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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- ☐ _____
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The *Medicare A Bulletin* is published quarterly by Medicare Communication and Education, to provide timely and useful information to Medicare Part A providers in Florida.

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

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

A PHYSICIAN'S FOCUS

Comprehensive Error Rate Testing (CERT)

First Coast Service Options, Inc. (FCSO) is a traditional Medicare contractor with claim processing responsibility as a fiscal intermediary (Medicare Part A) in Florida, and as a carrier (Medicare Part B) in Connecticut and Florida. Other Medicare contractors that have responsibility to process claims include the durable medical equipment regional carriers (DMERC) and the regional home health and hospice intermediaries (RHHI). The Centers for Medicare & Medicaid Services (CMS) also utilizes contractors that do not have direct claims processing responsibility such as quality improvement organizations (QIO) and program safeguards contractors (PSC). PSCs focus on certain aspects of the Medicare program such as specific types of medical review and fraud detection and prevention. One PSC, AdvanceMed of Richmond, Virginia, has responsibility for CERT – the comprehensive error rate-testing program.

Error rates are not new to the Medicare program. The Office of the Inspector General (OIG) has been reporting error rates based on medical reviews for services during 1996-2002. A national error rate has been reported based on a sample of claims paid by contractors during part of a given year. The paid claims of 50 beneficiaries were reviewed for selected contractors. Some 5,000-8,000 claims were reviewed yearly. The error rates reported ranged from 13.8 percent in 1996 to 6.3 percent in 2002.

The CERT program will produce several error rates based on medical reviews done by the CERT contractor for services performed in 2001 forward. Because of the different methodology and definitions, comparison to previously reported OIG rates will not be valid. A much larger sample of claims, approximately 200 claims processed monthly by each contractor, will be requested from providers and physicians in the respective contractor's jurisdiction. Eventually, some 200,000 paid or denied claims will be assessed per year. All contractors processing Medicare claims will be included in the process. Several error rates will be reported, including:

- *paid claim error rate* (dollars paid incorrectly/total dollars paid),
- *claim processing error rate* (claim lines paid incorrectly plus claim lines denied incorrectly, and total claim lines processed), and
- *provider compliance rate* (dollar value of claims submitted correctly/dollar value of total claims submitted).

The findings will be used to develop and supplement programs and processes directed at improving claim processing and provider billing practices. The goal is to pay claims correctly.

A major problem noted in preliminary reports is failure of providers and physician offices to respond to request for medical records. FCSO data from AdvanceMed shows 30-75 percent line item errors due to failure to submit documentation. If you do not provide documentation, AdvanceMed will determine that your claim was paid in error and the contractor will request a refund for that claim. If you submit the documentation and an error is noted, you are only liable for the amount in error and no further assessment or audit will be done. Documentation will only be requested on previously processed claims.

The CERT program may take a few years to develop benchmarks. However, the program will have the most benefit for the Medicare program if providers and physicians submit documentation promptly when requested. If one or more of your claims are sampled, a letter from AdvanceMed will provide the details regarding the needed information and the name of a contact person. The CERT Web site is *www.psccert.org*. FCSO looks forward to using the CERT program to improve payment of claims for physicians and providers.

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About *The Medicare A Bulletin*

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

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

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

Who Receives the *Bulletin*?

Anyone may view, print or dowload the *Bulletin* from our provider education Web site. Providers who cannot obtain it from the Internet are required to register with us to receive a complimentary hardcopy (please see the hardcopy registration in the Third Quarter 2003 issue).

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

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

FCSO Medicare Part A uses the same mailing address for *all* correspondence, and cannot designate that the *Bulletin* be sent to a specific person/department within a medical facility. To ensure continued receipt of all Medicare correspondence, providers must keep their mailing addresses current with the Medicare.

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.

Do You Have Comments?

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

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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.

GENERAL INFORMATION

Billing for Tositumomab and Iodine I-131 Tositumomab (Bexxar®) Therapeutic Regimen

The Centers for Medicare & Medicaid Services (CMS) has provided information about billing the Medicare program for Bexxar® therapeutic regimen effective for services furnished on or after July 1, 2003, for claims submitted on or after October 1, 2003.

The Bexxar® therapeutic regimen is administered in two separate steps: the dosimetric and the therapeutic. Each step consists of a sequential infusion of tositumomab followed by Iodine I-131 tositumomab. The dosimetric step involves radionuclide scanning to determine the biodistribution of tositumomab. The procedure encompasses administration of non-radiolabeled tositumomab and whole body radionuclide scanning following administration of Iodine I-131 tositumomab. The purpose of the dosimetric dose is to determine individual pharmacokinetics and the amount of radioactivity to be delivered in the therapeutic dose. Determining appropriate biodistribution involves making a qualitative comparison of isotope uptake in several organ systems between three scans taken over the seven days following the dosimetric administration of Iodine I-131 tositumomab. The therapeutic step is administered 7-14 days after the dosimetric step.

Billing Guidelines

When the Bexxar® therapeutic regimen is furnished to beneficiaries in a hospital outpatient department that is paid under the hospital outpatient prospective payment system (OPPS), hospitals are to bill using the following CPT/HCPCS codes:

- **HCPCS code G3001**, **Administration and supply of tositumomab, 450 mg** to bill for the infusion of tositumomab during the dosimetric/diagnostic step and to bill for the infusion of tositumomab during the therapeutic step.

  Note: G3001 is a new code with an effective date of July 1, 2003.

- HCPCS code 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) for the Bexxar® dosimetric dose using Iodine I-131 tositumomab.

  Note: HCPCS code G0273 includes all scans taken during the dosimetric step. G0273 should be billed only once, no matter how many scans are performed.

- HCPCS code G0274, Radiopharmaceutical therapy, non-Hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies) for the Bexxar® therapeutic dose using Iodine I-131 tositumomab.

- ***CPT 77300*** to bill for dosimetry calculation.

Hospitals paid under the OPPS, billing for Bexxar® therapeutic regimen shall not bill using the following codes:

- *CPT* codes for diagnostic administration of radiopharmaceuticals (*78990* and *78999*) or diagnostic scanning (*78800–78803*).
- *CPT* codes for therapeutic administration of radiopharmaceuticals (*79900*), radiopharmaceutical therapy (*79100*, *79400*), or infusion or instillation of radioelement solution (*77750*).

Payment for HCPCS code G3001 will be made under APC (ambulatory payment classification) 9129.

The OPPS payment for HCPCS codes G0273 includes payment for all scans.

The OPPS payment for HCPCS codes G3001, G0273, and G0274 includes payment for both the radiopharmaceutical and administration of the radiopharmaceutical.

Critical access hospitals and other hospital outpatient departments not paid under OPPS are to continue to utilize their current billing practices and payment will be made under the current payment methodology for hospitals not subject to OPPS.

In situations where hospitals may have already submitted a claim using codes other than *77300*, G3001, G0273 and G0274 to bill for Bexxar® therapeutic regimen for services furnished on or after July 1, 2003 but before January 1, 2004, they may submit an adjustment claim to receive payment for *77300*, G3001, G0273 and G0274. ❖

Source: CMS Pub. 100-20 Transmittal #1, CR 2914

Billing Guidelines and Payment of Incomplete Screening Colonoscopies

Medicare covers colorectal cancer screening tests/procedures for early detection of colorectal cancer, when coverage conditions are met. Coverage of screening colonoscopies are subject to certain frequency limitations and are billed using the following HCPCS codes:

G0105 Colorectal cancer screening; colonoscopy on individual at high risk

G0121 Colorectal screening; colonoscopy on individual not meeting criteria for high risk.

In some instances, a provider may begin a screening colonoscopy, but, because of extenuating circumstances, be unable to complete the procedure. At another time, the provider may attempt and complete the intended screening colonoscopy on the patient. This situation parallels those of diagnostic colonoscopies in which the provider is unable to complete the colonoscopy because of extenuating circumstances and must attempt a complete colonoscopy at a later time. If coverage conditions are met, Medicare pays for both the uncompleted colonoscopy and the completed colonoscopy, whether the colonoscopy is screening or diagnostic in nature.

Because screening colonoscopies G0105 and G0121 are subject to frequency limitations, the common working file (CWF) must be able to distinguish between services that are subject to the frequency limitation from those that are not. It is not appropriate to count the incomplete colonoscopy toward the beneficiary's frequency limit for a screening colonoscopy because that would preclude the beneficiary's being able to obtain a covered completed colonoscopy.

Effective January 1, 2004, CWF will be modified so that it will ignore incomplete screening colonoscopies when it calculates frequency limitations for this benefit.

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay for the interrupted colonoscopy as long as the coverage conditions are met for the incomplete procedure. However, the frequency standards associated with screening colonoscopies will not be applied by CWF. When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for this procedure as long as coverage conditions are met, and the frequency standards will be applied by CWF. This policy is applied to both screening and diagnostic colonoscopies.

Billing Guidelines

When submitting a facility claim for the interrupted colonoscopy, providers are to suffix the colonoscopy HCPCS codes with modifier 73 or 74, as appropriate, to indicate that the procedure was interrupted. This billing guideline applies to hospital outpatient departments under OPPS, hospitals not subject to OPPS, and critical access hospitals (CAHs) not electing method II payment.

CAHs that have elected method II payment must use modifier 53 to identify an incomplete screening colonoscopy (physician professional services) billed with revenue code 096x, 097x, and/or 098x). These CAHs will also bill the technical or facility component of the interrupted colonoscopy with revenue code 075x (or other appropriate revenue code) using modifier 73 or 74 as appropriate.

Reimbursement Guidelines

If covered, payment for interrupted screening colonoscopies (HCPCS codes G0105 and G0121 with modifier 73 or 74) will be made under OPPS for hospital outpatients departments. Payment for hospitals not subject to OPPS will be made under payment methodologies currently in place, and payment for critical access hospitals (CAHs) not electing method II will be made on a reasonable cost basis.

If covered, payment for screening colonoscopies (HCPCS codes G0105 and G0121) will be made under OPPS for hospital outpatient departments; for hospitals not subject to OPPS, under payment methodologies currently in place, and on reasonable cost basis for CAHs not electing method II.

For CAHs electing method II payment, payment for professional services for interrupted screening colonoscopies, (HCPCS codes G0105-53 and G0121-53) will be made under payment methodologies currently in place as indicated in section 3610.19 of the Part A Medicare Intermediary Manual (MIM) if all other coverage requirements are met.

For CAHs electing method II payment, payment for professional services for screening colonoscopies, (HCPCS codes G0105 and G0121) will be made under payment methodologies currently in place as indicated in section 3610.19 of the Part A MIM if all other coverage requirements are met.

Medicare expects providers to maintain adequate information in the patient's medical record in case it is needed by the contractor to document the incomplete procedure. ❖

Source: CMS Transmittal A/B 03-114, CR 2822

Correction to Payment Rate for Oxaliplatin (Eloxatin™)

The July 2003 update of the hospital outpatient prospective payment system contained the erroneous amount of $96.46 payment rate for Eloxatin™ (HCPCS code C9205 – injection, oxaliplatin, per 5 mg). The **correct payment rate** for HCPCS code C9205 is **$94.46**. All other information regarding oxaliplatin including the minimum unadjusted copayment amount is correct.

Effective with the October 1, 2003, PRICER software update, claims containing HCPCS code C9205 (APC 9205) with dates of service on or after July 1, 2003, through September 30, 2003, have been adjusted to offset overpayment. ❖

Source: CMS Notification Dated August 20, 2003

Billing for Fecal Leukocyte Examination Under a CLIA Certificate for Provider-Performed Microscopy Procedures

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) require a facility to be appropriately certified for each test performed. A facility that has a CLIA certificate for provider-performed microscopy (PPM) procedures may only perform tests that are categorized as either PPM procedures or waived tests under CLIA.

The healthcare common procedure coding system (HCPCS) code G0026 (fecal leukocyte examination) was discontinued on December 31, 2002. For calendar year (CY) 2003, HCPCS code 89055 (Leukocyte count, fecal) was suggested as a possible code to be used for the discontinued G0026. However, under CLIA, the fecal leukocyte examination permitted for a PPM procedure certificate does not include a fecal leukocyte count. For CY 2003, Medicare contractors were instructed to permit the use of existing HCPCS code Q0111 (Wet mounts, including preparations of vaginal, cervical or skin specimens) for fecal leukocyte examination claims submitted by facilities with a valid PPM procedure CLIA certificate with dates of services on or after January 1, 2003

The wording of HCPCS code 89055 was revised for CY 2004 to read "Leukocyte assessment, fecal, qualitative or semiquantitative." The revised text meets the CLIA definition of PPM procedure for the fecal leukocyte examination.

The preamble to the CLIA regulations published on April 24, 1995, (HSQ-216-FC), stated that the fecal leukocyte examination is a form of the wet mount examination and mentioned that this test met the criteria for inclusion in PPM procedures category. The CLIA regulations also require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests categorized as provider-performed microscopy (PPM) procedures or waived complexity under CLIA in facilities having a valid CLIA certificate for PPM procedures, laboratory claims are currently edited at the CLIA certificate level

Billing Instructions

To report services for fecal leukocyte examination for services provided **on or after January 1, 2003,** through **December 31, 2003,** use HCPCS code Q0111.

To report services for fecal leukocyte examination for services provided **on or after January 1, 2004,** use CPT code *89055*. ❖

Source: CMS Transmittal AB-03-127, CR 2843,
CMS Pub 100-4 Transmittal #12, CR 2924

Payment Amount for the Influenza Virus Vaccine

The Centers for Medicare & Medicaid Services (CMS) has issued payment allowance for influenza virus vaccine when payment is based on 95 percent of the average wholesale price (AWP).

Effective September 1, 2003 the Medicare Part B payment allowance for influenza virus vaccine codes (*CPT 90658* and *CPT 90659*) is $9.95. Annual Part B deductible and coinsurance amounts do **not** apply.

All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination must take assignment on the claim for the vaccine.

Note: The whole virus vaccine (CPT 90659) has not been produced for the 2003 flu season; therefore, providers should not bill 90659 for the influenza virus vaccine, regardless of the inclusion of a payment rate in previous CMS notifications. If claims are inadvertently submitted with 90659, however, they will be paid the same allowance as CPT 90658.

Fee rates apply to the freestanding end-stage renal disease (ESRD) and comprehensive outpatient rehabilitation facility (CORF) providers. Services provided in hospital outpatient settings, skilled nursing facilities and critical access hospitals are reimbursed based on reasonable cost. ❖

Source: CMS Pub. 100-20 Transmittal #3, CR 2918

Addition to the 2004 ICD-9-CM Update

The National Center for Health Statistics (NCHS) has added three new diagnosis codes to the 2004 update to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) effective for all hospital discharges and outpatient services occurring **on or after October 1, 2003.** The new codes are:

079.82	SARS-associated coronavirus
480.3	Pneumonia due to SARS-associated coronavirus
V01.82	Exposure to SARS-associated coronavirus

The ICD-9-CM Addendum containing the new, revised, and deleted ICD-9-CM diagnosis codes for 2004 may be accessed on the CMS Web site at *www.cms.hhs.gov/medlearn/icd9code.asp* and on the NCHS Web site at *www.cdc.gov/nchs/icd9.htm*. ❖

Source: CMS Transmittal AB-03-129, CR 2842

Use of Modifier GY to Identify Clinical Diagnostic Laboratory Services Not Covered by Medicare

In November 2002, Medicare implemented 23 national coverage determinations (NCDs) for clinical diagnostic laboratory services. These NCDs are specific down to the ICD-9-CM code level and included lists of ICD-9-CM codes that are covered and those that are not covered by Medicare. The ICD-9-CM codes that are not covered by Medicare are codes that are excluded from coverage based on technical denials, such as routine screening services, rather than denial due to lack of medical necessity. Laboratories are permitted to bill beneficiaries for services that are not covered by Medicare for reasons other than medical necessity without providing for an advance beneficiary notice (ABN).

Medicare clinical diagnostic laboratory services are processed using a standardized laboratory edit module. This edit module returns a message to the local contractor indicating whether the claim passed the NCDs coverage edits, is denied for diagnoses on the noncovered list, or is denied as not medically necessary. Healthcare Common Procedure Coding System (HCPCS) coding provides for a modifier GY to be used to indicate an item or service that is statutorily excluded or does not meet the definition of any Medicare benefit. At present, the laboratory edit module response is not affected by the use of this modifier.

By January 1, 2004, the clinical diagnostic laboratory service edit module will be changed to consider the presence of the modifier GY in selecting the appropriate response for claims for clinical diagnostic laboratory services. Use of the modifier GY will result in a not covered response from the edit module in all cases. Laboratories should append the modifier GY to the *CPT* procedure codes for any service where the appropriate diagnosis for that service is on the list of diagnoses that are not covered by Medicare. ❖

Source: CMS Pub 100-4 Transmittal #11, CR 2933

Grace Period Established for 2004 HCPCS Annual Update

The 2004 Healthcare Common Procedure Coding System (HCPCS) Update is effective for services provided **on or after January 1, 2004.** However, the Centers for Medicare & Medicaid Services extends a 90-day grace period where either 2003 or 2004 HCPCS codes are accepted. This grace period applies to claims received prior to April 1, 2004, which include 2003 discontinued codes for dates of service January 1, 2004 or later. The three-month grace period also applies for discontinued HCPCS codes.

Therefore, effective January 1, 2004 through March 31, 2004, providers may use either 2003 and/or 2004 HCPCS codes. **Effective April 1, 2004, Medicare will only accept 2004 HCPCS codes.**

Additions, revisions and discontinued procedure codes comprised in by the 2004 annual HCPCS update will be published in the December 2003/January 2004 *Medicare A Bulletin* Special Issue

The January 2004 outpatient code editor (OCE) release will contain the 2003 discontinued codes and the new 2004 codes. The April 2004 OCE release will contain only the 2004 codes. Claims with services furnished **on or after January 1, 2004,** received **on or after April 1 2004,** containing 2003 discontinued codes will be returned to the provider. ❖

Source: CMS Transmittal AB-03-140, CR 2896

Pneumococcal Pneumonia Vaccine Payment Increase Effective October 1, 2003

Effective October 1, 2003, the Medicare Part B payment for the pneumococcal pneumonia vaccine will be increased to the lower of the charge billed to Medicare or $18.62. Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners, and suppliers who administer the pneumococcal pneumonia vaccination must take assignment on the claim for the vaccine.

For additional information about immunizations, refer to the Immunizations Quick Reference Guide at *www.cms.hhs.gov/medlearn/refimmu.asp*. ❖

Source: CMS Notification Dated August 20, 2003

Correction to Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

The third quarterly home health (HH) consolidated billing (CB) update for calendar year 2003 was published in the Fourth Quarter 2003 *Medicare A Bulletin* (page 24). Among other changes, it removed HCPCS code A4421 (Ostomy supply misc) from the list of supply codes subject to HH CB. CMS has notified Medicare contractors that removing HCPCS code A4421 was an error and this code has been restored to the list of codes used to enforce existing HH consolidated billing edits.

Providers and suppliers interested in an updated complete list of codes subject to HH CB may refer to the HH CB master code list available at *www:cms.hhs.gov/providers/hhapps/*. ❖

Source: CMS Transmittal AB-03-136, CR 2892

October 2003 Update to the DMEPOS Fee Schedule

The durable medical equipment, prosthetics, orthotics, and supplies **(**DMEPOS) fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The following issues are part of the October 2003 quarterly update to the DMEPOS fee schedule effective for items furnished **on or after October 1, 2003.**

Revision to Fee Schedule for L0462

The fee schedule amounts that were implemented for code L0462 on July 1, 2003, were based on incorrect pricing information. Code L0462 is a thoracic-lumbar-sacral-orthosis (TLSO). The durable medical equipment regional carriers (DMERCs) are revising the base fee schedule amounts for this code as part of the October quarterly update for the 2003 DMEPOS fee schedule.

Compression Garments in the Treatment of Venous Stasis Ulcers

Effective for items furnished **on or after October 1, 2003,** gradient compression stockings falling under the following HCPCS codes may be covered under the surgical dressing benefit when:

- the beneficiary has an open venous stasis ulcer that has been treated by a physician or other health care professional requiring medically necessary debridement, and
- the gradient stocking can be proven to deliver compression greater than 30 mm Hg. and less than 50 mm Hg:

L8110 gradient compression stocking, below knee, 30-40 mm Hg, each

L8120 gradient compression stocking, below knee, 40-50 mm Hg, each

Modifier AW (item furnished in conjunction with a surgical dressing) must be added to these codes.

HCPCS Addition

Effective for items furnished on or after October 1, 2003, the following codes were added to the Healthcare Common Procedure Coding System (HCPCS):

K0622 Conforming bandage, non-elastic, knitted/woven, non-sterile width less than three inches, per roll

K0623 Conforming bandage, non-elastic, knitted/woven, sterile width less than three inches, per roll

K0624 Light compression bandage, elastic, knitted/woven width less than 3 inches, per roll (at least 3 yards unstretched)

K0625 Self adherent bandage, elastic, non-knitted/non-woven, load resistance greater than or equal to 0.55 foot pounds at 50% maximum stretch, width less than 3 inches, per roll

K0626 Self-adherent bandage, elastic, non-knitted/ non-woven, load resistance greater than or equal to 0.55 foot pounds at 50% maximum stretch, width greater than or equal to 5 inches, per roll

Fiscal intermediaries process claims for items billed under HCPCS codes K0622 thru K0626, L0462, L8110 and L8120 that are furnished by outpatient hospital departments or skilled nursing facilities. All other claims for items billed under HCPCS codes K0622 thru K0626, L0462, L8110 and L8120 are processed by the DMERCs. ❖

Source: CMS Transmittal AB-03-100, CR 2802

Submitting New K Codes Under Outpatient Prospective Payment System

The Centers for Medicare & Medicaid Services has notified fiscal intermediaries that the October 2003 outpatient prospective payment system (OPPS) outpatient code editor (OCE) version 4.3 and the non-OPPS OCE version 19.0 releases were inadvertently not updated to include the new surgical dressing HCPCS codes K0622-K0626 effective for claims with dates of service on or after October 1, 2003.

Action Required by Providers

Providers are requested **not** to report the above listed K codes until the January 2004 OPPS OCE version 5.0 and the non-OPPS OCE version 19.1 releases scheduled to be implemented on January 5, 2004.

In situations where additional services are reported on the same claim as the K codes, providers may remove the charges for the K codes from the claim in order to receive payment for the remaining services. In this instance, providers must submit an adjustment claim reflecting the K codes after January 5, 2004, in order to receive payment for the K codes. ❖

Source: CMS Notification Dated October 15, 2003

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing

CMS periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the home health (HH) prospective payment system (PPS). With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list which are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods.

Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing. Medicare contractors include fiscal intermediaries (FIs), carriers, and durable medical equipment regional carriers (DMERCs).

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

This notification provides the annual HH consolidated billing update for calendar year 2004. Quarterly updates may follow in the course of calendar year 2004 if necessary. The specific changes are described in the attached code list.

The HH consolidated billing master code list is available at the following at *www.cms.hhs.gov/providers/hhapps/#billing*.

New and Deleted Codes for Home Health Consolidated Billing

Code	Action	Replacement Code or Code Being Replaced
Non-Routine Supplies		
K0581	Delete	Replacement Code: A4416
K0582	Delete	Replacement Code: A4417
K0583	Delete	Replacement Code: A4418
K0584	Delete	Replacement Code: A4419
K0585	Delete	Replacement Code: A4420
K0586	Delete	Replacement Code: A4423
K058	Delete	Replacement Code: A4424
K0588	Delete	Replacement Code: A4425
K0589	Delete	Replacement Code: A4426
K0590	Delete	Replacement Code: A4427
K0591	Delete	Replacement Code: A4428
K0592	Delete	Replacement Code: A4429
K0593	Delete	Replacement Code: A4430
K0594	Delete	Replacement Code: A4431
K0595	Delete	Replacement Code: A4432
K0596	Delete	Replacement Code: A4433
K0597	Delete	Replacement Code: A4434
A4416	Add	Replaces Code: K0581
A4417	Add	Replaces Code: K0582
A4418	Add	Replaces Code: K0583
A4419	Add	Replaces Code: K0584
A4420	Add	Replaces Code: K0585
A4423	Add	Replaces Code: K0586
A4424	Add	Replaces Code: K0587
A4425	Add	Replaces Code: K0588
A4426	Add	Replaces Code: K0589
A4427	Add	Replaces Code: K0590
A4428	Add	Replaces Code: K0591
A4429	Add	Replaces Code: K0592
A4430	Add	Replaces Code: K0593
A4431	Add	Replaces Code: K0594
A4432	Add	Replaces Code: K0595
A4433	Add	Replaces Code: K0596
A4434	Add	Replaces Code: K0597
A4319	Delete	Replacement codes: A4216 & A4217
A4323	Delete	Replacement codes: A4216 & A4217
A4216	Add	Replaces A4319 & A4323
A4217	Add	Replaces A4319 & A4323
A4712	Delete	
A4622	Delete	Replacement codes: A7520, A7521 and A7522
A7520	Add	Replaces code: A4622
A7521	Add	Replaces code: A4622
A7522	Add	Replaces code: A4622
A7523	Add	Tracheostomy
A7524	Add	From or related to discontinued code, A4622 and/or A4623: Tracheostomy
A4623	Add	
A7525	Add	Replaces code: A4623
A7526	Add	Replaces code: A4623
K0621	Delete	Replacement code: A6407
A6407	Add	Replaces: K0621
A4248	Add	
A4366	Add	
A6025	Add	
A6441	Add	
A6442	Add	
A644	Add	
A6444	Add	
A6445	Add	
A6446	Add	
A6447	Add	
A6448	Add	
A6449	Add	
A6450	Add	
A6451	Add	
A6452	Add	
A6453	Add	
A6454	Add	
A6455	Add	
A6456	Add	
Therapies		
97755	Add. ❖	

Source: CMS Pub 100-4 Transmittal #10, CR 2931

Timeframe Filing Provision on Reconsiderations and Appeals—Reminder to Providers

Providers and beneficiaries that disagree with Medicare's initial determination have the right to request a review. **A request for a reconsideration or appeal must be submitted in writing within 120 days from the date of the initial Medicare notice.**

Section 1869(a)(3)(C) of the Social Security Act eliminates the distinction between the 60-day time limit for requesting a Part A reconsideration and the 180-day time limit for requesting a Part B review by creating a 120-day time limit for filing requests for appeal of all Medicare initial determinations. On October 1, 2002, the Centers for Medicare & Medicaid Services (CMS) implemented the uniform 120-day timeframe for requesting a reconsideration or appeal of and initial determination on a Medicare Part A or B claim.

Requests for a reconsideration or appeal of a Medicare Part A claim must be submitted to the fiscal intermediary to this address:

First Coast Service Options, Inc.
Medicare Part A Appeals
P. O. Box 45053
Jacksonville, FL 32232-5053. ❖

Requirements for Medicare Hearings—Reminder to Providers

To help reduce the number of hearing requests dismissed each month, and to handle your requests quicker, please remember that a request for a Medicare hearing (Part A or Part B) *must* meet a number of requirements before the request can be accepted:

- the service at issue must have been reviewed (appealed),
- the hearing request must be made within six months of the date of the review determination, and
- the amount in controversy must be at least $100.00.

Under the aggregation rules, claims may be combined to meet the amount in controversy requirement. When requesting a hearing officer hearing the provider ***must*** clearly state that he/she is aggregating claims to meet the amount in controversy requirement ***and*** the provider must specify in the appeal request the specific claims that are being aggregated. If the request for the hearing officer hearing does not specifically state that the claims are being aggregated, and/or does not list the specific claims being aggregated, each claim will be treated as an individual request for a hearing; those that do not meet the amount in controversy requirement will be dismissed. ❖

New Online CMS Manual System Announcement

Beginning October 1, 2003, CMS will transition from a paper-based manual system to a Web-based system. The process includes the streamlining, updating, and consolidating of CMS' various program instructions into an electronic Web-based manual system for all users. The new system is called the online CMS Manual System and is located at *http://www.cms.hhs.gov/manuals*.

The new online CMS Manual System will be organized by functional area, (e.g., eligibility, entitlement, claims processing, benefit policy, program integrity). The functional orientation of the new manual will eliminate significant redundancy within the manuals and will streamline the updating process, thus making CMS program instructions available in a more timely and accessible fashion.

Specifically, the CMS Manual System will include the following functional areas:

Pub. 100-01 – Medicare General Information, Eligibility, and Entitlement
Pub. 100-02 – Medicare Benefit Policy
Pub. 100-03 – Medicare National Coverage Determinations
Pub. 100-04 – Medicare Claims Processing
Pub. 100-05 – Medicare Secondary Payer
Pub. 100-06 – Medicare Financial Management
Pub. 100-07 – Medicare State Operations
Pub. 100-08 – Medicare Program Integrity
Pub. 100-09 – Medicare Contractor Beneficiary and Provider Communications
Pub. 100-10 – Medicare Quality Improvement Organization
Pub. 100-11 – Reserved
Pub. 100-12 – State Medicaid
Pub. 100-13 – Medicaid State Children's Health Insurance Program
Pub. 100-14 – Medicare End Stage Renal Disease Network Organization
Pub. 100-15 – Medicare State Buy-In
Pub. 100-16 – Medicare Managed Care
Pub. 100-17 – Medicare Business Partners Systems Security
Pub. 100-18 – Medicare Business Partners Security Oversight
Pub. 100-19 – Demonstrations
Pub. 100-20 – One-Time Notification

The table on the next page identifies what current paper-based manuals were used to construct the new Internet-only manuals. The Internet-only manuals will have a detailed crosswalk to indicate specific section of the old manuals to where the information now appears in the new manuals.

New Online CMS Manual System Announcement (continued)

Paper-Based Manuals	Internet-Only Manuals
Pub. 06 – Medicare Coverage Issues Pub. 09 – Medicare Outpatient Physical Therapy Pub. 10 – Medicare Hospital Pub. 11 – Medicare Home Health Agency Pub. 12 – Medicare Skilled Nursing Facility Pub. 13 – Medicare Intermediary Manual, Parts 1, 2, 3, and 4 Pub. 14 – Medicare Carriers Manual, Parts 1, 2, 3, and 4 Pub. 21 – Medicare Hospice Pub. 27 – Medicare Rural Health Clinic and Federally Qualified Health Center Pub. 29 – Medicare Renal Dialysis Facility Pub. 60A – Intermediaries Pub. 60B – Carriers Pub. 60AB – Intermediaries/Carriers **Note:** Information derived from Pub. 6 to Pub. 60AB was used to develop Pub. 100-01 to Pub. 100-09 for the Internet-only manual.	Pub. 100-01 – Medicare General Information, Eligibility, and Entitlement Pub. 100-02 – Medicare Benefit Policy Pub. 100-03 – Medicare National Coverage Determinations Pub. 100-04 – Medicare Claims Processing Pub. 100-05 – Medicare Secondary Payer Pub. 100-06 – Medicare Financial Management Pub. 100-08 – Medicare Program Integrity Pub. 100-09 – Medicare Contractor Beneficiary and Provider Communications
Pub. 07 – Medicare State Operations	Pub. 100-07 – Medicare State Operations
Pub. 19 – Medicare Peer Review Organization	Pub. 100-10 – Medicare Quality Improvement Organization
Pub. 45 – State Medicaid	Pub. 100-12 – State Medicaid Pub. 100-13 – Medicaid State Children's Health Insurance Program
Pub. 81 – Medicare End Stage Renal Disease Network Organizations	Pub. 100-14 – Medicare End Stage Renal Disease Network Organizations
Pub. 24 – Medicare State Buy-In	Pub. 100-15 – Medicare State Buy-In
Pub. 75 – Health Maintenance Organization/Competitive Medical Plan Pub. 76 – Health Maintenance Organization/Competitive Medical Plan (PM) Pub. 77 – Manual for Federally Qualified Health Maintenance Organizations	Pub. 100-16 – Medicare Managed Care
Pub. 13 – Medicare Intermediaries Manual, Part 2 Pub. 14 – Medicare Carriers Manual, Part 2	Pub. 100-17 – Business Partners Systems Security
Pub. 13 – Medicare Intermediaries Manual, Part 2 Pub. 14 – Medicare Carriers Manual, Part 2	Pub. 100-18 – Business Partners Security Oversight
Demonstrations (PMs)	Pub 100-19 – Demonstrations
Program instructions that impact multiple manuals or have no manual impact.	Pub 100-20 – One-Time Notification

Source: CMS Pub. 100-20, Transmittal #2, CR 2886

Timely Claim Filing Guidelines for All Medicare Providers

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

Dates of Service	*Last Filing Date*
October 1, 2001 – September 30, 2002	by December 31, 2003
October 1, 2002 – September 30, 2003	by December 31, 2004
October 1, 2003 – September 30, 2004	by December 31, 2005*****
October 1, 2004 – September 30, 2005	by December 31, 2006*****

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

Periodic interim payment (PIP) providers must submit claims by the last day of the year following the year of the discharge date.

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

Billing Mammography with CAD Codes

CMS has issued revised Medicare instructions effective January 1, 2004, that change codes for the billing of computer aided detection devices (CADs) in conjunction with film and digital mammography services by deleting the two existing CAD codes and replacing them with new codes. The revisions are as follows:

- **Mammography screening** billing instructions have been updated to add new CAD code *76083*, to be billed in conjunction with screening film mammography *CPT* code *76092*, effective January 1, 2004. CAD code *76085* should not be reported for claims with dates of service on or after January 1, 2004.
- **Diagnostic mammography** billing instructions have been updated to add a new CAD code *76082* to be billed in conjunction with diagnostic film mammography codes *76090* or *76091* effective January 1, 2004. CAD code G0236 should not be reported for claims with dates of service on or after January 1, 2004.
- Diagnostic and screening mammography performed with new technologies section has been updated as follows:
  - A new CAD code *76083* has been added to be billed in conjunction with screening digital mammography code G0202 effective January 1, 2004.
  - CPT code *76085* should not be reported for claims with dates of service on or after January 1, 2004.
  - A new CAD code *76082* has been added to be billed in conjunction with diagnostic digital mammography codes G0204 or G0206 effective January 1, 2004.
  - CAD code G0236 should not be reported for claims with dates of service on or after January 1, 2004.
  - A statement has been added to clarify that CAD equipment does not have to be certified by the Food and Drug Administration (FDA).
- **Mammography billing charts for billing for CADs** has been added to provide a guide for billing of CAD codes in various time frames.
- **Application of age and frequency edits** has been added to reflect proper application of the common working file (CWF) to apply to CAD code *76083* when billed in conjunction with screening mammographies.

Mammography billing and coverage guidelines may be found in CMS Pub.100-4 – Medicare Claim Processing Manual, chapter 18 – Preventive and Screening Services, section 20. ❖

Source: CMS Transmittal 1896, CR 2632

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 November 3, 2003, the interest rate applied to Medicare overpayments is **12.00 percent**, based on the revised PCR. The following table lists previous interest rates.

Period	Interest Rate
August 11, 2003 – November 2, 2003	12.125%
April 28, 2003 – August 10, 2003	11.625%
February 11, 2003 – April 27, 2003	10.75%
November 19, 2002 – February 10, 2003	11.25%
August 8, 2002 – November 18, 2002	12.625%
May 8, 2002 – August 7, 2002	11.75%
February 1, 2002 – May 7, 2002	12.625%
October 31, 2001 – January 31, 2002	13.25%
August 7, 2001 – October 30, 2001	13.25%
April 26, 2001 – August 6, 2001	13.75%
February 7, 2001 – April 25, 2001	14.125% ❖

Source: CMS Transmittal AB-03-122; CR 2432
CMS Pub. 100-6 Transmittal #25, CR 2828

2004 Holiday Schedule

First Coast Services Options, Inc will observe the following holiday schedule in 2004:

January 1, (Thursday)	New Year's Day
January 19, (Monday)	Martin Luther King Jr. Day
April 9, (Friday)	Good Friday
May 31, (Monday)	Memorial Day
July 5, (Monday)	Independence Day
September 6, (Monday)	Labor Day
November 25, (Thursday)	Thanksgiving Holiday
November 26, (Friday)	Thanksgiving Holiday
December 23, (Thursday)	Christmas Holiday
December 24, (Friday)	Christmas Holiday. ❖

Payment Denial for Medicare Services Furnished to Alien Beneficiaries Who Are Not Lawfully Present in the United States

Section 401 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) prohibited aliens who are not "qualified aliens" from receiving Federal public benefits including Medicare. The term "qualified alien" is defined to include six groups of aliens as follows:

1. Aliens who are lawfully admitted for permanent residence under the Immigration and Nationality Act (Act).
2. Aliens who are granted asylum under section 208 of the Act.
3. Refugees admitted into the United States under section 207 of the Act.
4. Aliens who are paroled into the United States under section 212(d)(5) of the Act for a period of at least one year.
5. Aliens whose deportation is being withheld under section 243(h) of the Act.
6. Aliens who are granted conditional entry pursuant to section 203(a)(7) of the Act as in effect prior to April 1, 1980.

Two groups of qualified aliens were added to the statute after the original enactment of the restriction in the 1996 Welfare Reform statute. These groups are:

1. Certain Cuban and Haitian entrants to the United States.
2. Certain "battered aliens."

Under the terms of the PRWORA, nonqualified aliens cannot receive Medicare benefits.

Section 5561 of the Balanced Budget Act of 1997 (BBA) amended section 401 of the PRWORA to create a Medicare exemption to the prohibition on eligibility for nonqualified alien beneficiaries, who are lawfully present in the United States and who meet certain other conditions.

Under the provisions of the final rule, payment may be made for services furnished to an alien who is lawfully present in the United States (and, provided that with respect to benefits payable under Part A of Title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], who was authorized to be employed with respect to any wages attributable to employment which are counted for purposes of eligibility for Medicare benefits). The definition for "lawfully present in the United States" is found at 8 CFR 103.12.

Payment for Medicare Benefits

No Medicare payment will be issued for services furnished to an alien beneficiary who is not lawfully present in the United States on the date the services are rendered. Providers may advise beneficiaries appealing the initial Medicare determination to provide the Social Security Administration with the appropriate documentation establishing that on the date the services were furnished he or she was lawfully present in the United States. ❖

Source: CMS Transmittal AB-03-115, CR 2825

Medicare Part A Enhancements for Mailing Remittance Advices and Checks

During October 2003, First Coast Service Options, Inc. (FCSO) is implementing enhancements to the mail distribution for Medicare Part A remittance advices (RAs), laboratory notices and Medicare checks.

Medicare Part A allows providers to utilize multiple addresses for receipt of remittance advices and checks. Often the RA requires more than one envelope. In addition, some providers receive a "laboratory notice" that is generally included with the RA. Currently, the first in a series of envelopes is addressed to the provider, and additional envelopes are bound to the addressed envelope for mailing.

The enhancements are:

- RAs will be mailed in multiple envelopes that are no longer bound together.
- An address page identifies the total envelopes for the mailing:

  Envelope #1 of 4 Envelope #4 of 4

The return address on the address page includes the CMS identity marl and the FCSO return address.

The enhancements will not change mailings for multiple addresses:

- Checks will be mailed to the address on the check. Some providers use a separate mailing address for checks, such as a lock box, bank or corporate mailing address.
- RAs will be mailed to the address on the RA. If the addresses are the same, the check and RA will be mailed together.
- If there is a laboratory notice and a remittance advice, both documents will be mailed to the RA address. If there is no RA, the lab notice will be mailed to the address on the lab notice.

Be aware that RAs mailed in separately addressed envelopes may not all arrive at the provider facility at the same time. Providers should allow sufficient time for receipt of all envelopes associated with a mailing, as indicated on the address page. ❖

Medicare Deductible and Coinsurance Amounts for Calendar Year 2004

Medicare beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible, for 61-90 days spent in the hospital. A beneficiary has 60 lifetime reserve days of coverage, which he or she may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each 21-100 days of skilled nursing facility services furnished during a spell of illness.

Calendar Year 2004 Part A Deductible and Coinsurance Amounts

Part A Hospital (Inpatient)	Calculation per Benefit Period	CY 2004 Benefit Period
Deductible – 1 through 60 days	Current year inpatient deductible	$876.00 per benefit period
Coinsurance – 61 through 90 days	Rate is ¼ of current year inpatient deductible amount	$219.00 per day
Lifetime Reserve – 91 through 150 days (non-renewable days)	Rate is ½ of current year inpatient deductible amount	$438.00 per day
Skilled Nursing Facility (SNF)	**Calculation Per Benefit Period**	**CY 2004 Benefit Period**
SNF – 1 through 20 days	No deductible or coinsurance (full days)	$0 per benefit period
SNF – 21 through 100 days	Rate is 1/8 of current year inpatient deductible amount	$109.50 per day
Blood Deductible	**Annual Requirement**	**CY 2004**
Part A/Part B	Satisfied via Part A and or Part B services	3 pints annually
Part B – Outpatient	**Annual Requirement**	**CY 2004**
Annual Deductible	Satisfied via Part B outpatient and or physician/supplier services (Part B)	$100.00

Source: CMS Pub. 100-4 Transmittal #21, CR 2969

Trading Partner Agreement—Automatic Crossover

Medicare of Florida has electronic trading partner agreements with many private insurers to provide electronic transfer or "Automatic Crossover" of Medicare Part A claim information. The following insurers currently participate in the Medicare Part A electronic crossover program.

Note: Certain companies (*) function as a clearinghouse, which provides Medicare with the eligibility to receive the cross-over claim, and then forwards the claim to the supplemental insurer to process benefits.

Anthem Insurance Incorporated
APWU (American Postal Workers Union)
Bankers Life and Casualty
BCBS of Alabama
BCBS of Delaware
BCBS of Florida
BCBS of Illinois
BCBS of Massachusetts
BCBS of Minnesota
BCBS of New Hampshire
BCBS of Wisconsin
Capital Blue Cross
CareFirst BCBS
Continental Life Insurance
Empire BCBS
GHI (Group Health Insurance)
HDM (Health Data Management) (*)
Aid Association for Lutherans
American Republic Insurance
BCBS of Texas
Central Benefits Life Insurance
Celtic Life Insurance
Continental General Insurance Company
Highmark Services
Mutual Protective (Medico Life)
North American Insurance Company
Oxford Life Insurance
Pacific Care Health Plan Administrators
Physicians Mutual
Pyramids Life
Savers Life Insurance
State Farm Insurance Company
USAble Life Insurance
Unified Life Insurance
Medicaid, Florida
Medicaid, Georgia
Medicaid, Kentucky
Medicaid, Wisconsin
Mutual of Omaha
Olympic Health Management
Pioneer Life Insurance Company
Standard Life & Accident
Tricare, Incorporated
United Teachers Association
Wellmark, Incorporated ❖

AMBULANCE SERVICES

2004 Ambulance Transition Schedule—Reminder Notice

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

When fully implemented, the fee schedule replaces the current retrospective reasonable cost reimbursement system for providers and the reasonable charge system for ambulance suppliers.

The ambulance fee schedule is subject to a five-year transition period as follows:

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

*Previous and current year percentages

The foregoing schedule signifies that, during the transition schedule, the Medicare allowed amount, for ambulance services, mileage, and separately billable supplies will comprise a blended rate. The blended rate will include a portion of the fee schedule, and a portion of the provider's reasonable cost or the supplier's reasonable charge. (For providers billing ambulance services to FIs, all supplies and services rendered are considered part of the base rate and are not separately billable under the ambulance fee schedule.

- During Year 1, the fee schedule amount was comprised of only 20 percent of the blended amount, and the remaining 80 percent of the blended amount was based on the provider's reasonable cost or the supplier's reasonable charge.
- During Year 2, the fee schedule amount was comprised of 40 percent of the blended amount and the provider's reasonable cost or the supplier's reasonable charge was comprised of the remaining 60 percent.
- During Year 3, the fee schedule amount will comprise 60 percent of the blended amount, and the provider's reasonable cost or the supplier's reasonable charge will comprise the remaining 40 percent.
- During Year 4, the fee schedule amount will comprise 80 percent of the blended amount, and the provider's reasonable cost or the supplier's reasonable charge will comprise the remaining 20 percent.
- Beginning with Year 5, for services and supplies furnished, and mileage incurred, beginning January 1, 2006, and each year thereafter, the full fee schedule will comprise the entire Medicare allowed amount, and no portion of the provider's reasonable cost or the supplier's reasonable charge shall be considered. ❖

Source: CMS Transmittal AB-03-146, CR 2834

Adjustment to the Rural Mileage Payment Rate for Ground Ambulance Services

The ambulance fee schedule payment includes a rural adjustment to take into consideration the regional and operational variances in the cost of providing services in different areas of the country.

Effective January 1, 2004, the mileage rate for ground ambulance services originating in rural areas remains 150 percent of the urban mileage rate for the first 17 miles; the payment rate for ground ambulance miles 18 to 50, inclusive, will be equivalent to the urban mileage rate with no rural adjustment. The new payment rate for ground ambulance miles applies to all ground ambulance service claims with dates of service on or after January 1, 2004. ❖.

Source: CMS Transmittal AB-03-110, CR 2767

MEDICARE SECONDARY PAYER

Revision to the Medicare Secondary Payer Working Aged Provision

Section 10.2 of the Medicare Secondary Payer manual (Pub. 100-05) addressing individuals not subject to the limitation on payment under the working aged provision has been revised. The last bullet on the list below has been added. This addition is effective on April 1, 2004.

The Medicare secondary payer provision for working aged does not apply to:

- Individuals enrolled in Part B only.
- Individuals enrolled in Part A on the basis of a monthly premium. Anyone who is under age 65. (Medicare is secondary to large group health plans that cover at least one employer of 100 or more employees for certain disabled individuals under age 65.)
- Individuals covered by a health plan other than a group health plan (GHP) as defined above, e.g., one that is purchased by the individual privately, and not as a member of a group, and for which payment is not made through an employer.
- Employees of employers of fewer than 20 employees who are covered by a single employer plan. Members of multi-employer plans, which have been approved by CMS for the "multi-employer exemption", whom the plan identified as employees of employers with fewer than 20 employees.
- Retired beneficiaries who are covered by GHPs as a result of past employment and who do not have GHP coverage as the result of their own or a spouse's current employment status.
- Individuals enrolled in single employer GHPs of employers of fewer than 20 employees.
- Members of multi-employer plans whom the plan identified as employees of employers with fewer than 20 employees, provided the plan formally elected to exempt the plan from making primary payment for employees and spouses of employees of specifically identified employers with fewer than 20 employees.
- Domestic partners who are given "spousal" coverage by the group health plan. Federal law defines spouse as a person of the opposite sex who is a husband or a wife. Thus a domestic partner cannot be recognized as a spouse. ❖

Source: CMS Pub 100-5 Transmittal #2, CR 2252

OUTPATIENT REHABILITATION SERVICES

Billing Guidelines for Outpatient Rehabilitation Services

This provider education article discusses the background of the outpatient rehabilitation services limitation regulation, therapy modifiers, applicable outpatient rehabilitation Healthcare Common Procedure Coding System (HCPCS) and revenue codes, and billing instructions. In addition, it includes information resources for outpatient rehabilitation services.

Background

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997 required payment under a prospective payment system for outpatient rehabilitation services, which includes the following services:

- Physical therapy, including outpatient speech-language pathology; and
- Occupational therapy.

Section 4541(c) of the BBA required application of a financial limitation to all outpatient rehabilitation services. These limits do not apply to therapy rendered by outpatient departments of hospitals unless the beneficiary is a resident of either a Medicare-certified skilled nursing facility or a Medicare-certified portion of a skilled nursing facility. These limits were applied in 1999. However, due to a congressionally imposed moratorium, the limits have not been effective during the years 2000, 2001, or 2002. The outpatient rehabilitation services financial limitations were initially planned to resume on July 1, 2003, but their implementation has been delayed. The limitations on outpatient rehabilitation therapy services have been implemented again on September 1, 2003.

Therapy Modifiers

For any applicable rehabilitation therapy service that is rendered, providers/suppliers must report one of the following therapy modifiers, which were effective on January 1, 2003:

GN – Services delivered under an outpatient speech-language pathology plan of care.

GO – Services delivered under an outpatient occupational therapy plan of care.

GP – Services delivered under an outpatient physical therapy plan of care.

Note: These therapy modifiers do not allow a provider to deliver services that they are not recognized by Medicare to perform.

Billing Guidelines for Outpatient Rehabilitation Services (continued)

Applicable Outpatient Rehabilitation HCPCS and Revenue Codes

The CPT/HCPCS code list for outpatient rehabilitation services was revised in Transmittal B-03-065 to include additional codes that will not apply to the financial limitations when billed by physicians and non-physician practitioners, as appropriate.

These codes supersede the codes listed in section 3653 of the Medicare Part A Intermediary Manual, Part 3.

This listing of CPT/HCPCS codes does not imply that services are covered.

HCPCS codes apply to each financial limitation except as noted below.

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
92597	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*+	

CPT 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 carrier determines coverage for *CPT*/HCPCS codes G0279, G0280, 0020T and 0029T.

* These codes will not apply to the financial limits when they are not done under a therapy plan of care and they are billed by providers of services who are represented by any specialty codes except 65 and 67 (PT in private practice, OT in private practice), also 73 and 74 (which were incorrectly noted in AB-03-018 and have since been reassigned to specialties that are not therapy services.) Specialty codes 73 and 74 will be removed in a future instruction. Physicians and nonphysician practitioners should only use therapy modifiers (GP, GN, GO) with the above codes when the services are provided under a therapy plan of care.

** If an audiology procedure (*CPT codes 92601-92604*) 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 HCPCS codes are billed under a speech-language pathology plan of care, they should be accompanied with a GN modifier and applied to the financial limitation.

Billing Instructions

If the PT, OT, and SLP modifiers (GP, GO, and GN) are not billed with revenue codes 42x, 43x, or 44x, the claim will be returned to the provider.

Claims with the appropriate modifiers under revenue codes 42x, 43x or 44x, but with HCPCS other than those identified above, may result in charges being incorrectly applied to the therapy caps.

Providers should be aware that billing a modifier inappropriately with HCPCS or revenue codes that are not listed above may result in charges incorrectly applied to whichever therapy cap the modifier denotes. This incorrect billing deprives the recipient of benefits to which they are entitled and which are not subject to the financial limitation.

The HCPCS codes marked + on the list above may or may not be considered outpatient rehabilitation services, depending on the circumstances and the practitioners involved. These codes always represent therapy services when done by therapists. They also represent rehabilitation therapy services when done by physicians and non-physician practitioners who are licensed to provide therapy services and the services are not isolated medical services (e.g., a cast) but part of an episode of care whose goal is rehabilitation. When outpatient rehabilitation therapy services are billed, therapy modifiers must be used and all requirements for rehabilitation therapy services must be followed, including a plan of care.

Diagnostic audiology codes do not require therapy modifiers (see audiology procedure footnote in above list). Audiology services are not subject to therapy caps. Speech-language pathologists are not qualified to perform diagnostic audiology services. The audiology codes will be removed from the list in a future instruction.

Outpatient Rehabilitation Services Resources

Program Memoranda

– Transmittal B-03-065 dated August 22, 2003
– Transmittal B-03-051 dated July 16, 2003
– Transmittal AB-03-097 dated July 3, 2003
– Transmittal AB-03-085 dated June 10, 2003
– Transmittal AB-03-073 dated May 23, 2003
– Transmittal AB-03-057 dated May 2, 2003
– Transmittal AB-03-018 dated February 7, 2003

Therapy Resources Web Site

www.cms.hhs.gov/medlearn/therapy

– Medicare therapy news
– Frequently asked questions
– General information documents
– Therapy medical review operations
– General research tools for therapy topics
– Research tools for specific therapy topics
– Evidence-based literature review
– Join therapy cap listserv (electronic mailing list). ❖

Source: CMS Notification Dated September 5, 2003

MEDICARE CREDIT BALANCE REPORT

Provider Credit Balance Reporting Instructions—Form CMS-838

The Centers for Medicare & Medicaid Services (CMS) has revised and replaced existing guidelines related to provider reporting of Medicare credit balances. Medicare law requires participating providers to furnish information about payments made to them and to refund any monies incorrectly paid. All participating providers must file a Medicare Credit Balance Report – Form CMS-838 (10/03) with their fiscal intermediary (FI) quarterly to help ensure that all monies owed to Medicare are repaid in a timely manner. The Medicare Credit Balance Report – Form CMS-838 (10/03) is available for downloading from CMS Web site at *www.cms.hhs.gov/forms/cms838.pdf*.

Credit Balance Definition

A credit balance is an improper or excess payment made to a provider as a result of patient billing or claim processing errors. Examples of Medicare credit balances may include one of the following instances:

- A provider is paid twice for the same service, either by Medicare or by Medicare and another insurer.
- A provider is paid for services planned but not performed, or for a noncovered service.
- A provider is overpaid because of errors made in calculating beneficiary deductible and/or coinsurance amounts.
- A hospital that bills and is paid for outpatient services included in a beneficiary's inpatient claim.

Credit balances **would not** include proper payments made by Medicare in excess of a provider's charges such as diagnosis related group (DRG) payments made to hospitals under the Medicare prospective payment system.

For purposes of completing Form CMS-838 (10/03), a Medicare credit balance is an amount determined to be refundable to Medicare. Generally, when a provider received an improper or excess payment for a claim, it is reflected in the accounting records (patient account receivables) as a "credit." However, Medicare credit balances include monies due the program regardless of its classification in a provider's accounting records.

Example: If a provider maintains credit balance accounts for a stipulated period and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider must identify and repay all monies due the Medicare program.

Medicare Part A Credit Balance Reporting Guidelines

All providers of health care services participating in the Medicare program are required to submit a quarterly report. If there are multiple provider numbers for specific units within the facility (e.g., psychiatric, skilled nursing facility (SNF), end stage renal disease (ESRD), physical medicine or rehabilitation), a report is to be submitted for each provider number. Part A inpatient credit balances should be reported separate from Part B of A outpatient credit balances by reporting them on a separate Form CMS-838. Note: Outpatient services (Part B of A) must be billed to the provider's FI on Form UB-92 CMS-1450. Guidelines for reporting overpayments for Part B (physician services) claims filed on Form CMS-1500 may be found on our provider education Web site *www.floridamedicare.com*, under "Shared Content" section select "Forms" and from Forms: Written Correspondence the "Medicare B Financial Services Department" pamphlet may be downloaded.

A complete credit balance report need to be submitted to Medicare within 30 days after the close of each calendar quarter. A *complete Medicare credit balance report* consists of a certification page, a detail page (both documents are part of Form CMS-838) and a corrected Form UB-92 CMS-1450 for claim adjustments. Quarter endings are the last day of the following months: March, June, September and December. The report should include all claims reflecting a Medicare credit balance as of the last day of the reporting quarter.

Quarter Ending	Report Due
March 31	April 30
June 30	July 30
September 30	October 30
December 31	January 30

First Coast Service Options, Inc. (FCSO) recommends that facilities identify credit balances daily and resolve them as soon as they are discovered. Providers do not need to wait to the quarter ending to correct a credit balance. Credit balances should be corrected by submitting a void claim or adjustment claim electronically as soon as they are discovered.

Only the credit balances still outstanding as of the last day of the quarter should be reported on Form CMS-838. In most cases, the provider is expected to report a ZERO credit balance report each quarter.

Medicare credit balance reports should only be submitted to the appropriate intermediary that processed the claim with the credit balance.

Provider Credit Balance Reporting Instructions—Form CMS-838 (continued)

Do not submit multiple reports during a quarter. Only submit one report per facility at quarter ending.

Do not list a claim submitted on a previous credit balance report. When mailing credit balance reports for entities with multiple providers, include a separate list that identifies the provider number for each report included in the mailing. This will immediately alert Medicare to a possible problem in the event one or more of these reports are not received.

Mailing Addresses

Please mail the complete quarterly credit balance report, which includes the certification page and the detail page (both documents are part of Form CMS-838) and attach a corrected Form UB-92 CMS-1450 when submitting claim adjustments. Mail this documentation to the following address:

First Coast Service Options, Inc.
Quality & Control Department – 10T
Attention: Tammie Beyerlein
532 Riverside Avenue
Jacksonville, FL. 32202

Fax Policy

In the past, FCSO has allowed providers to fax Form CMS-838. However, these forms are no longer accepted via fax. Please send the complete Medicare credit balance report to the address above.

Credit Balance Low Utilization Providers

Providers with extremely low Medicare utilization do not have to submit a CMS-838. A low utilization provider is defined as a facility that files a low utilization Medicare cost report as specified in the Provider Reimbursement Manual-1, section 2414.4.B, or files less than 25 Medicare claims per year.

Suspension of Payments

Each facility has 30-31 days from the end of each calendar quarter to submit their Form CMS-838 Report. As a courtesy, a reminder notice that the report is due is mailed to facilities within five days following the end of the quarter. If the report is not received within 15 days of the date the letter is written a 100 percent suspension against payments to the provider will be initiated.

FCSO will also attempt to call the credit balance liaison for each facility. Please ensure we have the correct contact person for each facility in our records.

The rescinded suspension requires that there are no delinquent credit balance reports from any quarters.

Completing the Certification Page

Form CMS-838 consists of a certification page and a detail page. An officer (the chief financial officer or chief executive officer) or the administrator of your facility must sign and date the certification page. Even if no Medicare credit balances are shown in your records for the reporting quarter, you must still have the form signed and submitted to your FI in attestation of this fact. Only a signed certification page needs to be submitted if your facility has no Medicare credit balances as of the last day of the reporting quarter. An electronic file (or hard copy) of the certification page is available from your FI.

Completing the Credit Balance Report (Form CMS-838)

Begin completing the CMS-838 by providing the information required in the heading area of the detail page(s) as follows:

- The full name of the facility.
- The facility's provider number. If there are multiple provider numbers for designated units within the facility (e.g., psychiatric, SNF, ESRD, physical medicine and rehabilitation), complete a separate Medicare credit balance report for each provider number.
- The month, day and the year of the reporting quarter (e.g., 09/30/2003).
- An "A" if the report page(s) reflects Medicare Part A (inpatient) credit balances, or a "B" if it reflects Part B of A credit balances (outpatient).
- The number of the current detail page and the total number of pages forwarded, excluding the certification page (e.g., page 1 of 3).
- The name, telephone number and email address of the individual who may be contacted regarding any questions that may arise with respect to the credit balance data.

Complete the data fields for each Medicare credit balance by providing the following information:

Column 1	The last name and first initial of the Medicare beneficiary (e.g., Doe, J.).
Column 2	The Medicare health insurance claim number (HICN) of the Medicare beneficiary.
Column 3	The internal control number/document control number (ICN/DCN) assigned by Medicare when the claim is processed; (the DCN/ICN appears on the remittance advice of the paid claim).
Column 4	The three-digit number indicating the type of bill (TOB), (e.g., 111 – inpatient; 131 – outpatient; 831 – same-day surgery, etc.) (See UB CMS-1450 billing instructions).
Columns 5/6	The month, day and year the beneficiary was admitted and discharged, if an inpatient claim, or "from" and "through" dates if an outpatient service. Indicate dates of services for the specific claim on which the credit balance has occurred using numerals (e.g., 01/01/2003).
Column 7	The month, day and year (e.g., 01/01/2003) the claim was paid. If a credit balance is caused by a duplicate Medicare payment, the paid date and ICN must correspond to the most recent payment.
Column 8	Report an "O" if the claim is for an open Medicare cost reporting period or a "C" if the claim pertains to a closed cost reporting period. (An open cost report is one for which a notice of program reimbursement [NPR] has not yet been issued. A cost report is not

Provider Credit Balance Reporting Instructions—Form CMS-838 (continued)

considered open if it was reopened for a specific issue such as graduate medical education or malpractice insurance).

Column 9 The amount of the Medicare credit balance that was determined from the provider's patient accounting records.

Column 10 The amount of the Medicare credit balance identified in column 9 being repaid with the submission of the report. (As discussed below, Medicare credit balances should be repaid at the time the Form CMS-838 is submitted to Medicare).

Column 11 Report a "C" when a check is being submitted with the Form CMS-838 to repay the credit balance amount shown in column 9, or an "A" if an adjustment request is being submitted. An "E" should be reported if the correction has been entered electronically, but has not finalized as of quarter ending.

Column 12 The amount of the credit balance that remains outstanding (column 9 minus column 10). Show a zero if full payment is made.

Column 13 The reason for the Medicare credit balance by entering a "1" if it is the result of duplicate Medicare payments, a "2" for a primary payment by another insurer, or a "3" for other reasons (please indicate the reason).

Column 14 The value code to which the primary payment relates, using the appropriate two-digit code as follows: (This column should be completed only if the credit balance was caused by a payment when Medicare was not the primary payer. If more than one code applies, enter code applicable to the payer with the largest liability).

12 – Working Aged
13 – End Stage Renal Disease
14 – Auto No-Fault/Liability
15 – Workers' Compensation
16 – Other Government Program
41 – Black Lung
42 – Veteran Affairs
43 – Disability
44 – Conditional Payment
47 – Liability Other that Auto

Column 15 The name and address of the primary insurer identified in column 14 or the back of the form may be used for additional information if required and/or for detailed explanations of credit balances. Where applicable, the effective date of the "other" insurer must be noted on the back of the Form CMS-838.

Payment of Amounts Owed Medicare

Providers must pay all amounts owed Medicare (column 9 of the report) at the time the credit balance is submitted. Providers must submit payment, by check or adjustment bill.

- Payments by check must also be accompanied by a separate claim adjustment, electronic or hardcopy, for all individual credit balance that pertain to open cost reporting periods. The FI will ensure that the monies are not collected twice.
- Submission of the detailed information on the CMS-838 may not be accepted by the FI as an adjustment bill.
- Claim adjustments, whether as payment or in connection with a check, must be submitted as adjustment bills (electronic or hardcopy). If the claim adjustment was submitted electronically, this must be shown on the CMS-838 (see instructions for column 11).
- There is a limited exception for MSP credit balances. Federal regulations at 42 CFR 489.20 (h) state that "if a provider receives payment from both Medicare and another payer that is primary to Medicare", the provider must identify MSP related credit balance in the report for the quarter in which the credit balance was identified, even if repayment is not required until after the date the report is due. If the provider is not submitting a payment (by check or adjustment bill) for an MSP credit balance with the CMS-838 because of the 60-day rule, the provider must furnish the date the credit balance was received. Otherwise, the FI must assume that the payment is due and will issue a recovery demand letter and accrue interest without taking this 60-day period into consideration.
- If the amount owed Medicare is so large that immediate repayment would cause financial hardship, contact your FI regarding an extended repayment schedule.

If you have any questions pertaining to Medicare provider credit balance reports contact Tammie Beyerlein at (904) 791-6687. ❖

Source: CMS Transmittal A-03-072, CR 2810

EXAMPLE – Medicare Credit Balance Report—Detail Page

Provider Name: Hospital Y

Provider Number: XX-XXXX

Quarter Ending: September 30, 2003

Medicare Part: A (A or B of A)

Beneficiary Name	HIC Number	ICN Number	Type of Bill	Admission Date	Discharge Date	Paid Date	Cost Report Open/ Close	Amount of Credit Balance	Amount Repaid	Method of Payment	Medicare Amount Outstanding	Reason for Credit Balance	Value Code	Primary Payer & Address
John Doe	123456789A	Xxxxxxxxxxxx	131	01/01/03	01/02/03	02/01/03	O	$100.00	0	A	$100.00	2	14	Geico

GENERAL COVERAGE

Coverage of Compression Garments in the Treatment of Venous Stasis Ulcers

The accepted standard of care for the treatment of venous stasis ulcers includes the use of sustained limb compression. In the past, gradient compression stockings have not been covered for this purpose. Effective for items furnished **on or after October 1, 2003,** gradient compression stockings that serve a therapeutic or protective function and that are needed to secure a primary dressing may be covered as surgical dressings when the following requirements have been met.

Effective for items furnished **on or after October 1, 2003,** gradient compression stockings falling under the following HCPCS codes may be covered under the surgical dressing benefit when:

- the beneficiary has an open venous stasis ulcer that has been treated by a physician or other health care professional requiring medically necessary debridement, and
- the gradient stocking can be proven to deliver compression greater than 30 mm Hg. and less than 50 mm Hg:

L8110 gradient compression stocking, below knee, 30-40 mm Hg, each

L8120 gradient compression stocking, below knee, 40-50 mm Hg, each

Modifier AW (item furnished in conjunction with a surgical dressing) must be added to these codes.

HCPCS codes with L8110 and L8120 with modifier AW should be used for gradient compression stockings only when the above requirements have been met.

Fiscal intermediaries process claims for items billed under HCPCS codes L8110 and L8120 that are furnished by outpatient hospital departments or skilled nursing facilities. Durable medical equipment regional carriers process all other types of bill. ❖

Source: CMS Transmittal AB-03-090, CR 2739

Implantable Automatic Defibrillators—National Coverage Determination

This provider education article discusses the background of the national coverage determination (NCD) to expand coverage of implantable automatic defibrillators for services rendered on or after October 1, 2003, coverage guidelines, billing instructions for providers who render services to managed care patients, and billing instructions for providers who render services to fee-for-service patients.

Background

The NCD will be effective on October 1, 2003, to expand coverage of implantable automatic defibrillators for Medicare managed care and fee-for-service patients. Providers will be reimbursed for services provided to managed care patients for implantable automatic defibrillators that fall under the expanded coverage indications effective October 1, 2003, according to the NCD on a fee-for-service basis until capitation rates are adjusted to account for this expanded coverage.

Coverage Guidelines

The following services are covered when rendered **on or after July 1, 1991:**

- Documented episode of cardiac arrest due to ventricular fibrillation (VF), not due to a transient or reversible cause.

The following services are covered when rendered **on or after July 1, 1999:**

- Documented sustained ventricular tachyarrhythmia (VT), either spontaneous or induced by an electrophysiology (EP) study, not associated with an acute myocardial infarction (MI) and not due to a transient or reversible cause.
- Documented familial or inherited indications with a high risk of life-threatening VT, such as long QT syndrome or hypertropic cardiomyopathy.

As stated in the NCD, the following indications will be covered when rendered **on or after October 1, 2003:**

- Coronary artery disease with a documented prior MI, a measured left ventricular ejection fraction = 0.35, and inducible, sustained VT or VF at EP study. (The MI must have occurred more than 4 weeks prior to defibrillator insertion. The EP test must be performed more than 4 weeks after the qualifying MI.);
- Documented prior MI and a measured left ventricular ejection fraction = 0.30 and a QRS duration of > 120 milliseconds. Patients must not have:
  a) New York Heart Association classification IV;
  b) Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm;
  c) Had a coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) within past 3 months;
  d) Had an enzyme-positive MI within past month;
  e) Clinical symptoms or findings that would make them a candidate for coronary revascularization; or
  f) Any disease, other than cardiac disease (e.g., cancer, uremia, liver failure), associated with a likelihood of survival less than 1 year.

Implantable Automatic Defibrillators—National Coverage Determination (continued)

As stated in the NCD, effective October 1, 2003, the following additional coverage guidelines apply:

- All patients considered for implantation of a defibrillator must not have irreversible brain damage, disease, or dysfunction that precludes the ability to give informed consent;
- MIs must be documented by elevated cardiac enzymes or Q-waves on an electrocardiogram. Ejection fractions must be measured by angiography, radionuclide scanning, or echocardiography; and
- All other indications remain noncovered except in Category B IDE (investigational device exemption) clinical trials (60 CFR 48417) or as a routine cost in clinical trials defined under CIM 30-1.

Note: Refer to Coverage Issues Manual, Section 35-85 (revisions effective October 1, 2003).

Billing Instructions for Providers Who Render Services to Managed Care Patients

The following instructions apply to providers who render expanded implantable automatic defibrillator services to managed care patients:

- Providers are encouraged not to submit claims for services rendered on or after October 1, 2003, because Medicare will not be able to process the claims until January 5, 2004.
- Physicians must use modifier KZ (new coverage not implemented by managed care) when billing for services rendered **on and after October 1, 2003.**
- Providers billing fiscal intermediaries on or after October 1.2003, must use condition code 78 (payment for coverage not implemented by HMO).
- Providers who are paid under the outpatient prospective payment system (OPPS) must bill all services related to this expanded coverage on one claim and for the same date of service, using condition code 78.
- Providers billing carriers and providers who are paid under the OPPS must split the bills if they overlap September 2003 and October 2003.
- Patients who receive these services must pay any applicable coinsurance amounts.
- For services rendered to managed care patients whose indications fall outside this expanded coverage, providers must not bill using condition code 78 or modifier KZ.

Billing Instructions for Providers Who Render Services to Fee-for-Service Patients

The following instructions apply to providers who render expanded implantable automatic defibrillator services to fee-for-service patients:

- Claims for these services cannot be billed using modifier KZ, condition code 78, or for services outside of this expanded coverage.

Procedure Codes

The new G codes listed below are payable under OPPS effective October 1, 2003. These new G codes are **not** payable under the Medicare physician fee schedule and, therefore, should not be billed to Medicare carriers.

G0297 G0298 G0299 G0300

ICD-9-CM Procedure Code:

37.94 (Implantation and replacement of automatic cardioverter/defibrillator, total system) for type of bills 11x.

Note: The physician should bill for the appropriate service from the range of CPT codes below. These services should be billed to the appropriate Medicare carrier for payment.

33240 33241 33243 33244 33245 33246 33249. ❖

Source: CMS Transmittal AB-03-134, CR 2880 and CMS PUB. 100-20 Transmittal 4, CR 2922

Diagnosis Code for Screening Pap Smear and Pelvic Examination Services—Effective Date Correction

An article regarding additional allowable diagnosis codes for Pap smear and pelvis examinations was published in the Fourth Quarter 2003 *Medicare A Bulletin* (page 45). In that article, we indicated this change to be based on the date the services are provided; however, the additional diagnoses are effective for **services processed on or after October 1, 2003.** We apologize for any inconvenience this may have caused.

ICD-9-CM Codes and Definitions

The following is a list of diagnosis codes for low-risk or high-risk patients for Pap smear and pelvic examinations:

Low Risk

V76.2	Cervix (routine cervical Papanicolaou smear)
V76.47	Special screening for malignant neoplasm, vagina
V76.49	Special screening for malignant neoplasm, other sites

High Risk

V15.89	Other

There are no changes to the CPT/HCPCS codes used to bill screening Pap smears. ❖

Source: CMS Transmittal AB-03-054, CR 2637

Guidelines for Medicare Part B Laboratory Testing

This article explains the Centers for Medicare & Medicaid Services (CMS) coverage policies for diagnostic and screening prostate specific antigen (PSA) laboratory tests under Medicare Part B. It also explains the importance of including the date of service on orders for laboratory testing.

Diagnostic PSA Laboratory Testing

- Under section 4554(b)(1) of the Balanced Budget Act (BBA), Public Law 105-33 mandated the use of negotiated rulemaking with interested parties in the laboratory community to promote uniformity, administrative simplicity, and program integrity regarding coverage and administrative policies for clinical diagnostic laboratory services payable under Medicare Part B. As a result of this negotiated rulemaking, a national coverage decision (NCD) was developed for the diagnostic PSA test, which is a tumor marker for adenocarcinoma of the prostate and may be useful in the differential diagnosis of men presenting with as yet undiagnosed disseminated metastatic disease. When used in conjunction with other prostate cancer tests, such as digital rectal examination, the PSA test may assist in the decision-making process for diagnosing prostate cancer. PSA also serves as a marker in following the progress of most prostate tumors once a diagnosis has been established, as an aid in the management of prostate cancer patients, and in detecting metastatic or persistent disease in patients following treatment. The test is of proven value in differentiating benign from malignant disease men with lower urinary tract signs and symptoms (i.e., hematuria, slow urine stream, hesitancy, urgency, frequency, nocturia, and incontinence) as well as patients with palpably abnormal prostate glands on physical exam, and in patients with other laboratory or imaging studies that suggest the possibility of a malignant prostate disorder.
- The NCD for diagnostic PSA tests does not apply to screening PSA tests.
- Use *CPT*/HCPCS code *84153* for diagnostic PSA testing.

Screening PSA Laboratory Testing

- Screening PSA testing measures the level of prostate specific antigen in the patient's blood for the early detection of the marker for adenocarcinoma of the prostate subject to coverage, frequency, and payment limitations as follows:
  - Covered at a frequency of once every 12 months for men who have attained age 50 if at least 11 months have passed following the month in which the last Medicare-covered screening PSA test was performed; and
  - Must be ordered by the patient's physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife who is authorized under state law to perform the examination, fully knowledgeable about patient's medical condition, and who would be responsible for using the results of any examination (test) performed in the overall management of the patient's specific medical problem which includes explaining the results of the test to the patient.
- Use HCPCS code G0103 for the screening PSA test.

Date of Service for Laboratory Testing

During the clinical diagnostic laboratory services negotiated rulemaking, CMS learned that there was considerable variability regarding the date of service on laboratory claims. In order to promote uniformity, the committee recommended a national policy related to the date of service on laboratory claims. CMS published a proposed rule for public comment on March 10, 2000 (65 FR 13082) and published the rule final on November 23, 2001 (66 FR 58788). The final rule states that:

- The date of service for laboratory tests that is reported on the claim is to be the date the tested specimen was collected; and
- The person obtaining the specimen must furnish the date of collection of the specimen to the entity billing Medicare.

Physicians or their staff who draw specimens for testing must report the date of collection of the specimen on orders for laboratory tests. Laboratories may refuse to perform tests on orders for laboratory tests that do not include the information they need in order to seek payment for services performed, i.e., the date of collection of the specimen. ❖

Source: CMS Transmittal AB-03-132, CR 2841

New Diagnosis Code for Influenza Virus Vaccine Claims

The Centers for Medicare & Medicaid Services (CMS) has issued a new diagnosis code for billing influenza virus vaccine claims.

All Medicare institutional providers, Part B physicians, nonphysician practitioners, and suppliers who administer the influenza virus vaccine must use the new diagnosis code ICD-9-CM, V04.81 for claims with dates of service **on and after October 1, 2003.**

Claims for influenza virus vaccines with dates of service on and after October 1, 2003, submitted to Medicare fiscal intermediaries with the old influenza virus vaccine diagnosis code ICD-9-CM, V04.8 will be returned to the provider.

Claims from Medicare institutional providers involving new ICD-9-CM codes do not have a 90-day grace period for the old code. ❖

Source: CMS Notification Date October 15, 2003

January 2004 Update to the Laboratory National Coverage Determination

National coverage determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published as a final rule on November 23, 2001. Nationally uniform software has been developed by Computer Science Corporation and incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs are processed uniformly throughout the nation effective January 1, 2003. Below is a list of changes included in the January 2004 release of the edit module for clinical diagnostic laboratory services.

1. The following diagnosis codes to the list of ICD-9-CM Codes Covered by Medicare for the prothrombin time (PT) and fecal occult blood test (FOBT) NCDs:
   - 863.91, pancreas head with open wound into cavity;
   - 863.92, pancreas body with open wound into cavity;
   - 863.93, pancreas tail with open wound into cavity;
   - 863.94, pancreas multiple and unspecified sites with open wound into cavity;
   - 863.95, appendix with open wound into cavity; and,
   - 863.99, other gastrointestinal sites with open wound into cavity.
2. The, following diagnosis codes are deleted from the list of ICD-9-CM Codes Covered by Medicare for PT and partial thromboplastin time (PTT) NCDs:
   - V72.81, pre-operative cardiovascular examination (from PTT);
   - V72.83, other specified pre-operative examination (from PTT); and,
   - V72.84, pre-operative examination, unspecified (from PT and PTT).
3. In Program Memorandum AB-03-104 (CR 2814) CMS announced the addition of diagnosis code 401.1, benign essential hypertension, to the list of covered diagnoses for lipid testing. However, the corresponding change to the narrative of the lipid NCD that authorizes this code was not notified. By inclusion in this notice CMS is announcing a change to the narrative of the lipid NCD included in the July 17, 2003 decision memorandum posted to the Web site *www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=94*. The third bullet listed in the lipid NCD indications section is amended to read: "Any form of atherosclerotic disease, or any disease leading to the formation of atherosclerotic disease."
4. In Program Memorandum AB-03-104, CMS announced a number of ICD-9-CM codes that were deleted by the update to ICD-9-CM codes that became effective October 1, 2003. A 90-day grace period was provided for the provider and laboratory community to adapt to these changes. Thus, while CMS announced the changes in CR 2814, the software was not altered to deny claims when these codes were used. However, the grace period expires with the January update of the software and the following ICD-9-CM codes will be denied: 282.4, 331.1, 348.3, 530.2, 600.0, 600.1, 600.2, 600.9, 767.1, 790.2, V04.8, V43.2, V53.9, V54.0, V65.1. ❖

Source: CMS Pub 100-20 Transmittal #10, CR 2940

New CLIA Waived Tests

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

CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

New CLIA Waived Tests Continued Next Page

New CLIA Waived Tests (continued)

CPT Code	Test Name	Manufacturer	Effective Date	Use
*80101QW**	ADC CLIA Waived Marijuana (THC) Test	Advance Diagnostics Corporation (ADC)	4/29/03	Screening test for the presence/ detection of cannabinoids (THC) in urine
*80101QW**	ADC CLIA Waived Multiple Drug Test Card	Advance Diagnostics Corporation (ADC)	4/29/03	Screening test for the presence/ detection of cannabinoids (THC), cocaine metabolites, methamphetamine opiates and phencyclidine (PCP) in urine.
*80101QW**	ADC CLIA Waived Marijuana (THC) and Cocaine Test	Advance Diagnostics Corporation (ADC)	4/30/03	Screening test for the presence/ detection of cannabinoids (THC), cocaine metabolites in urine.
*83001QW***	Applied Biotech, Inc. RU25 Plus FSH Menopause Test	Applied Biotech, Inc.	6/24/03	Detects follicle stimulating hormone in urine.
*83518 QW***	Beckman Coulter ICON Microalb	Beckman Coulter	5/13/03	Determination of low concentrations of albumin in urine by immunoassay, which is helpful for early detection in patients at risk for developing renal disease.
*85018 QW***	Hemocue Donor Hemoglobin Checker System	HemoCue	5/14/03	Measures hemoglobin level in whole blood.
*86308QW**	Genzyme OSOM Mono Test	Wyntek Diagnostic, Inc.	3/6/03	Quantitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infections mononucleosis.
*87077QW**	GI Supply, Div. Chek-Med Systems HP One	Phamatech	3/24/03	Presumptive identification of Helicobacter pylori in gastric biopsy tissue, which has been shown to cause chronic active gastritis (ulcers).
*87804 QW***	Binax Now® Flu A Test	Quidel Corporation	5/8/03	Qualitative detection of influenza type A antigen in nasal wash and nasopharyngeal swab specimens.
*87804 QW***	Binax Now® Flu B Test	Quidel Corporation	5/8/03	Qualitative detection of influenza type B antigen in nasal wash and nasopharyngeal swab specimens.
*87880 QW***	Acon® Strep A Twist Rapid Test	Acon Laboratories, Inc.	6/12/03	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.
*87880 QW***	Beckman Coulter Icon SC Strep A Test	Acon Laboratories, Inc.	8/6/03	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.
*87880 QW***	Instant Technologies iStrep Strep A	Acon Laboratories, Inc.	7/3/03	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.

***Test implemented October 1, 2003
****Test implemented January 1, 2004

Source: CMS Pub. 100-20 Transmittal #5, CR 2791, PCM #0327503
CMS Pub. 100-20 Transmittal #12, CR 2935, PCM #0330001

CRITICAL ACCESS HOSPITAL SERVICES

October 2003 Update to the Medicare Outpatient Code Editor for Hospitals not Paid under the Outpatient Prospective Payment System

The Medicare outpatient code editor (OCE) specifications (version 19.0) have been updated with the October 2003 new additions, changes, and deletions to the *Current Procedural Terminology, Fourth Edition*/Healthcare Common Procedure Coding System (*CPT-4*/HCPCS) codes.

This OCE (version 19.0) update is used to process bills from hospitals that are not paid under the hospital outpatient prospective payment system. Below are the specifications to the October 2003 update to the Medicare OCE.

Changes Retroactive to August 1, 2000

Noncovered List Changes

Added to the list of noncovered procedures, effective August 1, 2000:

J1055 J3520 J3535 J3570 Q2001

Changes Retroactive to July 1, 2003

HCPCS Code Changes

Added to the list of valid HCPCS, effective July 1, 2003:

G3001

Changes Effective October 1, 2003

HCPCS Code Changes

Added to the list of valid HCPCS, effective October 1, 2003:

C9208 C9209 G0296 G0297 G0298 G0299
G0300 Q4075 Q4076 Q4077 Q4078

Nonreportable List Changes

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

C9208 C9209 Q4075 Q4076 Q4077

Noncovered List Changes

Removed from the list of noncovered procedures, effective October 1, 2003:

L8110 L8120 ❖

Source: CMS Transmittal A-03-077, CR 2897

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* mailing 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*.

NEW LMRP IMPLEMENTATION

83880: B-Type Natriuretic Peptide (BNP)—New Policy

Congestive heart failure (CHF) is characterized by a progressive activation of the neurohormonal systems that control vasoconstriction and sodium retention; the activation of these systems plays a role in its pathogenesis and progression. As the heart fails, B-type natriuretic peptide (BNP), a cardiac neurohormone is secreted from the cardiac ventricles in response to ventricular volume expansion and pressure overload. Used in conjunction with other clinical information, rapid measurement of BNP is useful in establishing or excluding the diagnosis and assessment of severity of CHF in patients with acute dyspnea so that appropriate and timely treatment can be initiated. BNP levels are also useful for risk stratification among patients with acute coronary syndrome (myocardial infarction with or without T-wave elevation and unstable angina). For the purposes of this policy, the total and N terminal assays are both acceptable.

This LMRP is being developed to allow providers access to this new technology, and to provide indications and limitations for this procedure.

Effective Date

Implementation of this policy is effective for services processed **on or after January 5, 2004**. ❖

90901: Biofeedback—New Policy

CPT code *90901* – Biofeedback training by any modality was aberrant based on Medicare Part B data for services from January 1, 2003 through June 30, 2003. Based on these findings, the policy was revised to define the indications and limitations of coverage, establish a procedure to diagnosis application, and clarify the appropriate use of procedure code *90901*.

Effective Date

Implementation of this policy is effective for services processed **on or after January 5, 2004**. ❖

G0237: Respiratory Therapeutic Services—New Policy

HCPCS codes G0237, G0238, and G0239 are new codes for respiratory therapy services. Per the *Federal Register*, December 31, 2002 (Vol. 67, No. 251), pages 79965-80184, there is no pulmonary rehabilitation benefit category. HCPCS codes G0237, G0238, and G0239 were developed to provide more specificity about the services being delivered by respiratory therapists. A policy is being developed to define the indications and limitations of coverage, further define the HCPCS codes, identify a procedure to diagnosis relationship, and clarify coding guidelines, as well as the documentation requirements.

Effective Date

Implementation of this policy is effective for services processed **on or after January 5, 2004**. ❖

ADDITIONS/REVISIONS TO EXISTING LMRPS

33215: Implantation of Automatic Defibrillators—Addition to Policy

The local medical review policy for implantation of automatic defibrillators was last revised on January 1, 2003. Since that time, the policy has been revised to include the following ICD-9-CM diagnosis codes to the "ICD-9 Codes that Support Medical Necessity" section of the policy:

996.01 Mechanical complication of cardiac device, implant, and graft due to cardiac pacemaker (electrode)
V53.31 Fitting and adjustment of other device, cardiac pacemaker.

Effective Date

The above revision is effective for services processed **on or after September 11, 2003**.

In addition, this policy has been revised based on Transmittal 173, Change Request 2880, (dated August 22, 2003). This transmittal specified the expanded coverage to include:

> Coronary artery disease with a documented prior myocardial infarction (MI), a measured left ventricular ejection fraction < 0.35, and inducible, sustained ventricular tachyarrhythmia or ventricular fibrillation at electrophysiology study; or documented prior MI and a measured left ventricular ejection fraction < 0.30 and a QRS duration of > 120 milliseconds.

33215: Implantation of Automatic Defibrillators—Addition to Policy (continued)

The policy has been revised to include the addition of ICD-9-CM diagnosis code 412 (Old myocardial infarction) to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy. In addition, language has been added to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy.

All other indications for defibrillators not otherwise specified in the CIM section 35-85 remain noncovered except when furnished in accordance with Food and Drug Administration approved protocols governing category B investigational device exemption (IDE) clinical trials as stated in 60 FR 48417.

Effective Date

These revisions are effective for services furnished **on or after October 1, 2003**. ❖

43235: Diagnostic and Therapeutic Esophagogastroduodenoscopy—Addition to Policy

The local medical review policy (LMRP) for diagnostic and therapeutic esophagogastroduodenoscopy was last updated on January 1, 2003.

A request was received from a provider to add ICD-9-CM diagnosis code V12.79 (Personal history of other diseases of digestive system) to the "ICD-9-CM Codes that Support Medical Necessity" section of the LMRP. After reviewing the information provided, it was determined this request was appropriate.

Therefore, the "ICD-9-CM Codes that Support Medical Necessity" section of the LMRP has been updated to include ICD-9-CM diagnosis code V12.79 for the following *CPT* codes: *43235, 43236, 43239, 43241, 43243-43251, 43255* and *43258.*

Effective Date

This revision is effective for services processed **on or after September 11, 2003**. ❖

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

The local medical review policy for magnetic resonance angiography has been revised to incorporate CMS expansion of coverage for MRA of the pelvis. Per Change Request 2673, the MRA policy was revised to define the indications and limitations of coverage, as well as, adding ICD-9-CM diagnosis codes to the ICD-9-CM Codes that Support Medical Necessity portion of the policy for MRA of the pelvis (72198).

Effective Date

This revision is effective for services processed **on or after January 5, 2004**. ❖

95900: Nerve Conduction Studies—Addition to Policy

The local medical review policy for nerve conduction studies was last updated effective October 1, 2002. Since that time the policy has been revised to include additional indications. The following ICD-9 CM diagnosis codes have been added to the policy for *CPT* codes *95900, 95903, and 95904:*

724.2	724.3	728.2	728.85
736.05	736.79	781.3	

In addition, the policy language has been updated to reflect the latest guidelines from the American Association of Electrodiagnostic Medicine.

Effective Date

This revision is effective for services processed **on or after September 11, 2003**. ❖

88142: Pap Smears—Revision to Policy

The local medical review policy for Pap smears has been revised to incorporate CMS expansion of coverage for PAP smears. The indications and limitations of coverage have been revised based on CMS transmittal AB-03-054 (Change Request 2637). In addition, ICD-9-CM codes V76.47 and V76.49 have been added to the ICD-9-CM Codes that Support Medical Necessity for screening Pap smears.

Effective Date

This revision is effective for services processed **on or after October 1, 2003**. ❖

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

The latest revision for local medical review policy for hyperbaric oxygen therapy was effective April 1, 2003. Program Memorandum AB-03-102, Change Request 2769, dated July 25, 2003, was issued to correct transmittal AB-02-183, Change Request 2388, as the original PM did not include some pertinent information regarding diagnosis codes and bill types. Revisions include: addition of ICD-9-CM diagnosis code 707.15 (Ulcer of other part of foot) to the "ICD-9-CM Codes That Support Medical Necessity" section of the policy for this therapy and deletion of ICD-9-CM diagnosis code 707.0 (Decubitus ulcer) from this section of the policy.

In addition, code-22x (skilled nursing facility) has been added to the "Type of Bill Code" section of the policy.

Effective Date

These revisions are effective for services furnished **on or after April 1, 2003**. ❖

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

EPO: Epoetin alfa (Formerly Q0136: Epoetin (Procrit®) and Q9920: Chronic Renal Failure Erythropoietin (Epogen®)—Revision to Policy

The local medical review policies (LMRPs) for epoetin (Procrit®) and chronic renal failure erythropoietin have been combined in one policy titled EPO: Epoetin alfa.

Erythropoietin is a glycoprotein that stimulates red blood cell production. It is produced in the kidneys and stimulates the division and differentiation of committed erythroid progenitors in the bone marrow.

This policy was revised to define the indications and limitations of coverage and/or medical necessity; and to clarify the appropriate use of epoetin alfa.

The following CPT/HCPCS codes are included in the LMRP:

Q0136	Injection, epoetin alpha, (for non ESRD use), per 1,000 units
Q9920-Q9940	Injection of EPO, per 1000 units, at patient HCT of 20 or less to 40 or above

The following major revisions have been incorporated in the policy:

- The LMRPs for epoetin and chronic renal failure erythropoietin have been combined. The new policy title is EPO – Epoetin alfa.
- Laboratory requirements for initiation of epoetin alfa therapy have been revised.
- The following "Indications and Limitations of Coverage and/or Medical Necessity" have been added to the policy:
  - Anemia associated with malignancy
  - Anemia associated with the management of hepatitis C
- The "Coding Guidelines" section of the LMRP has been revised with updated dual diagnosis requirements. In addition, Program Memorandum Transmittal A-01-106 (Change Request 1839) instructed hospitals billing EPO for patients with chronic renal failure who are not on a regular course of dialysis to utilize type of bill 13x and report charges under revenue code 636 with HCPCS code Q0136 and without value codes 48, 49, and 68. Therefore, type of bill codes 13x (Hospital) and 85x (Critical access hospital) are no longer applicable to HCPCS codes Q9920-Q9940.

Effective Date

Implementation of the new revised policy EPO – Epoetin alfa is effective for services processed **on or after January 5, 2004**. ❖

G0030: Positron Emission Tomography (PET) Scan—Revision to Policy

The local medical review policy for positron emission tomography (PET) scan was last updated January 1, 2003. CMS transmittal AB-03-092, Change Request 2687 provided expanded coverage for noninvasive imaging of the perfusion of the heart using FDA-approved ammonia N-13 tracer. Coverage was also expanded to include restaging of recurrent residual thyroid cancers of follicular cell origin that have been previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin >10ng/ml and negative I-131 whole body scan.

Providers will need to familiarize themselves with the appropriate codes for the billing of these expanded services

Effective Date

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

G0248: Home Prothrombin Time International Normalized Ratio (INR) Monitoring—Addition to Policy

The local medical review policy (LRMP) for home prothrombin time international normalized ratio (INR) was implemented on July 1, 2002.

CMS Transmittal A-03-076 (Change Request 2887) dated August 29, 2003, provides billing instructions for hospitals when billing for HCPCS code G0249 (Provision of test materials and equipment for home INR monitoring to patient with mechanical heart valves who meets Medicare coverage criteria; includes provision of materials for use in the home and reporting of test results to a physician; per 4 tests).

The Coding Guidelines section of the LMRP has been revised to state that Medicare will allow hospitals to bill up to three units of G0249 at a time in order to cover up to twelve tests so that the service is billable on a date when a patient would attend the clinic for a face-to-face visit.

Effective Date

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

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

J0150: Adenosine (Adenocard®, Adenoscan®)—Correction to Previously Published Article

A revision for the local medical review policy for adenosine (Adenocard®, Adenoscan®) was published in the Fourth Quarter 2003 *Medicare A Bulletin* page 38. In that article, the descriptor for HCPCS code J0151 was incorrect. The correct descriptor for HCPCS code J0151 is injection, adenosine, 90 mg. ❖

J0207: Amifostine (Ethyol®)—Addition to Policy

The LRMP for Amifostine (Ethyol®) was last updated on June 22, 2001.

A request was received from a provider to add ICD-9-CM diagnosis code 238.7 (Neoplasm of uncertain behavior of other lymphatic and hematopoietic tissues [Myelodysplastic syndrome]) to the "ICD-9-CM Codes that Support Medical Necessity" section of the LMRP. After reviewing the information provided, it was determined this request was appropriate.

Therefore, the "ICD-9 Codes that Support Medical Necessity" section of the LMRP has been updated to include ICD-9-CM code 238.7 for HCPCS code J0207.

The following indication has been added to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LMRP:

> Myelodysplastic syndrome (treatment) – for salvage treatment, as part of a combination regimen (e.g., erythropoietin, topotecan, etoposide, cytarabine), for the treatment of myelodysplastic syndromes (MDS).

In addition, type of bill 71x (rural health clinic) was removed from the LMRP and type of bill 85x (critical access hospital) was added to the LMRP.

Effective Date

This revision is effective for services processed **on or after October 9, 2003**. ❖

J0640: Leucovorin (Wellcovorin®)—Revision to Policy

The local medical review policy for leucovorin (Wellcovorin®) was implemented June 30, 2003. Since then the policy has been revised to correct an invalid ICD-9-CM diagnosis code. The ICD-9-CM code 181.0 is invalid and has been changed to 181 (Malignant neoplasm of placenta (choriocarcinoma). This correction is in the "ICD-9 Codes that Support Medical Necessity" section of the policy.

Effective Date

This revision is effective for services processed **on or after September 26, 2003**. ❖

J2355: Oprelvekin (Neumega®)—Addition to Policy

The local medical review policy (LRMP) for Oprelvekin (Neumega®) was implemented on January 20, 2000.

A request was received from a provider to add ICD-9-CM diagnosis code 273.3 (Macroglobulinemia) to the "ICD-9-CM Codes that Support Medical Necessity" section of the LMRP. After reviewing the information provided, it was determined this request was appropriate.

Therefore, the "ICD-9-CM Codes that Support Medical Necessity" section of the LMRP has been updated to include ICD-9-CM diagnosis code 273.3 for HCPCS code J2355. The billing of oprelvekin requires dual diagnoses. To ensure reimbursement for this service, dual diagnoses **must** be submitted. Providers must use ICD-9-CM diagnosis codes 140.0-202.98 or 273.3 **and** 287.4 (thrombocytopenia due to drugs) to report the approved indication for J2355.

In addition, type of bill 71x (rural health clinic) was removed from the LMRP and type of bill 85x (critical access hospital) was added to the LMRP.

Effective Date

This revision is effective for services processed **on or after September 26, 2003**. ❖

J9999: Antineoplastic Drugs—Addition to Policy

The local medical review policy for antineoplastic drugs was last updated effective September 29, 2003. The following revisions have been made since that time:

Indications and Limitations of Coverage and/or Medical Necessity

- The indication for off-label use of chemotherapeutic agents has been revised.
- The following off-label indications have been added to the respective agent:
  - Carboplatin – Hormone refractory prostate cancer (HRPC)
  - Docetaxel – Soft tissue sarcomas
  - Gemcitabine – Soft tissue sarcomas
  - Topotecan Hydrochloride – Cervical carcinoma

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

J9999: Antineoplastic Drugs—Addition to Policy (continued)

ICD-9 Codes that Support Medical Necessity

- The ICD-9-CM range for HCPCS codes J9181-J9182 (Etoposide) has been corrected from 186.0-186 to 186.0-186.9 (Malignant neoplasm of testis), effective for claims processed **on or after September 29, 2003.**
- The following ICD-9-CM codes have been added to the respective agent:
  - J9045 (Carboplatin) – 185 (Malignant neoplasm of prostate), effective for claims processed **on or after October 9, 2003.**
  - J9170 (Docetaxel) – 171.0-171.9 (Malignant neoplasm of connective and other soft tissue [soft tissue sarcomas]), effective for claims processed **on or after October 9, 2003.**
  - J9185 (Fludarabine) – 273.3 (Macroglobulinemia [Waldenstrom's macroglobulinemia]), effective for claims processed **on or after September 26, 2003.**
  - J9201 (Gemcitabine) – 171.0-171.9 (Malignant neoplasm of connective and other soft tissue [soft tissue sarcomas]), effective for claims processed **on or after October 9, 2003.**
  - J9350 (Topotecan hydrochloride) – 180.0-180.9 (Malignant neoplasm of cervix uteri), effective for claims processed **on or after October 9, 2003.** ❖

VISCO: Viscosupplementation Therapy for Knee—Addition to Policy

The local medical review policy for viscosupplementation therapy for knee was last updated on January 1, 2003.

Based on comments received from the provider community, revisions have been made to the "Indications and Limitations of Coverage and/or Medical Necessity," "ICD-9-CM Codes that Support Medical Necessity," "Reasons for Denials" and "Documentation Requirements" sections of the LMRP.

The following "Indications and Limitations of Coverage and/or Medical Necessity" apply to viscosupplementation therapy for knee:

- The patient must have painful osteoarthritis of the knee, and
- The patient must have an intolerance to nonsteroidal anti-inflammatory drugs (NSAIDs) with a condition such as peptic ulcer disease, or
- Mild analgesics such as acetaminophen have not been effective in pain reduction, and/or the patient has failed other conservative treatment, and
- Joint effusion, if any, must be removed prior to injection, and
- The patient should not be markedly obese, and
- The joint(s) injected must be the knee(s), and
- The patient has not had a previous reaction to an earlier administration of one of these medications.

ICD-9-CM diagnosis codes 715.16, 715.26 and 715.36 have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the LMRP. In addition, the LMRP has been revised to indicate ICD-9-CM codes 715.16, 715.26, 715.36 and 715.96 are applicable to HCPCS codes J7317 and J7320. Claims will no longer be denied when the patient has severe osteoarthritis and/or large joint effusions (joint effusion must be removed prior to injection).

In addition, the "Documentation Requirements" have been revised to state the physician should indicate in the patient's medical documentation the inability to take or respond to NSAIDs.

Effective Date

This revision is effective for claims processed **on or after August 29, 2003**. ❖

97001: Physical Medicine and Rehabilitation—Change in Policy Number

The local medical review policy number for physical medicine and rehabilitation has been changed from 97010 to 97001. ❖

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

ADDITIONAL INFORMATION ON LMRPS

J1563: Intravenous Immune Globulin

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

The following HCPCS codes are used when billing IVIG:

J1563 Injection, immune globulin, intravenous, 1 g
J1564 Injection, immune globulin, 10 mg

The IVIG dose is calculated based on the patient's weight, in kilograms, and the dose of IVIG, in milligrams. For example, an initial dose of 300 mg/kg for a two hundred (200) pound patient would be 27,300 mg. The final dose calculation must be converted from milligrams to grams to properly bill for IVIG. Therefore, 27,300 mg would be reported as 27.3 grams.

The following Coding Guidelines must be utilized when billing IVIG:

- Report J1563 when billing for multiple units of 1-gram quantities of IVIG. (In the example above, resulting in a dose of 27.3 grams, **27** represents the 1-gram quantities of IVIG.)
- One additional unit of J1563 can be reported for residual quantities greater than 0.75 gram. (In the example above, the residual quantity is less than 0.75 gram; therefore, an additional unit of J1563 would not be billed.)
- J1564 should be reported rarely and only during instances when patients receive residual quantities of IVIG less than 0.75 gram. (In the example above, resulting in a dose of 27.3, **.3** represents the residual quantity of IVIG less than 0.75 gram.)

In the example above, 27 service units of J1563 and 30 service units of J1564 should be reported. It would be inappropriate to bill J1563 with 27,300 units. ❖

Correction to Investigational Device Exemption Revised Requirements Article

An article on investigational device exemption (IDE) requirements was published in the Fourth Quarter 2003 *Medicare A Bulletin* page 40. In that article, the revenue code indicated to use in form locator 42 was listed incorrectly as 642. The correct revenue code to use in form locator 42 is **624**. Revenue code 624 is only applicable for medical investigational devices and procedures with FDA approved IDE's for clinical trial. We apologize for any inconvenience this may have caused. ❖

2004 ICD-9-CM Part A Local Medical Review Policy Changes

The 2004 update to the ICD-9-CM diagnosis coding structure is effective October 1, 2003. Providers are required to use the 2004-updated ICD-9-CM coding effective for all hospital discharges and outpatient services occurring **on or after October 1, 2003.** Due to the direct relationship between coding and reimbursement, it is particularly important that providers reimbursed under the outpatient prospective payment system (OPPS) used the appropriate ICD-9-CM coding. Other providers that code diagnoses and procedures (non-OPPS providers) are also affected. In addition, the new diagnosis coding is used in hospital outpatient billing.

Florida Medicare has revised local medical review policies (LMRPs), for procedure codes with specific diagnosis criteria that are affected by the 2004 ICD-9-CM update. The following table lists the LMRPs affected and the specific conditions revised as a result of the 2004 ICD-9-CM update:

LMRP Title	2004 Changes
A43235 Diagnostic and Therapeutic Esophagogastroduodenoscopy	Add V58.64 (Long-term (current) use of non-steroidal anti-inflammatories [NSAID]) for procedure codes 43235, 43236, 43239, 43241, 43243-43251, 43255, and 43258. Add type of bill code 85x (critical access hospital) **(Not related to 2004 ICD-9-CM update).**
A52282 Urethral Stents	Change 600.0-600.9 to 600.00-600.91 – Hyperplasia of prostate for procedure code 52282. Add type of bill code 71x (rural health clinic) **(Not related to 2004 ICD-9-CM update).**

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

2004 ICD-9-CM Part A Local Medical Review Policy Changes (continued)

LMRP Title	2004 Changes
A53850 Prostate Treatments	Change 600.0 to 600.00-600.01 (Hypertrophy (benign) of prostate) for procedure codes 53850, 53852, and 53853. Add type of bill code 71x (rural health clinic) **(Not related to 2004 ICD-9-CM update).**
A55700 Biopsy of Prostate Using Image Guidance	Change 600.0-600.9 to 600.00-600.91 (Hyperplasia of prostate) for procedure code 55700. Removed type of bill codes 12x and 14x (hospital) **(Not related to 2004 ICD-9-CM update).**
A70450 Computed Tomography Scans	Change 767.1 to 767.11 (Epicranial subaponeurotic hemorrhage [massive]) and 767.19 (Other injuries to scalp) for procedure codes 70450, 70460, and 70470. Add 781.94 (Facial weakness) for procedure codes 70450, 70460, and 70470. Removed type of bill codes 14x (hospital) and 22x and 23x (skilled nursing facility) **(Not related to 2004 ICD-9-CM update).** Add type of bill code 71x (rural health clinic) **(Not related to 2004 ICD-9-CM update).**
A70551 Magnetic Resonance Imaging of the Brain	Change 358.0-358.1 to 358.00-358.1 (Myasthenia gravis and myasthenic syndromes in diseases classified elsewhere) for procedure codes 70551, 70552, and 70553. Add 781.94 (Facial weakness) for procedure codes 70551, 70552, and 70553. Removed type of bill codes 14x (hospital) and 21x, 22x and 23x (skilled nursing facility) **(Not related to 2004 ICD-9-CM update).** ICD-9-CM diagnosis code 767.0 (Birth trauma, subdural and cerebral hemorrhage) was inadvertently omitted from the covered diagnosis code list in the policy. Florida Medicare apologizes for any inconvenience this may have caused. **(Not related to 2004 ICD-9-CM update.)**
A71010 Chest X-ray	Change 959.1 to 959.11 (Other injury of chest wall) and 959.19 (Other injury of other sites of trunk) for procedure codes 71010, 71015, 71020, 71021, 71022, 71023, 71030, 71034, and 71035. Change V43.2-V43.3 to V43.21-V43.3 (Organ or tissue replaced by other means, heart and heart valve) for procedure codes 71010, 71015, 71020, 71021, 71022, 71023, 71030, 71034, and 71035.
A72192 Computed Tomography of the Pelvis	Change 752.8 to 752.81 (Scrotal transposition) and 752.89 (Other specified anomalies of genital organs) for procedure codes 72192, 72193, and 72194. Change 820.00-820.99 to 820.00-820.9 (Fracture of neck of femur) for procedure codes 72192, 72193, and 72194 **(Not related to 2004 ICD-9-CM update).** Change 959.1 to 959.12 (Other injury of abdomen), 959.13 (Fracture of corpus cavernosum penis), and 959.14 (Other injury of external genitals) for procedure codes 72192, 72193, and 72194. Add 995.91 (Systemic inflammatory response syndrome due to infectious process without organ dysfunction) and 995.92 (Systemic inflammatory response syndrome due to infectious process with organ dysfunction) for procedure codes 72192, 72193, and 72194.
A78460 Myocardial Perfusion Imaging	Add 414.07 (Coronary atherosclerosis of bypass graft (artery) (vein) of transplanted heart) for procedure codes 78460, 78461, 78464, 78465, 78478, and 78480. Add type of bill code 85x (critical access hospital) **(Not related to 2004 ICD-9-CM update).**
A78472 Cardiac Blood Pool Imaging	Change 414.00-414.06 to 414.00-414.07 (Coronary atherosclerosis) for procedure codes 78472, 78473, 78481, 78483, 78494, and 78496. Add type of bill code 85x (critical access hospital) **(Not related to 2004 ICD-9-CM update).**

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

2004 ICD-9-CM Part A Local Medical Review Policy Changes (continued)

LMRP Title	2004 Changes
A82108 Aluminum	Change 348.3 to 348.30-348.39 (Encephalopathy, not elsewhere classified) for procedure code 82108. Change 973 to 973.0 (Poisoning by antacids and antigastric secretion drugs) for procedure code 82108 **(Not related to 2004 ICD-9-CM update).** Add type of bill code 85x (critical access hospital) **(Not related to 2004 ICD-9-CM update).**
A82310 Total Calcium	Add 728.87 (Muscle weakness) and 728.88 (Rhabdomyolysis) for procedure code 82310. Add 780.01 (Coma) for procedure code 82310 **(Not related to 2004 ICD-9-CM update).** Add type of bill code 85x (critical access hospital) **(Not related to 2004 ICD-9-CM update).**
A82435 Chloride	Change 255.1 to 255.10-255.14 (Hyperaldosteronism) for procedure code 82435. Add type of bill code 85x (critical access hospital) **(Not related to 2004 ICD-9-CM update).**
A82784 Gammaglobulin (Immunoglobulins); IgA, IgD, IgG, IgM, Each	Change 600.0-600.9 to 600.00-600.91 (Hyperplasia of prostate) for procedure code 82784. Remove type of bill code 71x (Rural Health Clinic) **(Not related to 2004 ICD-9-CM update).**
A83735 Magnesium	Change 255.1 to 255.10-255.14 (Hyperaldosteronism) for procedure code 83735. Change 643.10-643.83 to 643.00-643.83 (Excessive vomiting in pregnancy) for procedure code 83735 **(Not related to 2004 ICD-9-CM update).** Add 728.87 (Muscle weakness) and 728.88 (Rhabdomyolysis) for procedure code 83735. Change 941.00-949.5 to 940.0-949.5 (Burns) for procedure code 83735 **(Not related to 2004 ICD-9-CM update).** Remove type of bill code 71x (Rural Health Clinic) **(Not related to 2004 ICD-9-CM update).** Add type of bill code 85x (critical access hospital) **(Not related to 2004 ICD-9-CM update).**
A84100 Serum Phosphorus	Change 348.3 to 348.30-348.39 (Encephalopathy, not elsewhere classified) for procedure code 84100. Add 728.87 (Muscle weakness) and 728.88 (Rhabdomyolysis) for procedure code 84100. Change E944.0-E944.5 to E944.0-E944.7 (Drugs, medicinal and biological substances causing adverse effects in therapeutic use, water, mineral, and uric acid metabolism drugs) for procedure code 84100 **(Not related to 2004 ICD-9-CM update).**
A92081 Visual Field Examination	Change descriptor for 282.60-282.69 (Sickle-cell disease) for procedure codes 92081, 92082, and 92083. Change 743.52-743.58 to 743.51-743.59 (Congenital anomalies of posterior segment) for procedure codes 92081, 92082, and 92083 **(Not related to 2004 ICD-9-CM update).** Remove type of bill code 71x (Rural Health Clinic) **(Not related to 2004 ICD-9-CM update).** Add type of bill code 85x (critical access hospital) **(Not related to 2004 ICD-9-CM update).**
A93000 Electrocardiography	Change 959.1 to 959.11-959.19 (Injury, trunk) for procedure codes 93000, 93005, and 93010. Change 995.0-995.89 to 995.0-995.94 (Certain adverse effects not elsewhere classified) for procedure codes 93000, 93005, and 93010 **(Not related to 2004 ICD-9-CM update).**

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

2004 ICD-9-CM Part A Local Medical Review Policy Changes (continued)

LMRP Title	2004 Changes
A93224 Electrocardiographic Monitoring for 24 Hours (Holter Monitoring)	Change descriptor for 414.06 (Coronary atherosclerosis of native coronary artery of transplanted heart) for procedure codes 93224, 93225, 93226, 93227, 93230, 93231, 93232, 93233, 93235, 93236, and 93237. Add 414.07 (Coronary atherosclerosis of bypass graft (artery) (vein) of transplanted heart) for procedure codes 93224, 93225, 93226, 93227, 93230, 93231, 93232, 93233, 93235, 93236, and 93237 Remove type of bill code 71x (rural health clinic) **(Not related to 2004 ICD-9-CM update).** Add type of bill code 85x (critical access hospital) **(Not related to 2004 ICD-9-CM update).**
A93303 Transthoracic and Doppler Echocardiography and Doppler Color Flow Velocity Mapping	Change 414.00-414.06 to 414.00-414.07 (Coronary atherosclerosis) for procedure codes 93307 and 93308. Change 414.00-414.06 to 414.00-414.07 (Coronary atherosclerosis) for procedure codes 93320, 93321, and 93325. Remove type of bill code 71x (rural health clinic) **(Not related to 2004 ICD-9-CM update).** Add type of bill code 85x (critical access hospital) **(Not related to 2004 ICD-9-CM update).**
A93312 Transesophageal Echocardiogram	Change 414.00-414.06 to 414.00-414.07 (Coronary atherosclerosis) for procedure codes 93312, 93313, 93314, 93315, 93316, 93317, and 93318. Remove type of bill code 71x (rural health clinic) **(Not related to 2004 ICD-9-CM update).** Add type of bill code 85x (critical access hospital) **(Not related to 2004 ICD-9-CM update).**
A93350 Stress Echocardiography	Change descriptor for 414.06 (Coronary atherosclerosis of native coronary artery of transplanted heart) for procedure code 93350. Add 414.07 (Coronary atherosclerosis of bypass graft (artery) (vein) of transplanted heart) for procedure code 93350.
A94760 Non-invasive Ear or Pulse Oximetry for Oxygen Saturation	Add 493.81 (Exercise induced bronchospasm) and 493.82 (Cough variant asthma) for procedure codes 94760 and 94761. Add 493.81 (Exercise induced bronchospasm) and 493.82 (Cough variant asthma) for procedure code 94762.
A94799 Pulmonary Rehabilitation Services	Change descriptor for 493.00 (Extrinsic asthma, unspecified), 493.10 (Intrinsic asthma, unspecified), and 493.20 (Chronic obstructive asthma, unspecified) for procedure code 94799. Add 493.81-493.82 (Other forms of asthma) for procedure code 94799.
A95857 Tensilon Test	Change 358.0 to 358.00-358.01 (Myasthenia gravis) for procedure codes 95857 and 95858. Removed type of bill codes 14x (Hospital) and 21x and 28x (Skilled Nursing Facility), and 75x (Comprehensive Outpatient Rehabilitation Facility) **(Not related to 2004 ICD-9-CM update).** Add type of bill code 85x (Critical Access Hospital) **(Not related to 2004 ICD-9-CM update).**

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

2004 ICD-9-CM Part A Local Medical Review Policy Changes (continued)

LMRP Title	2004 Changes
AA4644 Low Osmolar Contrast Media (LOCM)	Change 282.4 to 282.41-282.49 (Thalassemias) for procedure codes A4644, A4645, and A4646. Change descriptor for 282.60 (Sickle-cell disease, unspecified), 282.61 (Hb-SS disease without crisis), 282.62 (Hb-SS disease with crisis), 282.63 (Sickle-cell/Hb-C disease without crisis), and 282.69 (Other sickle-cell disease with crisis) for procedure codes A4644, A4645, and A4646. Add 282.64 (Sickle-cell/Hb-C disease with crisis) and 282.68 (Other sickle-cell disease without crisis) for procedure codes A4644, A4645, and A4646. Change descriptor for 493.00 (Extrinsic asthma, unspecified), 493.02 (Extrinsic asthma, with (acute) exacerbation), 493.10 (Intrinsic asthma, unspecified), 493.12 (Intrinsic asthma, with (acute) exacerbation), 493.20 (Chronic obstructive asthma, unspecified), 493.22 (Chronic obstructive asthma, with (acute) exacerbation), and 493.90 (Asthma, unspecified) for procedure codes A4644, A4645, and A4646. Add 493.92 (Asthma, with (acute) exacerbation) for procedure codes A4644, A4645, and A4646 **(Not related to 2004 ICD-9-CM update).** Add 785.52 (Septic shock) for procedure codes A4644, A4645, and A4646. Add type of bill code 85x (critical access hospital) **(Not related to 2004 ICD-9-CM update).**
AG0030 Positron Emission Tomography (PET) Scan	Change descriptor for 414.06 (Coronary atherosclerosis of native coronary artery of transplanted heart) for procedure codes G0030-G0047. Add 414.07 (Coronary atherosclerosis of bypass graft (artery) (vein) of transplanted heart) for procedure codes G0030-G0047. Remove type of bill code 14x (Hospital) **(Not related to 2004 ICD-9-CM update).**
AJ0151 Adenosine (Adenocard®, Adenoscan®)	Change 414.00-414.06 to 414.00-414.07 (Coronary atherosclerosis) for procedure code J0151. Remove type of bill code 14x (hospital) **(Not related to 2004 ICD-9-CM update).**

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

WIDESPREAD MEDICAL REVIEW PROBES

Therapeutic Radiology Port Films—Widespread Probe Review Results

Overview

CPT code *77417 (Therapeutic radiology port film(s))* was chosen for widespread probe medical review based on analysis of January – June 2002 data. According to the June 2002 release of the Florida Part A Reimbursement by Paid Month Report (trending over previous five years), Florida's outpatient hospital services (TOB 13x) increased 150 percent since implementation of the hospital outpatient prospective payment system (OPPS) reimbursement methodology. A widespread probe was conducted on a random sample of 100 claims from ten facilities billing therapeutic radiology port films, procedure code *77417*, over a one-year period from March 2002 – March 2003. These claims encompassed 352 services for 100 claims. The purpose of the widespread probe review was to determine if the services billed to Medicare were documented as having been performed, appropriately coded, medically reasonable and necessary, and covered Medicare services.

Summary

The summary of the findings is as follows:

- A total of 352 units were billed, 159 units were denied. Four facilities did not send in records for review and one facility sent incomplete documentation resulting in the denial of all services. The remaining services were denied because there was no documentation in the files to support billing of units greater that one per five fractions of therapy.
- Payments for $5,565.59 were reviewed. Payments for $2,475.95 were denied.
- These findings resulted in a 44 percent error rate for the usage of *CPT* code *77417*.

Based on these widespread probe findings, a local medical review policy will be developed for therapeutic radiology port films to define indications and limitations of coverage and/or medical necessity and clarify guidelines, as well as documentation requirements. Overpayments will be collected when the medical records did not sufficiently support the medical necessity for the additional films to be performed and education will be provided through the widespread probe education letter. Overpayments will be collected from providers that did not submit records for review and/or sent in incomplete records. ❖

HOSPITAL SERVICES

Clarification for Billing Under 2300 Provider Number by Hospital-Based Renal Dialysis Facilities

The Centers for Medicare & Medicaid Services (CMS) has issued clarification for hospital-based renal dialysis facility (RDF) regarding billing requirements related to provider number use. In several instances, hospital-based chronic RDFs are using the hospital provider number rather than the assigned RDF provider number.

The hospital-based renal facility has an assigned RDF provider number in the 2300-2499 series. It is required that the assigned RDF provider number be used on billing Form UB-92 CMS-1450 (or electronic equivalent) when billing for Part B outpatient renal services. These facilities are not to use the hospital provider number on these bills. The hospital provider numbers shall only be used by the hospital when billing for transplant services and related transplant services for past inpatient hospitalizations, in addition to other non-renal inpatient and outpatient hospital services. End-stage RDFs based in children's hospitals will bill for Part B outpatient maintenance dialysis services using the hospital provider number in the 3300-3399 series.

When a hospital-based chronic RDF does not have an assigned RDF provider number, that facility should contact the CMS regional office for that area, and request a number.

The provider number series for dialysis providers are as follows:

2300-2499 Chronic renal dialysis facilities **(hospital-based)**
2500-2899 Non-hospital renal facilities
2900-2999 Independent s*pecial purpose r*enal dialysis facility
3300-3399 Children's hospitals (excluded from prospective payment system)
3500-3699 Renal disease treatment centers **(hospital satellites)**
3799-3799 Hospital-ased s*pecial purpose* renal dialysis facility

All facilities shall use their appropriately assigned provider numbers on type of bills 72x. In the event that a facility changes from one type to another the provider number must reflect the facility's present type.

Example: Hospital provider number 100093 and the hospital-based chronic renal dialysis 2300-2499 series provider number 102327. The correct provider number for billing ESRD services on a type of bill 72x is 102377.

Effective for claims for date of services furnished **on or after January 1, 2004,** the fiscal intermediaries will ensure that type of bills 72x have the correct provider number series based on the type of renal disease facility.

A list of "*National Listing of Medicare Providers Furnishing Kidney Dialysis and Transplant Services*" is available at *www.cms.hhs.gov/esrd/8.asp* or *www.cms.hhs.gov/esrd/8e.pdf*. ❖

Source: CMS Transmittal A-03-082, CR 2877

Billing Instructions for Ventricular Assist Devices for Beneficiaries in a Medicare+Choice Plan

The Centers for Medicare & Medicaid Services (CMS) has recently expanded coverage for ventricular assist devices (VADs). Until Medicare capitation rates to Medicare+Choice (M+C) organizations are adjusted to account for this expanded VADs coverage, Medicare will pay providers on a fee-for-service basis for VADs that fall under the new indication for destination therapy. This notification provides billing instructions for claims for VADs for beneficiaries in a M+C plan.

The fee-for-service claim processing system automatically excludes claims for services provided for risk M+C beneficiaries except in certain circumstances for which editing has been created (e.g. NETT claims, clinical trial claims).

Billing Instructions

Hospitals are instructed to use condition code 78 (new coverage not implemented by HMO) when billing for services for VADs for beneficiaries in an M+C plan when conditions fall under the new indications for destination therapy, which are effective for services furnished **on or after October 1, 2003.**

M+C enrollees are liable for the coinsurance amounts applicable to services paid under Medicare fee-for service rules.

Claims for M+C organizations' beneficiaries with existing covered indications should **not** be billed with the condition code or modifier since the existing covered indications are currently included in the M+C plan's capitated rates. ❖

Source: CMS Pub 100-4 Transmittal #10, CR 2958

Supplemental Security Income/Medicare Beneficiary Data for Fiscal Year 2002

Updated data for determining additional payment amounts for hospitals with a disproportionate share of low-income patients is now available from CMS. The supplemental security income (SSI)/Medicare beneficiary data for inpatient prospective payment system is available electronically, and contains the name of the hospital, provider number, SSI days covered Medicare days, and the ration of Medicare Part A patient days attributable to SSI recipients. The file is located on the CMS Web site at *www.cms.hhs.gov/providers/hipps/dsh.asp*.

The data is used for settlement purposes for hospitals with cost reporting periods beginning during fiscal year 2002 (cost reporting periods beginning on or after October 1, 2001 and before October 1, 2002). ❖

Source: CMS Transmittal A-03-067, CR 2868

INPATIENT HOSPITAL SERVICES

Fiscal Year 2004 Inpatient Prospective Payment System, Long-Term Care Hospital, and Other Bill Processing Changes

This article outlines changes for the fiscal year 2004. The following changes addressed in this notification are effective for hospital discharges occurring on or after October 1, 2003, unless otherwise noted.

- Changes for hospital inpatient prospective payment system (IPPS) for fiscal year 2004. These changes for FY 2004 were published in the *Federal Register* on August 1, 2003.
- Long term care hospitals (LTCH) prospective payment system new GROUPER and diagnosis related group (DRG) changes that are effective October 1, 2003, for hospitals paid under LTCH PPS. LTCH PPS rate changes occurred July 1, 2003.
- Other bill processing changes.

ICD-9-CM Changes

ICD-9-CM coding changes are effective October 1, 2003. The new ICD-9-CM codes are listed, along with their DRG classifications in tables 6a and 6b of the August 1, 2003, *Federal Register*. The ICD-9-CM codes that have been replaced by expanded codes or other codes, or have been deleted are included in tables 6c and 6d. The revised code titles are in tables 6e and 6f.

GROUPER 21.0 assigns each case into a DRG based on the diagnosis, procedure codes, and demographic information (that is age, sex, and discharge status), and is effective with discharges occurring on or after October 1, 2003. Medicare code editor (MCE) 20.0 and outpatient code editor (OCE) versions 19.0 and 4.3 use the new ICD-9-CM codes to validate coding for discharges and outpatient services effective October 1, 2003.

Furnished Software Changes

The following software programs were issued for FY 2004:

A. IPPS PRICER 04.0 for discharges occurring on or after October 1, 2003. This processes bills with discharge dates on or after October 1, 1999.

Rates

Standardized Amount Update Factor		3.4%
Hospital Specific Update Factor		3.4%
National Adjusted Operating Standardized Amounts, Labor/Nonlabor		
Large Urban:	Labor	$3,146.06
	Nonlabor	$1,278.78
Other Area:	Labor	$3,096.25
	Nonlabor	$1,258.54
Adjusted Operating Standardized Amounts for Puerto Rico, Labor/ Nonlabor		
National/Large Urban:	Labor	$3,119.61
	Nonlabor	$1,268.03
National/Other Area:	Labor	$3,119.61
	Nonlabor	$1,268.03
PR/Large Urban:	Labor	$1,510.12
	Nonlabor	$607.86
PR/Other Area:	Labor	$1,486.22
PR/Other:	Nonlabor	$598.24
Common Fixed Loss Cost Outlier Threshold		$31,000.00
Federal Capital Rate		$415.47
Puerto Rico Capital Rate		$203.15
Outlier Offset-Operating National		0.949236
Outlier Offset-Operating Puerto Rico		0.976658
Outlier Offset-Operating National PR Blend		0.962947
IME Formula *[(1+ resident-to-bed ratio)**. 405-1]		1.35
MDH/SCH Budget Neutrality Factor		1.005522

The revised hospital wage indices and geographic adjustment factors are contained in tables 4a (urban areas), 4b (rural areas) and 4c (redesignated hospitals) of section VI of the addendum to the August 1, 2003, *Federal Register*.

Fiscal Year 2004 Inpatient PPS Long-Term Care Hospital, and Other Bill Processing Changes (continued)

Note: Some wage indices are incorrect in the August 1, 2003 ***Federal Register.*** A correction notice to the Federal Register will be issued shortly.

Postacute Care Transfer Policy

On October 1, 1998, CMS established a postacute care transfer policy which paid as transfers all cases which assigned to one of 10 DRGs if the patient is discharged to a psychiatric hospital or unit, an inpatient rehabilitation hospital or unit, a long term care hospital, a children's hospital, a cancer hospital, a skilled nursing facility, or a home health agency. Those DRGs were 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483.

Effective for discharges on or after October 1, 2003, the postacute care transfer policy is expanded, adding 21 additional DRGs to the original 10. They are: 12, 24, 25, 88, 89, 90, 121, 122, 127, 130, 131, 239, 277, 278, 294, 296, 297, 320, 321, 395, and 468.

DRGs 263 and 264 are deleted from the original 10 DRG list and will no longer be subject to this transfer policy effective October 1, 2003.

New Technology Add-On Payment

Hospitals providing InFUSE™ are eligible for a new technology add-on payment effective for discharges on or after October 1, 2003. Under 42 CRF 412.88 of the regulations, an add-on payment is made for discharges involving approved new technologies, if the total covered costs of the discharge exceed the DRG payment for the case (including adjustments for indirect medical education, disproportionate share, transfers, etc., but excluding outlier payments.) PRICER will calculate the total covered costs for this purpose by applying the cost-to-charge ratio (that is used for inpatient outlier purposes) to the total covered costs of the discharge. Payment for the eligible cases will be equal to:

- The DRG payment, plus
- The lesser of
  - 50 percent of the costs of the new medical service or technology; or
  - 50 percent of the amount by which the total covered costs (as determined above) of the case exceed the DRG payment; plus
- Any applicable outlier payments if the costs of the case exceed the DRG, plus adjustments for IME and DSH, and any approved new technology payment for the case plus the fixed loss outlier threshold. The costs of the new technology are included in the determination of whether a case qualifies for outliers.

PRICER will calculate InFUSE™ in the same way it calculates Xigris™ (identified by procedure code 00.11). In order to pay the add-on technology payment for InFUSE™, PRICER will look for the presence of two ICD-9-CM procedure codes, 84.51 and 84.52. If both are present, PRICER will calculate the new technology add-on only if the case groups to DRG 497 or 498. The maximum add-on payment for InFUSE™ is $8900.00.

It is possible to have both new technologies on the same claim. Should both new technologies be present, PRICER will calculate Xigris™ and then calculate InFUSE™, summing the two new technology payments. The total is in the field labeled "PPS-New-Tech-Payment-Add-On" returned from PRICER.

B. GROUPER 21.0 for discharges occurring on or after October 1, 2003. PRICER calls the appropriate GROUPER based on discharge date. Medicare contractors will receive the GROUPER documentation on or about August 1, 2003.

C. MCE 20.0 for discharges occurring on or after October 1, 2003, and OCE 19.0 and 4.3 for services furnished on or after October 1, 2003. These replace earlier versions and contain complete tables driven by date. The MCE and OCE select the proper internal tables based on discharge date. Medicare contractors will receive the MCE documentation on or about August 1, 2003.

ICD-9-CM procedure codes V53.01 and V53.02 should not be included in the "Unacceptable Principle Diagnosis" Edit. We will manually override the "Unacceptable Principle Diagnosis" edit in the MCE for these two codes effective for discharges on or after October 1, 2003, until the MCE is corrected.

The MCE has seven new edits, called limited coverage edits. These procedures were previously in the noncovered procedures list, but were covered under limited circumstances. The new edits will make it easier for Medicare to distinguish these services in order to override them when appropriate.

MCE Edit Description	Procedure Code
LVRS-Limited Coverage	3222 – Lung vol reduction surg
Lung Transplant-Limited Coverage	3350 – Lung transplant NOS 3351 – Unilat lung transplant 3352 – Bilat lung transplant
Combo Heart/Lung Transpl-Limit Cov	336 – Comb heart/lung transpla
Heart Transplant-Limited Coverage	3751 – Heart Transplantation
Imp imp pul hrt asst sys-Limit Cov	3766 – Imp imp pul hrt asst sys
Intest/M.Visceral Transpl-Limit Cov	4697 – Transplant of intestine
Liver Transplant-Limited Coverage	5059 – Liver transplant NEC

D. LTCH PRICER-LTC-DRGs and relative weights:

The annual update of the LTC-DRGs, relative weights and GROUPER software for FY 2004 are published in the annual IPPS final rule. The same GROUPER software developed by 3M for the Hospital Inpatient PPS will be used for the LTCH PPS. The LTCH PRICER was released to the maintainers on August 14, 2003.

- Version 21.0 of the hospital inpatient PPS GROUPER will be used for FY 2004, but with LTCH-specific relative weights reflecting the resources used to treat the medically complex LTCH patients.
- The annual update of the LTC-DRGs, relative weights, (geometric) average length of stay and 5/6th of the average length of stay (for short-stay outlier cases) for

Fiscal Year 2004 Inpatient PPS Long-Term Care Hospital, and Other Bill Processing Changes (continued)

FY 2004 was determined using the most recent available LTCH claims data (FY 2002).

- The LTC-DRGs, relative weights, (geometric) average length of stay and 5/6th of the average length of stay effective for discharges on or after October 1, 2003 can be found in Table 11 of this final rule and are in the LTCH PPS PRICER program.

Other Changes

Transfers under IPPS

Claims coded as LAMA (left against medical advice) with patient status code 07 will now be treated as transfers if the patient is subsequently admitted to another IPPS hospital on the same day. This will require systems changes to the standard systems and the common working file, and will not be implemented until April 1, 2004. CMS will issue detailed instructions shortly. Providers should code LAMAs with a patient status code 02 if the patient is admitted to another IPPS hospital on the same day.

LTCH PPS Cost-To-Charge Ratios

To ensure that the distribution of outlier payments remains equitable, for FY 2004 a LTCH overall Medicare cost-to-charge ratio is considered not to be reasonable if the value exceeds the combined (operating plus capital) upper (ceiling) cost-to-charge ratio thresholds calculated annually by CMS under the hospital inpatient PPS and published in the *Federal Register*. Effective for discharges occurring on or after October 1, 2003, the combined operating and capital upper limit (ceiling) on cost-to-charge ratios is 1.366 (1.203 plus 0.163). If the overall Medicare cost-to-charge ratio appears not to be reasonable, the fiscal intermediary will ensure that the underlying costs and charges are properly reported prior to assigning the appropriate combined statewide average. The appropriate (combined) statewide average cost-to-charge ratios for FY 2004 can be found in tables 8A and 8B of the IPPS Final Rule. ❖

Source: CMS Transmittal A-03-073, CR 2891

Inpatient Rehabilitation Facility: Prospective Payment System PRICER Changes for Fiscal Year 2004

On August 7, 2001, a final rule was published in the *Federal Register* that established the prospective payment system (PPS) for inpatient rehabilitation facilities (IRFs), as authorized under section 1886(j) of the Social Security Act (the Act). In that final rule, CMS set forth per discharge federal rates for federal fiscal year (FY) 2002. These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002. Annual updates to the IRF PPS rates are required by section 1886(j)(3)(C) of the Act.

On August 1, 2003, a final rule was published in the ***Federal Register*** (68 FR 45674) that sets forth the prospective payment rates applicable for IRFs for FY 2004. A new IRF PRICER software package will be released prior to October 1, 2003, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2003, through September 30, 2004.

The Medicare claim processing system will apply the FY 2004 IRF PPS payment rates to discharges that fall **on or after October 1, 2003**. ❖

Source: CMS Transmittal A-03-074, CR 2894

ESRD SERVICES

End-Stage Renal Disease Drug Pricing Update

The following revised ESRD drug-pricing list updates and replaces section 22 of the Medicare Part A ESRD processing manual. This list may also be used as a stand-alone reference for ESRD drugs and/or pharmacy services. Prices are effective for services rendered on or after January 1, 2003, for claims processed **on or after October 1, 2003**.

On January 1, 2003, the Centers for Medicare & Medicaid Services (CMS) implemented a single drug pricer (SDP) for drugs and biological to standardize prices for some of Medicare covered drug. The ESRD drug pricing list has been updated based on the Medicare fees established with the implemetation of the SDP initiative.

- The drugs listed in this section are arranged in alphabetical order, based on the first initial of the drug name.
- When a drug is billed on Form UB-92 CMS-1450, or electronic equivalent format, an ICD-9-CM diagnosis code (excluding 585 – Chronic renal disease) must be reported.
- Diagnosis code 585 – (Chronic renal disease) must be reported as principal diagnosis code on all ESRD type of bill (TOB 72x).

CPT/HCPCS CODE — *Current Procedural Terminology (CPT)* code, Healthcare Common Procedure Coding System (HCPCS), and locally assigned code reportable on Form UB-92 CMS-1450 or electronic equivalent.
NAME — Name of drug (brand name and/or generic).
PRICE — Medicare reimbursement allowance for specific drug administered via ESRD environment.

***CPT*/HCPCS CODE**	**NAME**	**PRICE**
J0170	Adrenalin, epinephrine, 1 mg/1 cc ampule	$ 2.35
J0210*	Aldomet, methyldopate HCL, up to 250 mg	$11.88
J2997	Alteplase, recombinant, activase, 1 mg	$36.70
00047	Amikin, Amikacin, 100 mg/2 cc	$11.11
J0280	Aminophylline, aminophyllin, 250 mg	$ 1.05
J0285	Amphotericin B, Fungizone, 50 mg	$11.06
J0290	Ampicillin sodium, 500 mg	$ 1.65
J0690	Ancef, cefazolin sodium, Kefzol, 500 mg	$ 2.25
J3430	Aquamephyton, phytonaidione (vitamin K), 1 mg	$ 2.42
J0380*	Aramine, metaraminol bitartrate, 10 mg	$ 1.27
J7504	Atgam, lymphocyte immune globine, 250 mg	$278.70
J2060	Ativan, lorazepam, 2 mg	$ 3.14
J0460	Atropine sulfate, 0.3 mg	$ 0.83
X0004	Azactam, aztreonam, 1 gm	$17.95
00151	Bactrim, 80 mg/ml-16 mg/ml, 5 cc	$ 3.07
J0530	Bicillin C-R, penicillin-G, 600,000 units	$11.92
J0540	Bicillin C-R, penicillin-G, 1,200,000 units	$23.40
J0550	Bicillin C-R, penicillin-G, 2,400,000 units	$50.12
J0560	Bicillin L-A,penicillin-G, 600,000 units	$ 9.89

***CPT*/HCPCS CODE**	**NAME**	**PRICE**
J0570	Bicillin L-A, penicillin-G, 1,200,000 units	$19.78
J0580	Bicillin L-A, penicillin-G, 2,400,000 units	$39.56
J0592	Buprenix, buprenorphine hydrochloride, 0.1 mg	$ 1.03
J0636	Calcijex, calcitriol, 0.1 mcg	$ 1.38
J0630	Calcitonin-salmon, up to 400 units	$38.41
X0014	Calcium chloride 10%, 10 cc	$2.10
J0610	Calcium gluconate, 10 ml	$ 1.02
J1955	Carnitine, levocarnitine, 1 gm	$34.20
J0710	Cefadyl, cephapirin sodium), 1 gm	$ 2.67
J0715	Ceftizoxime sodium, Cefizox, 500 mg	$ 4.96
00248	Cefobid, Cefoperazone sodium, 1 gm	$16.38
X0016	Cefotan, Cefotetan disodium gm	$11.04
J0698	Cefotaxime sodium, Claforan, 1 gm	$10.45
J0697	Cefuroxime sodium, 750 mg	$ 6.42
J0702	Celestone Soluspan, 3 mg-3mg/ml	$ 4.98
J0743	Cilastatin sodium imipenem, Primaxin I.V., 250 mg	$15.87
87000	Cipro, 200 mg	$13.69
X0017	Cleocin Phosphate, clindamycin phosphate, 300 mg	$ 3.41

*This drug is included in the composite rate.

End-Stage Renal Disease Drug Pricing Update (continued)

CPT/HCPCS CODE	NAME	PRICE
J0745	Codeine phosphate, 30 mg	$ 0.50
J0800	Corticotropin Acthar Gel 40 Units	$92.94
J0835	Cortrosyn, cosyntropin, 0.25 mg	$18.24
J9070	Cyclophosphamide, Cytoxan, 100 mg	$ 5.73
J9080	Cyclophosphamide, Cytoxan, 200 mg	$10.89
J9090	Cyclophosphamide, Cytoxan, 500 mg	$22.86
J9091	Cyclophosphamide, Cytoxan, 1 gm	$45.73
J9092	Cyclophosphamide, Cytoxan, 2 gm	$91.45
J2597	DDAVP, desmopressin acetate), 1mcg	$ 3.45
J1100	Decadron, dexamethasone sodium phosphate, 1 mg	$ 0.10
J2175	Demerol, meperidine HCL, 100 mg	$ .56
J1070	Depo-Testosterone, up to 100 mg	$ 4.95
J1080	Depo-Testosterone, 1 cc, 200 mg	$ 9.43
J0895	Desferal, deferoxamine mesylate), 500 mg/5 cc	$15.63
J1100	Dexamethasone sodium phosphate, 1 mg/ml	$ 0.10
J7060	Dextrose 5%, 500 cc	$ 9.04
J1730*	Diazoxide, Hyperstat, 300 mg/20 ml	$122.95
J1450	Diflucan, Fluconazole, 200 mg	$95.92
J1160*	Digoxin, Lanoxin, up to 0.5 mg	$ 1.79
J1165	Dilantin, phenytoin sodium, 50 mg	$ 0.86
J1170	Dilaudid, hydromophone, 4 mg	$ 1.55
J1200*	Diphenhydramine HCL (Benadryl), up to 50 mg	$ 1.61
Q4076*	Dopamine HCL, Intropin, 40 mg/1 cc	$ 0.62
J1240	Dramamine, dimenhydrinate, 50 mg	$ 0.38
J1364	Erythromycin lactobionate, 500 mg	$ 3.51
J0970	Estradiol valerate, Delestrogen, up to 40 mg	$ 1.62
J2916	Ferrlecit, sodium ferric gluconate complex in sucrose injection 12.5 mg	$ 8.17
00623	Flagyl, Metronidazole, 500 mg	$24.86
J9190	Fluorouracil, 500 mg	$ 2.07
X0100	Folic Acid, 5 mg/cc	$1.26
J0713	Fortaz, ceftazidime, 500 mg	$ 6.75
J1470	Gamma globulin, 2 cc	$24.35
J1550	Gamma globulin, 10 cc	$121.72

CPT/HCPCS CODE	NAME	PRICE
J1570	Ganciclovir sodium, Cytovene, 500 mg	$35.25
J1580	Garamycin, gentamicin, 80 mg	$ 1.90
J1630	Haldol, haloperidol, 5 mg	$ 6.83
J1644*	Heparin sodium 1000 units	$ 0.40
00739	Hepatitis B immune globulin, 1 ml	$135.43
90371	Hepatitis B immune globulin, 5 ml	$649.80
90740	Hepatitis B vaccine, dialysis or immunosupressed patient dosage (3 dose schedule), for intramuscular use	$110.92
90747	Hepatitis B vaccine, dialysis or immunosupressed patient dosage (4 dose schedule), for intramuscular use	$110.92
J0360*	Hydralazine HCL, Apresoline, 20 mg	$16.04
J1720	Hydrocortisone sodium succinate (Solu-Cortef), 100 mg	$ 2.49
J3410	Hydroxyzine HCL, 25 mg	$ 1.21
J1564	Immune globulin, Gammimune N, 10 mg	$43.00
J1563	Immune globulin, intravenous, 1 gm	$78.38
J7501	Imuran, Azathioprine, 100 mg	$59.84
J1790	Inapsine, droperidol), 5 mg	$ 2.81
J1800*	Inderal, propranolol HCL, 1 mg/1 cc	$11.63
J1750	Infed, iron dextran), 50 mg	$17.91
90657	Influenza virus vaccine, split virus, 6-35 months dosage	$ 4.98
90658	Influenza virus vaccine, split virus, 3 years and above dosage	$ 9.95
90659	Influenza virus vaccine, whole virus	$ 9.95
J1815*	Insulin, per 5 units	$ 0.10
J1840	Kantrex, kanamycin sulfate, 500 mg	$3.29
J1890	Keflin, cephalothin sodium, 1 gm	$10.26
J3301	Kenalog, triamcinolone acetonide), 10 mg	$ 1.60
J1940	Lasix, furosemide, 20 mg	$0.98
X0056	Levophed bitartrate, Norepinephrine bitartrate 4 cc	$10.43
X0043	Levothyroxine, 0.2 mg	$22.21
J1990	Librium, chlordiazepoxide hydrochloride, 100 mg	$24.99
J2000*	Lidocaine HCL, 50 cc	$ 3.99

*****This drug is included in the composite rate.

End-Stage Renal Disease Drug Pricing Update (continued)

CPT/HCPCS CODE	NAME	PRICE
00971	Mandol, Cefamandole, 1 gm	$8.61
J2150*	Mannitol 25%, in 50 cc	$3.27
J1051	Medroxyprogesterone acetate, Depo-Provera, 50 mg	$ 5.04
J0694	Mefoxin, cefoxitin sodium, 1 gm	$10.69
00987	Mezlin, Mezlocillin, 1 gm	$ 4.25
J2270	Morphine sulfate, 10 mg	$0.77
J7505	Muromonab-CD3, parenteral, 5 mg	$897.28
X0027	Nafcil, nafcillin sodium, 500 mg	$ 1.34
J2320	Nandrolone decanoate, Deca-Durabolin, 50 mg	$ 3.84
J2321	Nandrolone decanoate, Deca-Durabolin, 100 mg	$ 7.67
J2322	Nandrolone decanoate, Deca-Durabolin, 200 mg	$15.74
J2310	Narcan, naloxone HCL, 1 mg	$ 2.37
J3260	Nebcin, tobramycin sulfate, 80 mg	$ 4.46
J2300	Nubain, nalbuphine HCL, 10 mg/1 cc	$ 1.51
J2700	Oxacillin sodium, 250 mg	$ 0.80
J2501	Paracalcitol, 1 mcg	$ 5.02
J2510	Penicillin G procaine, aqueous, 600,000 units	$ 9.60
J2545	Pentam, 300 mg	$50.77
J2550	Phenergan, promethazine HCL, 50 mg	$ 2.85
J2560	Phenobarbital sodium, 120 mg	$ 1.62
01231	Pipracil, Piperacillin sodium, 1 gm	$ 7.00
90732	Pneumovax, Pneumococcal vaccine 0.5 cc	$18.62
J3480*	Potassium chloride, per 2 mEq/ml	$ 0.08
J1410	Premarin, estrogen congugated, 25 mg	$61.51
J0743	Primaxin-I.M., 500 mg	$31.74
J0743	Primaxin-I.V., 250 mg	$15.87
J0780	Prochlorperazine, Compazine, up to 10 mg	$ 4.18
J0256	Prolastin, alpha 1-proteinase inhibitor 10 mg	$133.00
J2680	Prolixin Decanoate, fluphenazine, 25 mg	$ 9.42
J2690*	Pronestyl, procainamide HCL, 1 gm	$ 1.43
J2720*	Protamine sulfate, 10 mg	$0.76
J2765	Reglan, metoclorpramide HCL, 10 mg	$ 1.99
J0696	Rocephin, ceftriaxone sodium, 250 mg	$14.92
J1563	Sandoglobulin, immune globulin, 1g	$78.38
X0102	Septra, 80 mg/ml-16 mg/ml, 5 ml	$ 3.07
X0038	Sodium bicarbonate 8.4%, 50 cc	$ 3.45
J2912	Sodium chloride 0,9%, per 2 ml	$ 1.37
00510	Sodium chloride 9%, 50 cc	$ 9.19
00511	Sodium chloride 9%, 100 cc	$ 6.03
00512	Sodium chloride 9%, 150 cc	$ 8.65
00513	Sodium chloride 9%, 250 cc	$ 9.19
00514	Sodium chloride 9%, 500 cc	$ 7.05
J1720	Solu Cortef, hydrocortisone sodium succinate 100 mg	$ 2.49
X0040	Solu Cortef 500 mg	$12.45
J2920	Solu-Medrol, methylprednisolone sodium succinate, up to 40 mg	$ 1.95
J2930	Solu-Medrol, methylprednisolone sodium succinate, up to 125 mg	$ 3.24
01478	Stadol, 1 mg	$ 7.09
01479	Stadol, 2 mg	$ 7.13
J3010	Sublimaze, fentanyl citrate, 2 cc	$ 0.93
J3070	Talwin Lactate, pentazocine HCL, 30 mg	$ 5.23
01601	Talwin Lactate, 60 mg	$10.46
J3120	Testosterone enanthate, Delatestryl enanthate, up to 100 mg	$ 8.98
J3130	Testosterone enanthate, Delatestryl enanthate, up to 200 mg	$17.96
J3150	Testosterone propionate, up to 100 mg	$ 1.71
90703	Tetanus toxoid, 1.ml	$14.37
J3230	Thorazine, chlorpromazine HCL, up to 50 mg	$ 4.40
01671	Ticar, Ticarcillin, 1 gm	$ 4.25
J3250	Tigan trimethobenzamide HCL, up to 200 mg	$ 1.55
X0042	Timentin, 100 mg-3 gm	$14.32
J3280	Torecan, thiethylprrazine maleate, up to 10 mg	$ 5.65
J3320	Trobicin, spectinomycin dihydrochloride, up to 2 g	$28.27
J0295	Unasyn, ampicillin sodium, per 1.5 g	$14.84
J3360	Valium, diazepam, 5 mg	$ 0.86
J3370	Vancocin, vancomycin HCL, 500 mg	$ 7.03
J1756	Venofer, iron sucrose, 1 mg	$66.00

*****This drug is included in the composite rate.

End-Stage Renal Disease Drug Pricing Update (continued)

CPT/HCPCS CODE	NAME	PRICE
X0057*	Verapamil, 5 mg	$ 2.32
J2250	Versed, midazolam HCL, 1 mg	$ 1.28
X0044	Vibramycin, Doxycycline, 100 mg	$14.01
J3420	Vitamin B-12 cyanocobalamin, up to 1,000 mcg	$ 0.13
00522	Water for injection, 30 cc	$ 1.69
00521	Water for injection, 500 cc	$30.17
J2501	Zemplar, paricalcitol, 1 mcg	$ 5.02
J0697	Zinacef, cefuroxime sodium, 750 mg	$6.42
J2405	Zofran, ondansetron HCL per 1 mg	$12.18
Q4075	Zovirax	$51.00

* This drug is included in the composite rate.

Correction to Levocarnitine Policy for End-Stage Renal Disease Patients

Policy guidelines for the implementation of the national coverage determination for intravenous levocarnitine (J1955) for use in the treatment of carnitine deficiency in end-stage renal disease patients for services provided **on or after January 1, 2003** were published in the January 2003 *Medicare A Bulletin* Special Issue (page 26). Since then, the Centers for Medicare & Medicaid Services (CMS) has removed types of bills 13x and 85x from this policy.

The applicable types of bill is:

- 72x – Free standing ESRD facility – reimbursed at 95 percent of the average wholesale price
  Hospital-based ESRD facility – reimbursed at cost (deductible and coinsurance apply). ❖

Source: CMS Transmittal AB-03-130, CR 2554

SKILLED NURSING FACILITY SERVICES

Annual Update to the Skilled Nursing Facility Prospective Payment System Rates

The Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* on August 4, 2003, (68 FR 46036) the annual updates to the prospective payment system (PPS) rates for skilled nursing facilities (SNFs), as required by statute for fiscal year (FY) 2004 (i.e., October 1, 2003, through September 30, 2004).

The methodology used for the update is identical to that used in the previous year. The rates will reflect an adjustment required by the statute. The statute mandates an update to the federal rates using the latest SNF full market basket. The base rate also has a 3.26 percent forecast error correction adjustment built in. The forecast error correction does not require anything additional from last year since it is built into the base rate.

The Medicare claim processing system will apply the FY 2004 SNF PPS payment rates that are effective beginning October 1, 2003, through September 30, 2004. ❖

Source: CMS Transmittal A-03-075, CR 2893

Guidelines for Skilled Nursing Facility Consolidated Billing

This provider education article discusses the background of the skilled nursing facility (SNF) consolidated billing regulation; services, supplies, and facilities included and excluded from SNF consolidated billing; professional and technical components of diagnostic tests; and ambulance services. In addition, the article includes information resources for SNF consolidated billing.

Background

Skilled nursing facility consolidated billing, which was effective for cost reporting periods beginning on or after July 1, 1998, states that SNFs must submit Medicare claims to the fiscal intermediary (FI) for all Part A and Part B services that its residents receive during the course of a covered Part A stay, except for a limited number of specifically excluded services. These services must be furnished either directly or under arrangement with outside providers. Section 4432(b) of the Balanced Budget Act of 1997 (BBA, PL 105-33), mandated the exclusion of entire categories of services from SNF consolidated billing. These services are separately billable to the Part B Medicare carrier and include the services of physicians and certain other types of medical practitioners.

Section 103 of the Balanced Budget Refinement Act of 1999 (BBRA, PL 106-113, Appendix F), effective on April 1, 2000, enacted a second more targeted set of exclusions for high cost, low probability services within a number of broader service categories (e.g., chemotherapy services) that otherwise remained subject to consolidated billing.

Effective January 1, 2002, Section 313 of the Benefits Improvement and Protection Act restricted SNF consolidated billing to the majority of services provided to patients in a Medicare Part A covered stay and only to physical, occupational, and speech-language therapy services provided to patients in a noncovered stay.

For claims with dates of service on or after April 1, 2001, for those services and supplies that are not specifically excluded by law and furnished to a SNF resident covered under the Part A benefit, physicians must forward the technical portions of any services to the SNF to be billed by the SNF to the FI. The SNF cannot receive additional payment for these technical services and is to pay the physician for the technical portion of the service. Physical, occupational, and speech-language therapy services provided to patients in a non-covered stay must also be forwarded to the SNF to be billed by the SNF to the FI for payment. It is the responsibility of the rendering physician or nonphysician practitioner to develop a business relationship with the SNF in order to receive payment from the SNF for services they render that are included in consolidated billing.

Services and Supplies Included in SNF Consolidated Billing

The SNF consolidated billing requirement confers on SNFs the billing responsibility for the entire package of services that residents receive including:

- All services and supplies received during the course of a Part A covered stay (including physical, occupational, and speech-language therapy services), with the exception of statutory exclusions; and
- For SNF residents in noncovered stays (e.g., Part A benefits exhausted or no prior qualifying hospital stay), physical, occupational, and speech-language therapy services.

Services and Supplies Excluded from SNF Consolidated Billing

The following are excluded from SNF consolidated billing and must be billed separately to the Medicare carrier:

- The professional component of physician services (see Section 1861(r) of the Social Security Act for the definition of a physician for Medicare purposes) except physical, occupational, and speech-language therapy services;
- Physician assistant services, when a physician assistant is working under a physician's supervision;
- Nurse practitioner services, when a nurse practitioner is working in collaboration with a physician;

Guidelines for Skilled Nursing Facility Consolidated Billing (continued)

- Clinical nurse specialists, when a clinical nurse specialist is working in collaboration with a physician;
- Certified mid-wife services;
- Qualified psychologist services; and
- Certified registered nurse anesthetist services.

Note: Physical, occupational, and speech-language therapy services included in SNF consolidated billing are subject to SNF consolidated billing regardless of who provides them, even if the services that type of practitioner normally provides are excluded from SNF consolidated billing.

The following are excluded from SNF consolidated billing and the institutional or technical component must be billed separately to the Medicare FI:

- The following services furnished on an outpatient basis by a hospital or critical access hospital (CAH):
  - Cardiac catheterization services;
  - Computerized axial tomography scans;
  - Magnetic resonance imaging;
  - Ambulatory surgery involving the use of an operating room;
  - Radiation therapy;
  - Emergency services;
  - Angiography;
  - Lymphatic and venous procedures; and
  - Ambulance services furnished in connection with any of the above outpatient hospital services.
- Maintenance dialysis received in a Renal Dialysis Facility by an End Stage Renal Disease patient;
- Certain dialysis-related services including covered ambulance transportation to obtain dialysis services;
- Erythropoietin for certain dialysis patients when given along with dialysis; and
- Hospice care related to a patient's terminal condition.

The following are excluded from SNF consolidated billing and must be billed separately to the Medicare carrier or FI, as appropriate:

- Ambulance trips that transport a patient to the SNF for initial admission or from the SNF following a final discharge (see below for additional ambulance services information);
- Services to risk based HMO enrollees; and
- The following services for residents in a Part A covered stay (only certain services in these categories are excluded):
  - Certain chemotherapy drugs;
  - Certain chemotherapy administrative services;
  - Certain radioisotope services; and
  - Certain customized prosthetic devices.

Facilities Included in SNF Consolidated Billing

- Medicare participating SNFs, including Medicare-certified distinct part SNFs and swing beds in all hospitals except CAHs.

Facilities Excluded from SNF Consolidated Billing

- Nursing homes that have no Medicare certification (e.g., do not participate at all in either the Medicare or Medicaid program);
- Nursing homes that exclusively participate only in the Medicaid program as a nursing facility;
- The non-participating portion of a nursing home that also contains a Medicare-certified distinct part SNF; and
- Swing beds in CAHs.

Professional and Technical Components of Diagnostic Tests

The professional component, or the physician's interpretation of a diagnostic test, is considered a physician service and is separately billable to the Medicare carrier. The technical component, or the diagnostic test itself, is considered a diagnostic test and is subject to consolidated billing. As an example, for diagnostic radiology services, the exclusion of physician services from consolidated billing applies only to the professional component of the diagnostic radiology service. The technical component of the diagnostic radiology service is considered a diagnostic test that must be billed to the Medicare FI by the SNF and is included in the SNF consolidated billing payment for covered Part A stays. Because the technical component is already included within Part A's comprehensive per diem payment to the SNF for the covered stay, an outside entity that actually furnishes the technical component would look to the SNF, rather than Part B, for payment.

Ambulance Services

Except for specific exclusions, SNF consolidated billing includes those medically necessary ambulance trips that are furnished during the course of a Part A stay. In most cases, ambulance trips are excluded from SNF consolidated billing when the covered Part A stay has ended, at which time the ambulance company must bill the Medicare carrier or FI directly for payment. The specific circumstances under which a patient may receive ambulance services that are covered by Medicare but excluded from SNF consolidated billing are:

- A medically necessary ambulance trip to a Medicare participating hospital or CAH for the specific purpose of receiving emergency or other excluded outpatient hospital services;
- A medically necessary ambulance trip after a formal discharge or other departure from the SNF, unless the patient is readmitted or returns to that or another SNF before midnight of the same day;
- An ambulance trip to receive dialysis or dialysis-related services;
- An ambulance trip for an inpatient admission to a Medicare participating hospital or CAH; and
- After discharge from a SNF, a medically necessary ambulance trip to the patient's home where he/she will

Guidelines for Skilled Nursing Facility Consolidated Billing (continued)

receive services from a Medicare participating home health agency under a plan of care.

Note: A patient's transfer from one SNF to another before midnight of the same day is not excluded from SNF consolidated billing. The first SNF is responsible for the ambulance services.

SNF Consolidated Billing Information Resources

- Consolidated Billing Web Site *www.cms.hhs.gov/medlearn/snfcode.asp.*
  - – General SNF consolidated billing information.
  - – HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing).
  - – Therapy codes that must be consolidated in a non-covered stay.
  - – All code lists are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.
- Program Memorandums *www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*
  - – Transmittal AB-03-094 dated July 3, 2003
  - – Transmittal AB-02-175 dated December 13, 2002
  - – Transmittal A-02-118 dated November 8, 2002
    1) Updated codes for exclusions
    2) SNF Help File
       a) HCPCS codes included in the SNF Part A payment.
       b) Codes that may be paid and on what basis to a SNF by the FI under Part B.
  - – Transmittal AB-02-038 dated March 27, 2002
- The SNF Help File will be available on a new CMS Web site in the near future.
- Medicare Carriers Manual Part 3, Section 4210. ❖

Source: CMS Notification Dated August 29, 2003

PROVIDER AUDIT ISSUES

Clarification on Billing Policy for Certified Transplant Centers

The Centers for Medicare & Medicaid Services (CMS) has notified fiscal intermediaries (FIs) of a discrepancy between section 2771 of the Provider Reimbursement Manual 15-1 and section 3612 of the Medicare Intermediary Manual (MIM) on how certified transplant centers (CTCs) should bill for the cost incurred for the acquisition or retrieval of organs.

Section 2771 of the Provider Reimbursement Manual 15-1 requires CTCs to establish a standard acquisition charge (SAC) that reflects the average cost associated with acquiring each type of organ. This section also specifies that when a CTC provides an organ to an organ procurement organization (OPO), it must bill its SAC to the OPO. However, the MIM 13-2, section 3612, allows the CTC to bill either the SAC or the departmental charges actually incurred for retrieval services provided to the OPO.

CMS has learned that many CTCs are billing departmental charges to OPOs for organ retrieval services, and that some intermediaries have begun to make adjustments to CTC cost reports when they find that departmental charges, rather than the SAC, were billed to OPOs.

Billing Policy for Certified Transplant Centers

Due to the recently discovered discrepancy between the two manual sections, CMS has instructed FIs to allow either method of billing (SAC or departmental charges) by a CTC to an OPO for organ retrieval services. Because either billing method is currently allowable, intermediaries are instructed not to make adjustments to the CTC cost reports based on which of these charging methodologies is used. The D-6 will continue to be audited by the intermediaries, but no adjustment will be made if the CTC is billing either the SAC established for the particular organ, or if the CTC is billing the hospital's actual departmental charges for the various services provided to the OPO for retrieval of the organs.

CTCs must still bill the SAC to third party payers, including Medicare, for organs acquired and transplanted. Departmental charges cannot be billed for this purpose. ❖

Source CMS Transmittal A-03-081, CR 2847

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

October 2003 Update to Hospital Outpatient Prospective Payment System

CMS has issued changes to the hospital outpatient prospective payment system (OPPS) for the October 2003 update. The October 2003 outpatient code editor (OCE) and the PPS PRICER software systems will reflect the Healthcare Common Procedure Coding System (HCPCS) codes and ambulatory payment classification (APC) additions and changes, and other revisions, identified in this notification. Unless otherwise noted, changes addressed in this notification are effective for services furnished **on or after October 1, 2003.**

New HCPCS Codes Under the Hospital OPPS

The following HCPCS code is effective for services furnished **on or after July 1, 2003:**

C9123 Transcyte, per 247 square centimeters (sq cm)
Assigned APC: 9123 *****PSI G

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

C9208 Injection, agalsidase beta, per 1 mg
Assigned APC: 9208 *****PSI G

C9209 Injection, laronidase, per 2.9 mg
Assigned APC: 9209 *****PSI G

G0296 PET imaging, full and partial ring PET scanner only, for restaging of previously treated thyroid cancer of follicular cell origin following negative I-131 whole body scan.
Assigned APC: 0714 *****PSI S

G0297 Insertion of single chamber pacing cardioverter defibrillator pulse generator
Assigned APC: 107 *****PSI T

G0298 Insertion of dual chamber pacing cardioverter defibrillator pulse generator
Assigned APC: 107 *****PSI T

G0299 Insertion or repositioning of electrode lead for single chamber pacing cardioverter defibrillator and insertion of pulse generator
Assigned APC: 108 *****PSI T

G0300 Insertion or repositioning of electrode lead (s) for dual chamber pacing cardioverter defibrillator and insertion of pulse generator
Assigned APC: 108 *****PSI T

L8110 Gradient compression stocking, below knee, 30-40 MMHG, each
Assigned APC: n/a *****PSI A

L8120 Gradient compression stocking, below knee, 40-50 MMHG, each
Assigned APC: n/a *****PSI A

Q4075 Injection, acyclovir, 5 mg
Assigned APC: n/a *****PSI N

Q4076 Injection, dopamine hydrochloride, 40 mg
Assigned APC: n/a *****PSI N

Q4077 Injection, treprostinil, 1 mg N/A
Assigned APC: n/a *****PSI N

Q4078 Supply of radiopharmaceutical diagnostic imaging agent, ammonia N-13, per dose
Assigned APC: 9025 *****PSI K

Newly-Approved Drugs and Biologicals Eligible for Pass-Through Payment

C9123 Transcyte, per 247 square centimeters
Assigned APC: 9123 *****PSI G
Effective for services furnished on or after July 1, 2003.

C9208 Injection, agalsidase beta, per 1 mg
Assigned APC: 9208 *****PSI G
Effective for services furnished on or after October 1, 2003.

C9209 Injection, laronidase, per 2.9 mg
Assigned APC: 9209 *****PSI G
Effective for services furnished on or after October 1, 2003.

Comprehensive List of Pass-Through Device Category Codes Effective October 1, 2003

Below is a complete listing of the device categories that are eligible for pass-through payment under the OPPS. 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.

New APC Groups

HCPCS Codes	Descriptor	Effective Date
C1765	Adhesion barrier	7/1/01
C1783	Ocular implant, aqueous drainage assist device	7/1/02
C1814	Retinal tamponade device, silicone oil	4/1/03
C1818	Integrated keratoprosthesis	7/1/03
C1884	Embolization protective system	1/1/03
C1888	Catheter, ablation, non-cardiac, endovascular (implantable)	7/1/02
C1900	Lead, left ventricular coronary venous system	7/1/02
C2614	Probe, percutaneous lumbar discectomy	1/1/03
C2618	Probe, cryoablation	4/1/01
C2632	Brachytherapy solution, iodine – 125, per mCi	4/1/03

APC Code	Group Title
9123	Transcyte, per 247 sq cm
9208	Injection, agalsidase beta
9209	Injection, laronidase

Modifications to Existing *CPT*/HCPCS Codes and APC Groups

The following changes have been made to the *CPT*/HCPCS code payment status indicators below:

Modifications to the HCPCS and APC group descriptors listed below have been revised from "seed" to "source." The 2004 annual HCPCS update will reflect these changes.

***CPT*/HCPCS Code**	**Payment SI***	**Effective Date of Change**
0029T	**A**	January 1, 2003
33240	**E**	October 1, 2003
33249	**E**	October 1, 2003
80050	**E**	August 1, 2000
G9016	**E**	April 1, 2002
J1055	**E**	January 1, 2001
J3520	**E**	January 1, 2001
J3535	**E**	January 1, 201
J3570	**E**	January 1, 2001
K0560	**N**	April 1,2003
K0610	**A**	July 1, 2003
K0611	**A**	July 1, 2003
K0612	**A**	July 1, 2003
K0613	**A**	July 1, 2003
K0614	**A**	July 1, 2003
Q2001	**E**	August 1, 2000

Additionally, the descriptor for APC 9025 has been modified from "Rubidium" to "Radiopharms used to image perfusion of heart."

HCPCS Code	**APC**	**Payment SI***	**Effective Date of Change**
C1716	1716	K	July 1, 2003
C1718	1718	K	July 1, 2003
C1719	1719	K	July 1, 2003
C1720	1720	K	July 1, 2003
C2616	2616	K	July 1, 2003

Prothrombin Time International Normalized Ratio Monitoring

When billing for G0249 ("Provision of test materials and equipment for home INR monitoring to patient with mechanical heart valve(s) who meets Medicare coverage criteria; includes provision of materials for use in the home and reporting of test results to a physician; per 4 tests"), Medicare will allow hospitals to bill for up to three units of G0249 at a time in order to cover up to 12 tests so that the service is billable on a date when a patient would attend the clinic for a face-to-face visit.

PET Scans for Thyroid Cancer and Perfusion of the Heart Using Ammonia N-13

The following two codes were newly created to support expanded coverage of PET scans.

G0296 PET imaging, full and partial ring PET scanner only, for restaging of previously treated thyroid cancer of follicular cell origin following negative I-131 whole body scan
Assigned APC: 0714 ***PSI** S

Q4078 Supply of radiopharmaceutical diagnostic imaging agent, ammonia N- 13, per dose.
Assigned APC: 9025 ***PSI** K

HCPCS codes G0296 and Q4078 are reportable under the hospital OPPS effective for services furnished **on or after October 1, 2003.** For perfusion of the heart using ammonia N-13, hospitals can use the current HCPCS code series for PET scans for perfusion of the heart (G0030-G0047). HCPCS code Q4078 (Ammonia N-13, per dose) and Q3000 (Rubidium Rb 82) are the only two tracers that are covered for HCPCS codes G0030-G0047 and G0296.

New Codes for Insertion of Implantable Cardioverter Defibrillators

Effective for services furnished on or after October 1, 2003, hospitals should discontinue reporting *CPT* codes *33240* and *33249*. Instead, effective for services furnished **on or after October 1, 2003,** hospitals should begin reporting one of the following new HCPCS codes, as appropriate:

G0297 Insertion of single chamber pacing cardioverter defibrillator pulse generator
G0298 Insertion of dual chamber pacing cardioverter defibrillator pulse generator
G0299 Insertion or repositioning of electrode lead for single chamber pacing cardioverter defibrillator and insertion of pulse generator
G0300 Insertion or repositioning of electrode lead(s) for dual chamber pacing cardioverter defibrillator and insertion of pulse generator

For services furnished on or after October 1, 2003, *CPT* codes *33240* and *33249* are not recognized under the OPPS and claims reporting these codes will be returned to the provider.

Transcyte Claims for Services Furnished July 1 through September 30, 2003

Hospitals that submitted claims for transcyte for services furnished during the period July 1 through September 30, 2003, may resubmit those claims for reprocessing using HCPCS code C9123 to reflect the pass-through payment amount for this biological effective for services furnished *on or after July 1, 2003.*❖

Source: CMS Transmittal A-03-076, CR 2887

***Definitions for the payment status indicators (PSIs) are:**
A Service not paid under OPPS (paid under DME/physician fee schedule
E Noncovered item or service (not payable under hospital OPPS)
G Drug/biological (payment made under transition pass-through payment
K Non pass-through drug/biological
N Incidental item/service (packaged into another service/APC group)
S Significant procedure – payment is allowed and multiple procedures reduction does not apply (not subject to multiple procedural discounting)
T Surgical services (multiple procedure payment rule applies)

FRAUD AND ABUSE

Office of Inspector General Special Advisory Bulletin, April 2003—Contractual Joint Ventures

This Special Advisory Bulletin addresses certain complex contractual arrangements for the provision of items and services previously identified as suspect in our 1989 Special Fraud Alert on Joint Venture Arrangements.[1] While much of the discussion in the 1989 Special Fraud Alert focused on investor referrals to newly formed entities, we observed that:

> [t]he Office of Inspector General has become aware of a proliferation of arrangements between those in a position to refer business, such as physicians, and those providing items or services for which Medicare or Medicaid pays. Some examples of the items or services provided in these arrangements include clinical diagnostic laboratory services, durable medical equipment (DME), and other diagnostic services. Sometimes these deals are called "joint ventures." *A joint venture may take a variety of forms: it may be a contractual arrangement between two or more parties to cooperate in providing services,* or it may involve the creation of a new legal entity by the parties, such as a limited partnership or closely held corporation, to provide such services. [Emphasis added.]

Notwithstanding that caution, the Office of Inspector General (OIG) is concerned that contractual joint venture arrangements are proliferating.[2]

A. Questionable Contractual Arrangements

The federal anti-kickback statute, section 1128B(b) of the Social Security Act (the Act), prohibits knowingly and willfully soliciting, receiving, offering, or paying anything of value to induce referrals of items or services payable by a federal health care program. Kickbacks are harmful because they can (1) distort medical decision-making, (2) cause overutilization, (3) increase costs to the federal health care programs, and (4) result in unfair competition by freezing out competitors unwilling to pay kickbacks. Both parties to an impermissible kickback transaction may be liable. Violation of the statute constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to five years, or both. The OIG may also initiate administrative proceedings to exclude persons from the federal health care programs or to impose civil money penalties for kickback violations under sections 1128(b)(7) and 1128A(a)(7) of the Act.

This Special Advisory Bulletin focuses on questionable contractual arrangements where a health care provider in one line of business (hereafter referred to as the "Owner") expands into a related health care business by contracting with an existing provider of a related item or service (hereafter referred to as the "Manager/Supplier") to provide the new item or service to the Owner's existing patient population, including federal health care program patients. The Manager/Supplier not only manages the new line of business, but may also supply it with inventory, employees, space, billing, and other services. In other words, the Owner contracts out substantially the entire operation of the related line of business to the Manager/Supplier – otherwise a potential competitor – receiving in return the profits of the business as remuneration for its federal program referrals.

Some examples of potentially problematic contractual arrangements include the following:

- A hospital establishes a subsidiary to provide DME. The new subsidiary enters into a contract with an existing DME company to operate the new subsidiary and to provide the new subsidiary with DME inventory. The existing DME company already provides DME services comparable to those provided by the new hospital DME subsidiary and bills insurers and patients for them.
- A DME company sells nebulizers to federal health care beneficiaries. A mail order pharmacy suggests that the DME company form its own mail order pharmacy to provide nebulizer drugs. Through a management agreement, the mail order pharmacy runs the DME company's pharmacy, providing personnel, equipment, and space. The existing mail order pharmacy also sells all nebulizer drugs to the DME company's pharmacy for its inventory.
- A group of nephrologists establishes a wholly-owned company to provide home dialysis supplies to their dialysis patients. The new company contracts with an existing supplier of home dialysis supplies to operate the new company and provide all goods and services to the new company.

These problematic arrangements typically exhibit certain common elements. First, the Owner expands into a related line of business, which is dependent on referrals from, or other business generated by, the Owner's existing business.[3] The new business line may be organized as a part of the existing entity or as a separate subsidiary. Typically, the new business primarily serves the Owner's existing patient base.

Second, the Owner neither operates the new business itself nor commits substantial financial, capital, or human resources to the venture. Instead, it contracts out substantially all the operations of the new business. The Manager/Supplier typically agrees to provide not only management services, but also a range of other services, such as the inventory necessary to run the business, office and health care personnel, billing support, and space. While the Manager/Supplier essentially operates the business, the billing of insurers and patients is done in the name of the Owner. In many cases, the contractual arrangements result in either practical or legal exclusivity for the Manager/Supplier through inclusion of non-competition provisions or restrictions on access. While the contract terms of these

Office of Inspector General Special Advisory Bulletin, April 2003—Contractual Joint Ventures (continued)

arrangements may appear to place the Owner at financial risk, the Owner's actual business risk is minimal because of the Owner's ability to influence substantial referrals to the new business.

Third, the Manager/Supplier is an established provider of the same services as the Owner's new line of business. In other words, absent the contractual arrangement, the Manager/Supplier would be a competitor of the new line of business, providing items and services in its own right, billing insurers and patients in its own name, and collecting reimbursement.

Fourth, the Owner and the Manager/Supplier share in the economic benefit of the Owner's new business. The Manager/Supplier takes its share in the form of payments under the various contracts with the Owner; the Owner receives its share in the form of the residual profit from the new business.

Fifth, aggregate payments to the Manager/Supplier typically vary with the value or volume of business generated for the new business by the Owner. While in some arrangements certain payments are fixed (for example, the management fee), other payments, such as payments for goods and services supplied by the Manager/Supplier, will vary based on the number of goods and services provided. In other words, the aggregate payment to the Manager/Supplier from the whole arrangement will vary with referrals from the Owner. Likewise, the Owner's payments, that is, the difference between the net revenues from the new business and its expenses (including payments to the Manager/Supplier), also vary based on the Owner's referrals to the new business. Through these contractual payments, the parties are able to share the profits of the new line of business.

B. Safe Harbor Protection May Be Unavailable

Under the kickback statute, a number of statutory and regulatory "safe harbors" immunize certain arrangements that might otherwise violate the anti-kickback statute. (See 42 U.S.C. 1320a-7b(b)(3); 42 CFR 1001.952.) To qualify for safe harbor protection, an arrangement must fit squarely in one of these safe harbor provisions. Some parties attempt to carve otherwise problematic contracting arrangements into several different contracts for discrete items or services (e.g., a management contract, a vendor contract, and a staffing contract), and then qualify each separate contract for protection under a "safe harbor." Such efforts may be ineffectual and leave the parties subject to prosecution for the following reasons.

First, many of these questionable joint venture arrangements involve contracts pursuant to which the Manager/Suppliers agree to sell items and services to the Owners at a discounted price. However, where a discount is given as part of an overarching business arrangement, it cannot qualify for protection under the discount safe harbor. Simply put, the discount safe harbor does not protect – and has never protected – prices offered by a seller to a buyer in connection with a common enterprise. To be protected under the discount safe harbor, a price reduction must be based on an *arms length transactio*n. (See 42 CFR 1001.952(h) under which "the term *discount* means a reduction in the amount a buyer . . . is charged for an item or service based on an arms-length transaction."). As we expressly stated in the preamble to the 1991 safe harbor regulations, the provision of items or services to a joint venture by a participant in the venture is not an "arms length" transaction:

> Another problem exists where an entity, which is both a provider and supplier of items or services and joint venture partner with referring physicians, makes discounts to the joint venture as a way to share its profits with the physician partners. Very often this entity furnishes items or services to the joint venture, and also acts as the joint venture's general partner or provides management services to the joint venture. . . . *These arrangements are not arms length transactions where the joint venture shops around for the best price on a good or service. Rather it has entered into a collusive arrangement with a particular provider or supplier of items or services that seeks to share its profits with referring physician partners. [We did] . . . not intend to* protect these types of transactions which are sometimes made to appear as 'discounts'. . . . [Emphasis added] (See 56 FR 35977; July 29, 1991).

In short, a discount is not based on arms length transaction if it is provided by a seller to a purchaser in connection with a common venture, regardless of whether the venture is memorialized in separate contracts.

Second, even if the various contracts could fit in one or more safe harbors, they would only protect the remuneration flowing from the Owner to the Manager/Supplier for actual services rendered. In the contractual arrangements that are the subject of this Bulletin, however, the illegal remuneration is often the difference between the money paid by the Owner to the Manager/Supplier and the reimbursement received from the federal health care programs. By agreeing effectively to provide services it could otherwise provide in its own right for less than the available reimbursement, the Manager/Supplier is providing the Owner with the opportunity to generate a fee and a profit.

The opportunity to generate a fee is itself remuneration that may implicate the anti-kickback statute.

C. Indicia of a Suspect Contractual Joint Venture

To help identify the suspect contractual joint ventures that are the focus of this Special Advisory Bulletin, we describe below some characteristics, which, taken separately or together, potentially indicate a prohibited arrangement. This list is illustrative, not exhaustive.

New Line of Business. The Owner typically seeks to expand into a health care service that can be provided to the Owner's existing patients. As illustrated in Part A, examples include, but are not limited to, hospitals expanding into DME services, DME companies expanding into the nebulizer pharmacy business, or nephrologists expanding into the home dialysis supply business.[4]

Captive Referral Base. The newly-created business predominantly or exclusively serves the Owner's existing patient base (or patients under the control or influence of the Owner). The Owner typically does not intend to expand the

Office of Inspector General Special Advisory Bulletin, April 2003—Contractual Joint Ventures (continued)

business to serve new customers (i.e., customers not already served in its main business) and, therefore, makes no or few *bona fide* efforts to do so.

Little or No *Bona Fide* Business Risk. The Owner's primary contribution to the venture is referrals; it makes little or no financial or other investment in the business, delegating the entire operation to the Manager/Supplier, while retaining profits generated from its captive referral base. Residual business risks, such as nonpayment for services, are relatively ascertainable based on historical activity.

Status of the Manager/Supplier. The Manager/Supplier is a would-be competitor of the Owner's new line of business and would normally compete for the captive referrals. It has the capacity to provide virtually identical services in its own right and bill insurers and patients for them in its own name.

Scope of Services Provided by the Manager/Supplier. The Manager/Supplier provides all, or many, of the following key services:

- day-to-day management
- billing services
- equipment
- personnel and related services
- office space
- training
- health care items, supplies, and services.[5]

In general, the greater the scope of services provided by the Manager/Supplier, the greater the likelihood that the arrangement is a contractual joint venture.

Remuneration. The practical effect of the arrangement, viewed in its entirety, is to provide the Owner the opportunity to bill insurers and patients for business otherwise provided by the Manager/Supplier. The remuneration from the venture to the Owner (i.e., the profits of the venture) takes into account the value and volume of business the Owner generates.

Exclusivity. The parties may agree to a non-compete clause, barring the Owner from providing items or services to any patients other than those coming from Owner and/or barring the Manager/Supplier from providing services in its own right to the Owner's patients.

As noted above, these factors are illustrative, not exhaustive. The presence or absence of any one of these factors is not determinative of whether a particular arrangement is suspect. As indicated, this Special Advisory Bulletin is not intended to describe the entire universe of suspect contractual joint ventures. This Bulletin focuses on arrangements where substantially all of the operations of a new line of business are contracted out to a would-be competitor. Arrangements involving the delegation of fewer than substantially all services, or delegation to a party not otherwise in a position to bill for the identical services, may also raise concerns under the anti-kickback statute, depending on the circumstances. ❖

Source: OIG Special Advisory Bulletin April 2003

[1] The 1989 Special Fraud Alert was reprinted in the Federal Register in 1994. See 59 FR 65372 (December 19, 1994). The Special Fraud Alert is also available on our web page at *http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html*.

[2] The kinds of contractual arrangements addressed in this Special Advisory Bulletin are sometimes referred to as "joint ventures" or "contractual joint ventures" or may be referenced by other terminology. For purposes of the analysis set forth in this Bulletin, a "joint venture" is any common enterprise with mutual economic benefit. The application of this Bulletin is not limited to "joint ventures" that meet technical qualifications under applicable state or common law.

[3] The Owner's referrals may be direct or indirect and may include not only ordering or purchasing goods or services, but also "arranging for" or "recommending" goods and services. See section 1128B(b) of the Act. For example, a hospital may generate business for a DME company, notwithstanding that orders for specific DME items must be signed by a physician who may or may not be a hospital employee.

[4] These examples are illustrative only. This list is not intended to suggest that other analogous ventures are not equally suspect.

[5] The Manager/Supplier may also provide marketing services, although in many instances no such services are required since the Owner generates substantially all of the venture's business from its existing patient base.

The Office of Inspector General (OIG) was established at the Department of Health and Human Services by Congress in 1976 to identify and eliminate fraud, abuse, and waste in the department's programs and to promote efficiency and economy in departmental operations. The OIG carries out this mission through a nationwide program of audits, investigations, and inspections.

The Fraud and Abuse Control Program, established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), authorized the OIG to provide guidance to the health care industry to prevent fraud and abuse and to promote the highest level of ethical and lawful conduct. To further these goals, the OIG issues Special Advisory Bulletins about industry practices or arrangements that potentially implicate the fraud and abuse authorities subject to enforcement by the OIG.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Contingency Plan for Health Insurance Portability and Accountability Act Transaction and Code Sets

The following article was provided by the Centers for Medicare & Medicaid Services (CMS) to announce the implementation of a contingency plan for HIPAA transaction and code sets as of October 16, 2003.

"After a careful analysis of Medicare provider, submitter, and other trading partner HIPAA readiness, Medicare will continue to accept and send standard and non-standard versions and/or formats for any electronic transaction for a limited time period beyond October 16, 2003.

This is a temporary measure to maintain provider cash flow and minimize operational disruption while trading partners who are not compliant on October 16, 2003, work with Medicare to achieve full compliance.

This contingency plan is only for a limited time. Providers who must continue to bill and receive non-compliant formats, should test and move into production on the HIPAA required formats as soon as possible, or risk possible cash flow problems." ❖

Source: CMS Notification Dated September 23, 2003

ELECTRONIC DATA INTERCHANGE

Medicare Electronic Data Interchange Enrollment

As a condition for beginning to transmit claims electronically to Medicare, a new EDI enrollment form is required from each interested provider. Once on file, a new form is not required for that provider as he/she participates in the Medicare program.

Specifically, a new EDI enrollment form is not required in any of the following situations:

(1) submission of transaction in a HIPAA format,
(2) as a condition of continued use of EDI,
(3) changing from one format (National Standard Format) to another (ANSI), or
(4) changing billing services/clearinghouses.

If you are a provider who does not currently submit claims electronically and who would like to begin, enrollment forms are available and can be downloaded from our provider education Web site at *www.floridamedicare*.com. If you have questions related to these forms, or to getting started submitting claims electronically, please call Medicare EDI Marketing/ Operations at 1-904-791-8767, option 1. ❖

Source: CMS Notification Dated July 29, 2003

EDUCATIONAL RESOURCES

Medicare Education and Training Presents:

MEDICARE AT THE MOVIES

Have you ever wanted to share popcorn with a Medicare Representative?

*Join us for a **free** one-day educational extravaganza – attend one "movie" or all!*

December 5, 2003

Shows and times are:

You've Got Mail!

8:30 a.m. – 10:30 a.m.

Rating: MS (Medicare Specialty Population)

Navigating FCSO's Web site: Do you frequently look for medical policies on FCSO's Web site? Do you want to learn how to find the latest HIPAA information? Then don't miss this opportunity to understand FCSO's Web site structure, content, and functions. Participants will also gain a basic understanding of Internet and browser functions.

A Few Good Cases

12:30 p.m. – 2:30 p.m.

Rating: MG (Medicare General Population)

Understanding the Appeals Process: Do you want to gain a better understanding of what happens when you request a review? Do you want to know what constitutes a medical necessity denial and how to avoid them? Does your documentation substantiate the services for which you billed as well as clearly convey the patient's condition? Don't miss this opportunity to learn how to avoid the top mistakes providers make when submitting reviews.

Modifier Matrix

3:00 p.m. – 5:00 p.m.

Rating: MN (Medicare Novice)

Modifiers Made Easy: Are you having problems matching modifiers to procedure codes? Do you want to know how to avoid billing invalid/inappropriate modifiers? Do you understand how modifiers affect your reimbursement? Then you don't want to miss this workshop.

HIPAA Lunch and Learn

Intermission: 11:00 a.m. – 12:00 noon

Chat with a FCSO HIPAA representative while you sit and eat your lunch. Learn about the CMS contingency plan, testing, and the way enforcement will work, as well as latest updates.

First Coast Service Options, Inc.
532 Riverside Avenue
Jacksonville, Florida

Want to know more? Visit our Web site at *www.floridamedicare.com* or call us at 1-904-791-8103.

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Please complete all portions of this form.

One form per person, per registration, please.

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Title/Position _____

Company/Organization _____

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Event Name _____

Event Date _____

City _____ **State** _____

3. To register:

Mail your completed form to:
First Coast Service Options, Inc.,
P.O. Box 45157
Jacksonville, FL 32232-5157

or

Fax your completed form to 1-904-791-6035

Important!

Seating Is Limited. Please submit your registration form as soon as possible. Seating for most events

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

A

B

C

C (continued)

D

E

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
Toll-Free
1-877-602-8816

BENEFICIARY

Toll-Free
1-800-333-7586
Hearing Impaired
1-800-754-7820

ELECTRONIC MEDIA CLAIMS

EMC Start-Up
1-904-791-8767, option 4

Electronic Eligibility
1-904-791-8131

Electronic Remittance Advice
1-904-791-6865

Direct Data Entry (DDE) Support
1-904-791-8131

PC-ACE Support
1-904-355-0313

Testing
1-904-791-6865

Help Desk (Confirmation/Transmission)
1-904-905-8880

Medicare Web Sites

PROVIDERS

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

BENEFICIARIES

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

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY

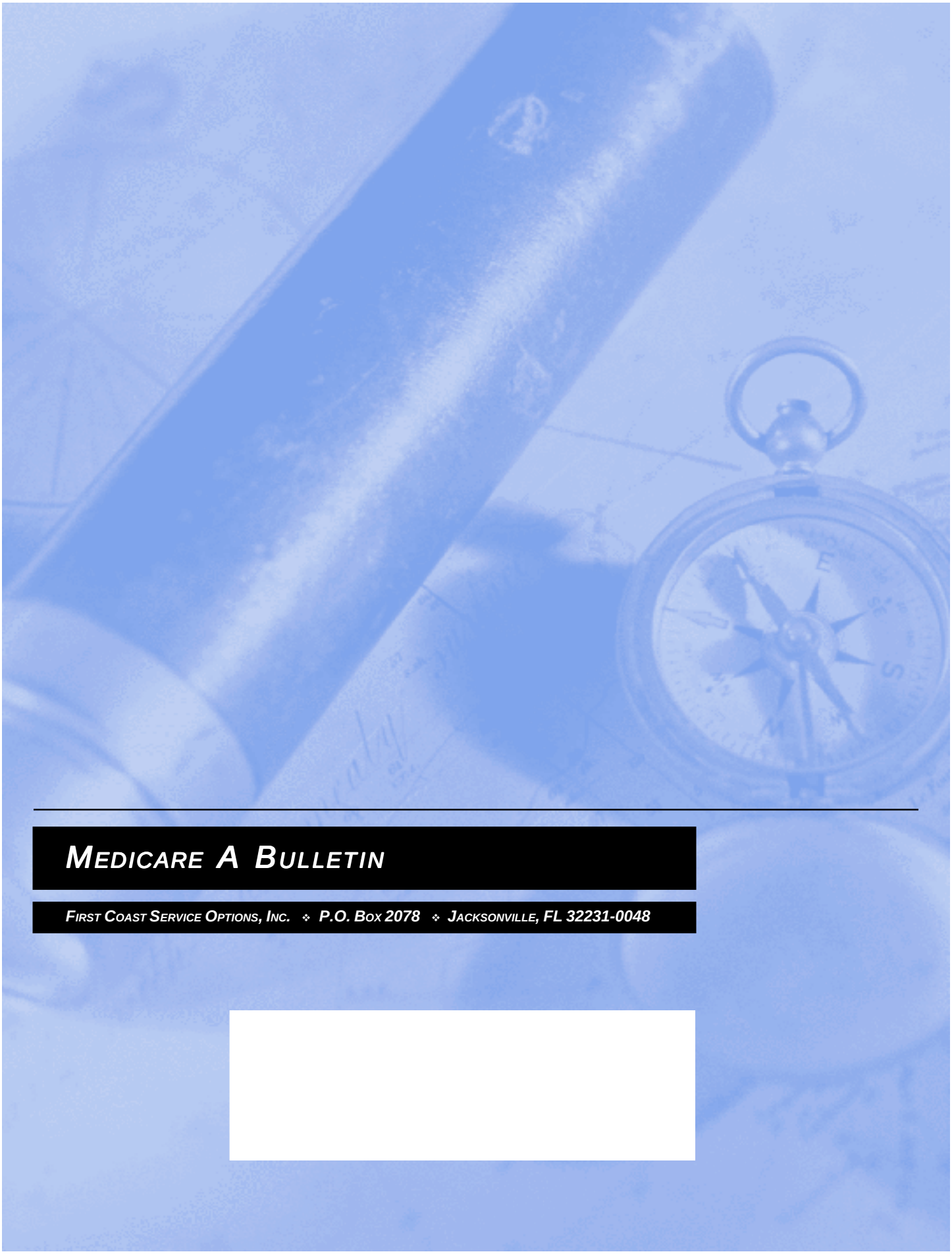
Home Health Agency Claims
Hospice Claims
Palmetto Goverment Benefit Administrators – Gulf Coast
34650 US Highway 19 North, Suite 202
Palm Harbour, FL 34684-2156

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)

Durable Medical Equipment Claims
Orthotic and Prosthetic Device Claims
Take Home Supplies
Oral Anti-Cancer Drugs
Palmetto Goverment Benefit Administrators
P. O. Box 100141
Columbia, SC 29202-3141

RAILROAD MEDICARE

Railroad Retiree Medical Claims
Palmetto Goverment Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001



MEDICARE A BULLETIN

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