEW REQUEST

Denied claims that may have been payable under the Medicare Part A program
Medicare Part A Reconsiderations
P. O. Box 45053
Jacksonville, FL 32232-5053

OVERPAYMENT COLLECTIONS

Repayment Plans for Part A Participating Providers
Cost Reports (original and amended)
Receipts and Acceptances
Tentative Settlement Determinations
Provider Statistical and Reimbursement (PS&R) Reports
Cost Report Settlement (payments due to provider or Program)
Interim Rate Determinations
TEFRA Target Limit and Skilled Nursing Facility Routine Cost Limit Exceptions
Freedom of Information Act Requests (relative to cost reports and audits)
Provider Audit and Reimbursement Department (PARD)
P.O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

MEDICARE REGISTRATION

American Diabetes Association Certificates
Medicare Registration – ADA
P. O. Box 2078
Jacksonville, FL 32231-2078

Phone Numbers

PROVIDERS

Customer Service Representatives
1-877-602-8816

BENEFICIARY

1-800-333-7586

ELECTRONIC MEDIA CLAIMS

EMC Start-Up
1-904-791-8767, option 4

Electronic Eligibility
1-904-791-8131

Electronic Remittance Advice
1-904-791-6865

Direct Data Entry (DDE) Support
1-904-791-8131

PC-ACE Support
1-904-355-0313

Testing
1-904-791-6865

Help Desk (Confirmation/Transmission)
1-904-905-8880

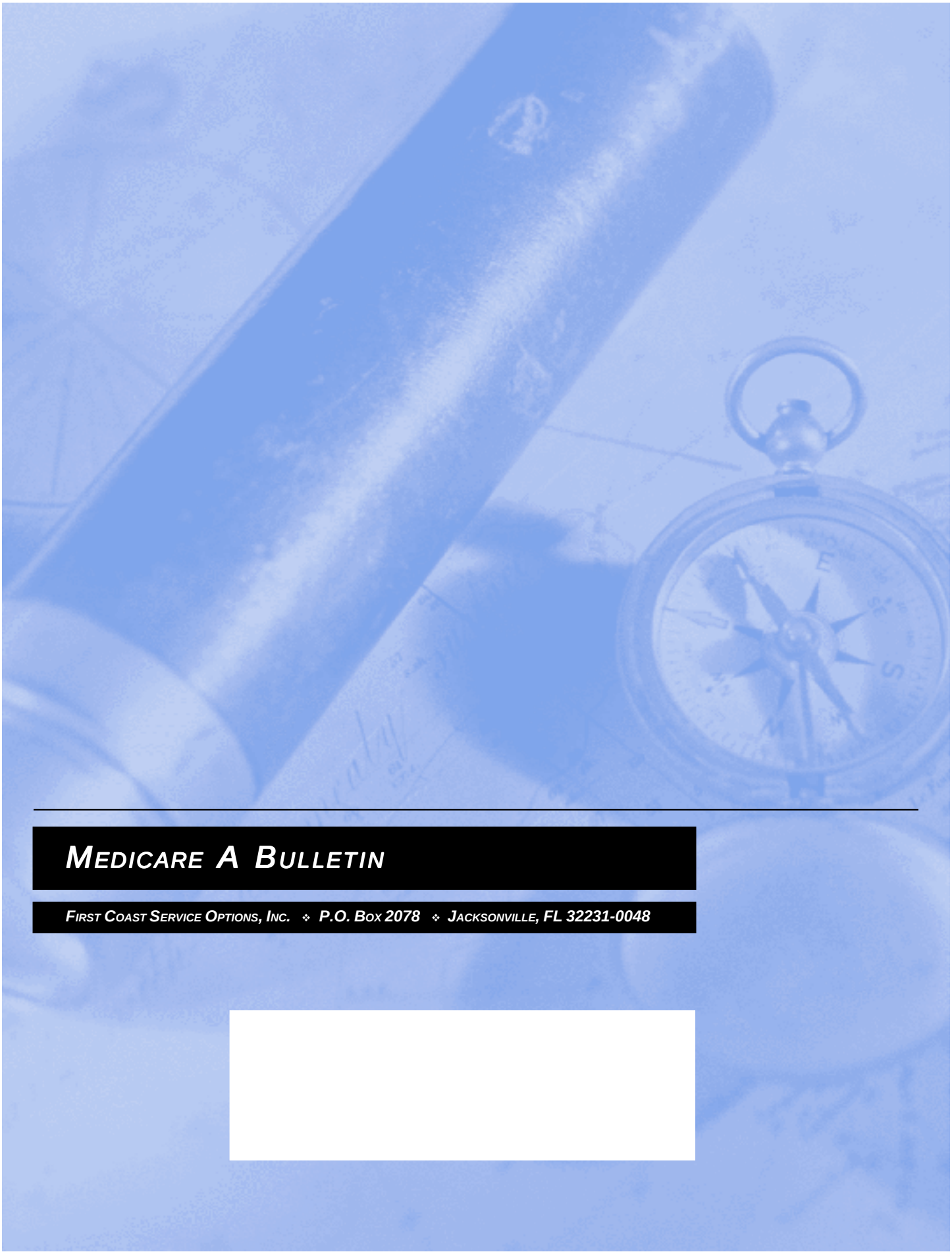
Medicare Web Sites

PROVIDERS

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

BENEFICIARIES

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



MEDICARE A BULLETIN

FIRST COAST SERVICE OPTIONS, INC. ❖ P.O. BOX 2078 ❖ JACKSONVILLE, FL 32231-0048