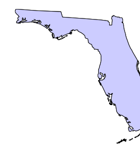
Medicare A Bulletin
A Newsletter for Florida Medicare Part A Providers



# In This Issue...

## Health Insurance Portability and Accountability Act

*A Letter to Providers from Thomas A. Scully, CMS Administrator on the Importance of Being Ready to Bill Medicare Effective October 16, 2003* ..... 5

*HIPAA Compliance after the October 16, 2003, Implementation Deadline* ..... 11

## Frequency of Billing

*Revision to the Frequency of Billing Guidelines for Providers, Including PIP Providers Billing Inpatient and Outpatient Services* ..... 19

## New Condition and Value Codes

*Establishment of these New Codes is Effective for October 16, 2003, to Coincide with HIPAA Implementation* ..... 21

## Financial Limitation for Outpatient Rehabilitation Services

*Delay in Implementation of this Initiative* ..... 25

## Local Medical Review Policies

*Implementation of New LMRPs and Additions/Revisions to Existing Medical Policies* ..... 32

## End-Stage Renal Disease

*Update to the Drug Pricing List* ..... 51

## Medicare *A Bulletin* Reader Survey

*Great Opportunity for Our Readers to Provide Comments by September 30, 2003* ..... 67

### Features

From the Medical Director ..... 3
About This Bulletin ..... 4
Electronic Data Interchange ..... 5
General Information ..... 18
Local Medical Review Policies ..... 32
General Coverage ..... 42
Hospital Services ..... 47
Skilled Nursing Facility Services ..... 49
End Stage Renal Disease ..... 51
Critical Access Hospital Services ..... 56
Outpatient Prospective Payment System ..... 58
Provider Audit and Reimbursement ..... 61
Educational Resources ..... 62

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

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

**Routing Suggestions**:

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

# Table of Contents

In This Issue ... 1

**From the Intermediary Medical Director**
***A Physician's Focus***
FCSO Office of the Medical Director Announces the Appointment of a New Medical Director ... 3

**About This Bulletin**
About The *Medicare A Bulletin* ... 4

**Electronic Data Interchange**
***The Health Insurance Portability and Accountability Act (HIPAA)***
Open Letter to Providers from CMS About HIPAA ... 5
HIPAA-AS Transactions and Code Sets: Testing and Updates ... 5
Will you Be Ready? — Time is Running Out! ... 6
CMS Southern Consortium's FREE HIPAA Presentations ... 7
Free CMS HIPAA Training ... 7
HIPAA Resources – Updated June 16, 2003 ... 8
Benefits of Electronic Claim Filing under HIPAA-AS ... 9
Are Small Providers Covered Entities under HIPAA? ... 10
HIPAA Information Series for Providers Now Available in English and Spanish ... 10
Guidance on HIPAA Privacy Rule Business Associate Provisions ... 11
HIPAA-Compliance after the October 16, 2003, Implementation Deadline ... 11
Remittance Advice Remark and Reason Code Update ... 13
New! — Call One Phone Number for Assistance with DDE and Medicare A EDI Transactions ... 17

**General Information**
Patient Status Code Update ... 18
Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment ... 18
Frequency of Billing Revision ... 19
Clarification on Mammography Computer Aided Detection Equipment ... 20
New Conditions and Value Codes Effective October 16, 2003 ... 21
Quarterly Date Change for 2003 Discontinued HCPCS Codes ... 24
Appeal Requests Submitted with Appropriate Supporting Documentation ... 24
CMS Quarterly Provider Update ... 25
***Outpatient Rehabilitation Services***
Delay in Implementation of Financial Limitation for Outpatient Rehabilitation Services ... 25
Financial Limitation of Claims for Outpatient Rehabilitation Services ... 25
***Ambulance Services***
Third Clarification Regarding Ambulance Fee Schedule Implementation ... 28
Clarification on Providing Advance Beneficiary Notices ... 31

**Medical Review Policies**
**Final Local Medical Review Policies**
Medical Policy Table of Contents ... 32
New LMRP Implementation ... 33
Additions/Revisions to Existing LMRPs ... 36
Additional Information on LMRPs ... 39
Comprehensive Data Analysis ... 41

**General Coverage**
New CLIA Waived Tests ... 42
Revision to Electrical Stimulation for the Treatment of Wounds ... 42
July 2003 Update to the Laboratory National Coverage Determination Edit Software ... 43
October 2003 Update to the Laboratory National Coverage Determination Edit Software ... 43
Ambulatory Blood Pressure Monitoring—Revision to National Coverage Determination ... 44
Revision to Coverage of Coverage of Hyperbaric Oxygen Therapy for the Treatment of Diabetic Wounds of the Lower Extremities ... 45
Diagnosis Code for Screening Pap Smear and Pelvic Examination Services ... 45
Psychiatric Diagnostic Interview Examination—Telehealth Services ... 45
Expanded Coverage of Positron Emission Tomography Scans ... 46

**Hospital Services**
Revision to Three-Day Payment Window Under the Short-Term Hospital Inpatient PPS ... 47
Clarification on Existing Policies Affecting Long-term Care Hospital ... 47
Assigning Liability for Line Items Excluded by Statute on Otherwise Covered Claims ... 48

**Skilled Nursing Facilities**
Clarification of Types of Bill 22x and 23x Submitted by Skilled Nursing Facilities ... 49
Quarterly Update for Skilled Nursing Facility Consolidated Billing ... 49
Claim Submission after Skilled Level of Care Ended ... 50

**End Stage Renal Disease**
End-Stage Renal Disease Drug Pricing Update ... 51
End-Stage Renal Disease Reimbursement for Automated Multi-Channel Chemistry Tests ... 54

**Critical Access Hospital Services**
July 2003 Update to the Medicare Outpatient Code Editor ... 56

**Outpatient Prospective Payment System**
July 2003 Update of the Hospital Outpatient Prospective Payment System ... 58
Further Guidance Regarding Billing Under OPPS ... 53
Holding Outpatient Rehabilitation Claims for *CPT* Code *92597* ... 54

**Provider Audit and Reimbursement**
Revision to Suspension, Offset, and Recoupment of Medicare Payments to Providers and Suppliers of Services ... 61

**Educational Resources**
Medicare Medifest 2003 "Tampa Florida" ... 62
Medifest Registration Form ... 63
Medifest Class Schedule ... 64
How Hospitals Can Bill Medicare for Inpatient
www.FloridaMedicare.com—Florida Medicare's Provider Education Web Site ... 66
Ready Survey—*Medicare A Bulletin* ... 67
Order Form – Part A Materials ... 69
Request For Reconsideration or Appeal of Part A Medicare Claim ... 73
Index to *Medicare A Bulletin* ... 70
Addresses, Web Sites, and Phone Numbers ... 75

***Medicare A Bulletin***

**Vol. 5, No. 4**
**Fourth Quarter**
**2003**

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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**

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# A PHYSICIAN'S FOCUS

## FCSO *Office of the Medical Director* Announces the Appointment of a New Medical Director

The First Coast Service Options, Inc. (FCSO) contractor medical directors provide medical leadership for the company. As a Medicare Part A fiscal intermediary and Part B carrier in Florida and Medicare Part B carrier in Connecticut, FCSO processes over 82 million claims for health care services and issues nearly $13 billion in Medicare benefits for the Centers of Medicare & Medicaid Services. FCSO houses its medical directors in the *Office of the Medical Director* (OMD) with locations in Jacksonville, Florida (904-791-6195) and Meriden, Connecticut (203-634-5407). The OMD priority areas include medical policy development (Carrier Advisory Committee process and local medical review policy), medical review and progressive corrective action (data analysis and education), quality improvement initiatives both internal and external to the organization, medical issues leadership, and professional/organizational relationships. A contractor medical director's success depends on good relationships with the physician and allied provider community at the individual, professional level and at the society, organization level. Recently, with the retirement of Dr. Sidney R. Sewell, FCSO and Medicare lost a respected and successful chief medical officer.

With this background, I am pleased to announce the appointment of a new contractor medical director, John M. Montgomery, M.D., M.P.H. John started with FCSO on July 9 at our Jacksonville office. He has responsibilities in Florida Medicare A and B while Dr. Frank Delli Carpini will continue his focus on Connecticut Medicare B from our Meriden office. I will focus on Medicare A and B from Jacksonville.

John received his BA and MD degrees from Brown University and Master of Public Health from Yale University. He has extensive experience in health care administration, planning, education, and research including public health practice as Chief Epidemiologist for the City of Jacksonville. He completed a Family Practice Residency at the Naval Hospital, Jacksonville and is board certified in Family Practice. He has also enjoyed a private practice with emphasis on family and emergency medicine. He has most recently served as the Director of Health Services/Medical Epidemiologist for the Duval County Health Department and interim Director of the Volusia County Health Department in Florida.

I, along with Dr. Delli Carpini in Connecticut, am excited about the opportunity to work closely with Dr. Montgomery in the Medicare program, a vital part of the American health care system.

James J. Corcoran, M.D., M.P.H.
FCSO Chief Medical Officer
James.Corcoran@fcso.com

## About *The Medicare A Bulletin*

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

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

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

### Who Receives the *Bulletin*?

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:

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

**Sign up to our *eNews* electronic mailing list**

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

# The Health Insurance Portability and Accountability Act (HIPAA)

## Open Letter to Providers from CMS About HIPAA

*The following is a letter to providers from Thomas A. Scully, CMS Administrator*

Dear Medicare Provider,

Will you be ready to bill Medicare effective October 16?

Should you be concerned about getting your Medicare claims paid starting October 16? If you are not ready to use the HIPAA standard transaction and code sets by October 16, you may not get paid!

HIPAA is more than a privacy law; it touches many aspects of health care, including the bills you submit to all health insurers, not just Medicare. Effective October 16, 2003, all electronic transactions covered by HIPAA must comply with these standards for format and content. For example, the electronic claim that a physician or hospital sends to a health plan must be compliant and health plans are only allowed to process compliant transactions. Any non-compliant claims submitted after the October deadline will be returned to you, unpaid.

You may have thought that you can still submit paper bills to Medicare, but in many cases, this is not true. The Administrative Simplification Compliance Act (ASCA) includes a provision that requires electronic submissions to Medicare effective October 16, 2003, with a few exceptions [1].

CMS and its contractors are eager to help you through this transition. Testing with your carrier or fiscal intermediary is required to assure that you and your business partners can send and receive HIPAA compliant transactions. Medicare contractors are ready to test with you now! To schedule testing, contact your Medicare carrier or fiscal intermediary. For more information, please review the helpful HIPAA resources, shown below.

Although we have all been working hard to achieve HIPAA compliance and the benefits it will bring, there is still much to be done. Time is growing short; please be sure to test and start sending and receiving HIPAA compliant transactions as early as possible to avoid any last-minute problems.

Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

[1] One of the major exceptions is for claims submitted by "a small provider of services or supplier." The term "small provider of services or supplier" is defined to mean: a provider of services with fewer than 25 full-time equivalent employees; or a physician, practitioner, facility or supplier (other than provider of services) with fewer than 10 full-time equivalent employees. There will be other limited exceptions.

*(Editor's note: For more information about "small provider" and "waivers" go to* www.cms.hhs.gov/hipaa/hipaa2.)

## HIPAA-AS Transactions and Code Sets: Testing and Updates

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

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

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

**Audrey Lipinski at 1-904-791-6865**

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

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

## Will you Be Ready? — Time is Running Out!

**October 16, 2003 is approaching quickly!**

By this time, all of us have heard so much about HIPAA-AS that we believe we know everything that there is to know about this initiative. However, the fact is that many providers, or their billing entities, have not begun testing their electronic transactions for HIPAA compliance. Please remember that HIPAA is a federal mandate and the law requires **all** electronic transactions to be exchanged in the HIPAA standard format (ASC X12N 4010A1) **starting October 16, 2003.**

If you are still submitting paper claims, note that the Administrative Simplification Compliance Act (ASCA) states that effective October 16, 2003, Medicare may not pay claims submitted on paper, with certain exceptions.

It is now vitally important for you to ensure your vendor and/or clearinghouse tests their HIPAA claims software with us. Upon successful completion of such testing, begin using the software for production electronic claim submissions.

This **required** testing is on a first come, first serve basis. Don't delay, have your vendor or clearinghouse contact us now to schedule a testing appointment.

- **Florida Part A providers call Audrey Lipinski at 904-791-6865**

To assist Medicare providers with being ready for this important initiative, the Centers for Medicare & Medicaid Services (CMS) has developed a series of user friendly documents to communicate to the health care community key concepts and requirements contained in HIPAA. This series of ten short papers gets straight to the point of describing HIPAA-AS and what it means to providers, and what providers need to know to prepare for the electronic transactions and code sets requirements for October 16, 2003. Below is a synopsis of the *HIPAA Information Series for Providers* available at www.cms.hhs.gov/hipaa/hipaa2/education/infoserie/:

1. **HIPAA 101** – Educate yourself and your staff on the basics of HIPAA law.
   Everyone covered by HIPAA will be required to provide the same information – standard formats for processing claims and payments, as well as for the maintenance and transmission of electronic health care information and data.
2. **Are You a Covered Entity?** – Determine whether you are a covered entity under HIPAA.
   HIPAA law affects many health care industries – health plans, clearinghouses, and health care service providers (including hospitals and doctors and the companies that furnish information technology products and services to them). HIPAA law and regulations apply to several different types of organizations commonly referred to as "covered entities".
3. **Key HIPAA Dates and Tips for Getting Ready** – Be aware of the HIPAA deadlines right around the corner and take steps to prepare for compliance.
   This series focuses in particular on HIPAA's electronic transactions and codes sets requirements and what providers need to know to prepare for them.
4. **What Electronic Transactions and Code Sets Are Standardized Under HIPAA?** – Review your business operations and the HIPAA Electronic Transactions & Code Sets.
   This paper discusses the various electronic transactions and code sets requirements and how they may be used in your office.
5. **Is Your Software Vendor or Billing Service Ready for HIPAA?** – Communicate with your vendors, billing services and clearinghouses. Know what questions you should be asking them.
   This paper discusses the relationship between providers and vendors, billing services, and clearinghouses and the importance of two-way communication for HIPAA compliance.
6. **What to Expect from Your Health Plans** – Insure you have the necessary two-way communication with each of your health plans. This is essential for compliance.
   This paper discusses the provider/health plan relationship and the importance of on-going communication in the HIPAA implementation process.
7. **What you Need to Know About Testing** – Test your office operations and insure that those who electronically process claims on your behalf have a testing plan in place.
   The testing process is a critical aspect of HIPAA implementation. It is where trading partners find errors, omissions, and conflicts in their systems — and correct them before the actual standard transactions are used.
   **Health plans, clearinghouses and vendors should be in the testing stage of HIPAA implementation for October 16, 2003 compliance. This includes actively testing with their providers.**
8. **Trading Partner Agreements** – Investigate and understand your trading partner agreements with your health plans.
   This paper focuses on the role of trading partner agreements in HIPAA implementation. TPA can provide valuable information about how electronic data interchange (EDI) will be conducted.
9. **Final Steps for Compliance with Electronic Transactions and Code Sets** – Take those final steps towards compliance and do not hesitate to get the help you need.
   ***Moving towards compliance.*** This paper highlights the final steps for complying with the electronic transactions and code sets requirements.
10. **Enforcement** – Learn about CMS' enforcement approach.
    This paper describes CMS' role and approach to enforcing HIPAA's electronic transactions and codes sets requirements. CMS will be responsible for developing and enforcing the administrative simplification requirements of HIPAA with the exception of the privacy requirements, which are overseen and enforced by the Department of Health & Human Services' Office for Civil Rights (OCR).

Again, the HIPAA Information Series for Providers is available at www.cms.hhs.gov/hipaa/hipaa2/education/infoserie/.

In addition, CMS' Southern Consortium has developed a series of four HIPAA presentations available to the public for free. To view this free CMS HIPAA Training Web cast sign on to www.eventstreams.com/cms/tm_001/ and select Health Plans/Third Party Agreements. ❖

## CMS Southern Consortium's FREE HIPAA Presentations

There is an informative series of HIPAA presentations that can be accessed via the Internet at no cost. To access these presentations, simply visit: *http://www.eventstreams.com/cms/tm_001/*

You may choose any of the following presentations:

1) HIPAA Message to Providers From the Southern Consortium Administrator (Coming Soon)
2) HIPAA Basics
3) Provider Steps to Getting Paid Under HIPAA
4) HIPAA Security (Coming Soon)

If you would like to have a standalone version of these presentations via a CD, please contact Dale Ivey at 1-404-562-7221 or *Divey@cms.hhs.gov*.

If you would like to access transcripts of the HIPAA Educational Audio Conferences that were held in partnership with the industry workgroups, WEDI and SHARP, they are available via *www.sharpworkgroup.com.*

- March 19, 2003, "Software Requirements for the 837p" – Audience: Small Vendors
- March 24, 2003, "How Will HIPAA Affect Your Group?" – Audience: Employer Groups, TPA, Plan Sponsors, and Plan Administrators
- March 26, 2003, " HIPAA Privacy" – National OCR Audio Conference – Audience: All Covered Entities and Interested Stakeholders
- March 31, 2003, "How to Get Paid Under HIPAA" – Audience: Nursing Homes, HHAs, and Hospice Organizations
- April 2, 2003, "How to Get Paid Under HIPAA" – Audience: Physicians and their office staff
- April 15, 2003, "How to Get Paid Under HIPAA" follow-up call. Audience: Physicians and their office staff
- April 23, 2003, "HIPAA Security: The Final Rule" – Audience: All covered entities and interested stakeholders
- April 30, 2003, "National CMS HIPAA Roundtable" – Focus: Administrative Simplification, specifically electronic transactions and code sets, and security – Audience: All covered entities and interested stakeholders
- May 1, 2003, "HIPAA Refresher Series – HIPAA Basics" – Audience: Indian Health Service; all covered entities and interested stakeholders
- May 7, 2003, "HIPAA Administrative Simplification" (Spanish) – Audience: All covered entities and interested stakeholders whose primary language is Spanish
- May 8, 2003, "HIPAA Refresher Series: How to get paid" – Audience: Indian Health Service; all covered entities and interested stakeholders
- May 14, 2003, "HIPAA Privacy and Security" (Spanish) – Audience: all covered entities and interested stakeholders whose primary language is Spanish
- May 15, 2003, "HIPAA Refresher Series: HIPAA Security and Privacy" – Audience: Indian Health Service; all covered entities and interested stakeholders

The HIPAA Information Series for Providers is a series of ten short papers gets straight to the point describing HIPAA and what it means to providers. Papers are available in both English and Spanish at: *http://www.cms.hhs.gov/hipaa/hipaa2/education/infoserie/*

FREE Listserves provide notices on HIPAA announcements, new tools and educational material, and related information.

- Regulations – *http://www.cms.hhs.gov/hipaa/hipaa2/regulations/Isnotify.asp*
- Outreach – *http://list.nih.gov/archives/hipaa-outreach-l.html*. ❖

## Free CMS HIPAA Training

The CMS Southern Consortium's Achieving Compliance Together Team has developed a series of HIPAA presentations. They can be accessed via the Internet and there is no cost to you. To access these presentations, simply go to: *http://www.eventstreams.com/cms/tm_001/*. You can choose any of the following presentations:

1) HIPAA Message to Providers from the Southern Consortium Administrator (coming soon)
2) HIPAA Basics
3) Provider Steps to Getting Paid under HIPAA
4) HIPAA Security (coming soon)

### Free Fax Back Service

The CMS Southern Consortium's Achieving Compliance Together Team has developed a HIPAA resource in an effort to reach those without Internet/email access! Have your fax number handy and call 1-800-874-5894.

Select Option 1 for the starter set: HIPAA information, resources, and transactions checklist, then follow the prompts. It's that easy! Other documents are also available (for example, information on Medicare's free billing software and a HIPAA glossary). ❖

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## HIPAA Resources – Updated June 16, 2003

### CMS

*Products/Resources*

- **Web site** – ***http://www.cms.hhs.gov/hipaa/hipaa2/*** – Answers to Frequently Asked Questions, links to other HIPAA sites, and information on the law, regulations, and enforcement are located here.
- **HIPAA Information Series for Providers – *http://www.cms.hhs.gov/hipaa/hipaa2/education/infoserie/*** This series of ten short papers gets straight to the point describing HIPAA, what it means to providers, and what is needed to prepare for the electronic transactions and code sets requirements for October 16, 2003. All ten papers are available on the Web site and most papers are now available in Spanish.
- **FREE CMS HIPAA Training Web cast – *http://www.eventstreams.com/cms/tm_001/*** – CMS' Southern Consortium has developed a series of HIPAA presentations. They are available for the public to view for free.
- **Conference for Employers** – Are you an employer in need of information on HIPAA? CMS Dallas and Atlanta offices are co–sponsoring this national conference with the Workgroup for Electronic Data Interchange (WEDI) and the Society for Human Resource Management (SHRM). For more information visit: ***http://www.wedi.org/public/articles/dis_viewArticle.cfm?ID=198*.**
- **Video and CD–ROM** – Coming Soon! CMS' HIPAA 101 Video and CD–ROM are packed with tips for preparing your office for HIPAA. Stay tuned to our Web site for information.
- **FREE Listserves** – Both listserves are operated by the U.S. Department of Health & Human Services
  **Regulations – *http://www.cms.hhs.gov/hipaa/hipaa2/regulations/lsnotify.asp*** – Sign up to receive notification when proposed or final rules on HIPAA have been published in the Federal Register (The Federal Register is the place where the government, upon passing a law, tells the public how the law will be implemented).
  ***New!* Outreach – *http://list.nih.gov/archives/hipaa-outreach-l.html*** – Sign up here to receive free notices on HIPAA announcements, new tools and educational material, and related information.
- **Small Provider Checklist Tool** – Use this tool to help you determine first steps you should be taking to prepare for HIPAA: *http://www.cms.hhs.gov/hipaa/hipaa2/education/ReadinessChkLst.pdf*. Also available in Spanish at *http://www.cms.hhs.gov/hipaa/hipaa2/education/ReadinessChkLstEsp.pdf*.
- **White Papers:**
  *Am I a Covered Entity Provider? http://www.wedi.org/snip/public/articles/coveredEntitiy.pdf.*
  *How HIPAA Is Reshaping the Way We Do Business. http://www.wedi.org/snip/public/articles/centMedicarencaid.pdf.*
- **Medicare Free / Low Cost Billing Software – *http://cms.hhs.gov/providers/edi/*** – If you bill Medicare, there is software available to you free or for a small charge. This software is designed only for Medicare claims. Check the above link for the appropriate contact in your state for more information.
- **CMS Medicaid HIPAA Web Address** – *http://www.cms.hhs.gov/medicaid/hipaa/adminsim/*. Also, see *http://www.cms.hhs.gov/medicaid/hipaa/adminsim/0203laconf/* for presentations from the 2003 National Medicaid HIPAA and MMIS Conference held in New Orleans February 9–13.

*Contact info for CMS*

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

### Other Resources

**HHS' Office for Civil Rights (Privacy) – *http://www.hhs.gov/ocr/hipaa/*** – The U.S. Department of Health & Human Services' Office for Civil Rights oversees the privacy requirements.

**New! Interim final rule: Civil Money Penalties** – ***http://www.hhs.gov/ocr/moneypenalties.html***
**Model "Business Associate Agreement"** at: ***http://www.hhs.gov/ocr/hipaa/contractprov.html***
**"Guidance Explaining Significant Aspects of the Privacy Rule"** at: ***http://www.hhs.gov/ocr/hipaa/privacy.html***.

**Top 15 Privacy Concerns** at*: http://www.regreform.hhs.gov/HIPAAQUIZ_0204171/sld001.htm.*

**Contact information**
*OCRPrivacy@hhs.gov* or
Call **1–866–627–7748**

- **WEDI SNIP Web site – *http://www.wedi.org/snip/*** – WEDI is an organization working to foster widespread support for the adoption of electronic commerce within healthcare and SNIP is a collaborative healthcare industry–wide process resulting in the implementation of standards and furthering the development and implementation of future standards. This Web site contains various resources on HIPAA administrative simplification.

  Find out if your state has a local WEDI SNIP affiliate – Go to *http://www.wedi.org/snip/public/articles/index%7E8.htm.*
  A resource for information on health plan electronic transaction changes – Go to *http://www.wedi.org/snip/CAQHIMPTOOLS/.* ❖

Source: CMS Region IV HIPAA Coordinator

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# Benefits of Electronic Claim Filing under HIPAA-AS

*The following article is being republished to stress the importance of promoting a consistent message within the provider community.*

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

### Requirement to Go to Electronic Claims

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

### Negative Fiscal Impact of Paper Claims

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

### Changes to Business Processes

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

## General HIPAA Information

### What is HIPAA?

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

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

### What are the HIPAA Transactions?

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

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

### What is a HIPAA Covered Entity?

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

### What Is "Electronic?"

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

### A Benefit to Consider

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

### HIPAA Deadlines

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

### Where To Go For Help:

CMS Web site: *http://www.cms.hhs.gov/hipaa/hipaa2*

HIPAA hotline: 1-866-282-0659

AskHIPAA mailbox: send an email to *askhipaa@cms.hhs.gov.*

For more information on privacy, visit *http://www.hhs.gov/ocr/hipaa.*

For privacy questions, call 1-866-627-7748. ❖

Source: CMS Notification Dated April 25, 2003

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## Are Small Providers Covered Entities under HIPAA?

As a health care provider, you have probably heard about HIPAA – the Health Insurance Portability and Accountability Act of 1996. HIPAA mandates new standards and procedures that promote standardization and efficiency in the health care industry. Today's health care industry relies more and more on advances in technology to help administer health care. Doctors, hospitals, clearinghouses, and health care vendors, such as billing services and software companies, use computers to conduct many of their health care transactions.

Congress passed HIPAA in response to the health care industry's increasing reliance on electronic transmission of health care data. The law will help streamline the administration of health care by requiring basic standards for conducting several transactions in electronic form, including processing claims and payments. It also governs disclosure of electronic patient protected health information and provides the minimum safeguards required to ensure the security of electronic health care information.

This document responds to many questions CMS has received from small providers – especially those small providers who currently do not conduct any of their health care transactions electronically. If you are a provider that conducts office operations manually, there are two important questions you should ask in order to determine if HIPAA applies to you:

### Does your office conduct *all* of the following transactions on paper, by phone, or by fax (from a dedicated fax machine, as opposed to faxing from a computer)?

- Submitting claims or managed care encounter information
- Checking claim status inquiry and response
- Checking eligibility and receiving a response
- Checking referral certifications and authorizations
- Enrolling and disenrolling in a health plan
- Receiving health care payments and remittance advice
- Providing coordination of benefits

If your office does not conduct any of the above standard transactions electronically and you do not have someone else conduct them electronically on your behalf – such as a clearinghouse or billing service – ***you are not a covered entity and HIPAA does not apply to you.***

***If you conduct any of these transactions electronically, you are a covered entity and you must comply with all HIPAA requirements, regardless of the size of your practice.***

### Do you bill Medicare and are you a small provider with fewer than 10 full-time equivalent employees?

**Effective October 16, 2003,** Medicare may not pay claims submitted on paper, with certain exceptions. One of the major exceptions is for claims submitted by "a small provider of services or supplier." **The term "small provider of services or supplier" is defined to mean:**

- a provider of services* with fewer than 25 full-time equivalent employees, and
- a physician, practitioner, facility, or supplier** (other than provider of services) with fewer than 10 full-time equivalent employees.

* *The term "provider of services" is defined for Medicare by section 1861(u) of the Social Security Act to include seven specific types of institutional or special purpose providers. This term generally describes hospitals, nursing facilities and other institutional providers that are paid through Medicare fiscal intermediaries (**Medicare Part A**).*

** The terms found in the phrase "physician, practitioner, facility or supplier" are used to describe entities that furnish Medicare services described in section 1861(s) of the Act, and are generally paid through Medicare carriers (**Medicare Part B**).

If you do not meet the small provider exception, you are required to submit your Medicare claims electronically, effective October 16, 2003. Once you begin submitting your claims electronically to Medicare, your answer to the first question above would be "no," and you would become a covered entity under HIPAA.

If you have additional questions about HIPAA, please visit the CMS Web site at *www.cms.hhs.gov/hipaa/hipaa2*. You will find a wealth of informative material developed specifically for the provider community. You may also call the CMS hotline at 1-866-282-0659 or email *askhipaa@cms.hhs.gov*. ❖

Source: CMS Web site (*www.cms.hhs.gov/hipaa/hipaa2*)

## HIPAA Information Series for Providers Now Available in English and Spanish

The first article in CMS' *HIPAA Information Series for Providers* series of ten articles, "HIPAA 101," was published in the Second Quarter *Medicare A Bulletin* (pages 37-40). Since then, CMS has completed the series, which is available on the CMS Web site at *http://www.cms.hhs.gov/hipaa/hipaa2/education/infoserie/*. The series is also available in a Spanish-language version at *http://www.cms.hhs.gov/hipaa/hipaa2/education/infoserieesp/*. ❖

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## Guidance on HIPAA Privacy Rule Business Associate Provisions

Medicare fee-for-service (FFS) contractors that perform healthcare activities involving the use of protected health information on behalf of the Medicare FFS health plan (i.e., claims processing functions) are business associates of the Medicare FFS health plan (the covered entity). By definition, a business associate is a person or entity that performs or assists in the performance of a function or activity involving the use or disclosure of individually identifiable health information on behalf of a covered entity (45 CFR section 164.103).

Medicare contractors that perform healthcare activities involving the use of protected health information on behalf of the Medicare FFS health plan are **not** business associates of providers, physicians, suppliers, or other health plans. Likewise, providers, physicians, suppliers, or other health plans are **not** business associates of the Medicare contractor, unless the provider, physician, supplier, or other health plan is doing work on behalf of the Medicare contractor.

Questions have been raised about whether there is a business associate relationship between Medicare contractors and the trading partners that receive crossover claims data from them. Currently, Medicare FFS contractors execute trading partner agreements (TPAs) with a host of payers, including Medigap insurers, Medicare supplemental/employee retiree health plans, multiple employer welfare trusts, as well as state Medicaid Agencies, for the purpose of exchanging adjudicated Medicare claims for secondary liability determination by those partners. This exchange of data is commonly referred to as the "claims crossover process." For coordination of benefits (COB) purposes, Medicare contractors and trading partners are not business associates since neither entity is doing work on the other's behalf; therefore, the Medicare FFS contractors should not sign business associate agreements with supplemental insurers (trading partners). Further, the Standard TPA for eligibility file-based COB, which CMS will soon be issuing, is not a business associate agreement.

Business associate provisions developed by CMS in accordance with Privacy Rule sample language, including instructions for ensuring compliance, will be added to Medicare FFS contractors' existing contracts shortly, in accordance with 45 CFR section 164.504(e)(2)(ii)(D). Medicare FFS contractors will incorporate this language into their subcontracts, either on the next contract modification cycle or by April 14, 2004, whichever is the earlier date. ❖

Source: CMS Transmittal AB-03-078, CR 2712

## HIPAA Compliance after the October 16, 2003, Implementation Deadline

To improve the efficiency and effectiveness of the health care system, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which included a series of "administrative simplification" provisions that required the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions. All covered entities must be in compliance with the electronic transactions and code sets standards by October 16, 2003.

The law is clear: October 16, 2003, is the deadline for covered entities to comply with HIPAA's electronic transaction and code sets provisions. After that date, covered entities, including health plans, may not conduct noncompliant transactions. With the October deadline just ahead, HHS has received a number of inquiries expressing concern over the health care industry's state of readiness. In response, the Department believes it is particularly important to outline its approach to enforcement of HIPAA's electronic transactions and code sets provisions. The Department will continue to provide technical assistance and issue guidance on the transactions and code sets provisions and compliance therewith.

### Enforcement Approach

The Secretary has made the Centers for Medicare & Medicaid Services (CMS) responsible for enforcing the electronic transactions and code sets provisions of the law.

CMS will focus on obtaining voluntary compliance and use a complaint-driven approach for enforcement of HIPAA's electronic transactions and code sets provisions. When CMS receives a complaint about a covered entity, it will notify the entity in writing that a complaint has been filed. Following notification from CMS, the entity will have the opportunity to 1) demonstrate compliance, 2) document its good faith efforts to comply with the standards, and/or 3) submit a corrective action plan.

**Demonstrating Compliance** – Covered entities will be given an opportunity to demonstrate to CMS that they submitted compliant transactions.

**Good Faith Policy** – CMS's approach will utilize the flexibility granted in section 1176(b) of the Social Security Act to consider good faith efforts to comply when assessing individual complaints. Under section 1176(b), HHS may not impose a civil money penalty where the failure to comply is based on reasonable cause and is not due to willful neglect, and the failure to comply is cured with a 30-day period. HHS has the authority under the statute to extend the period within which a covered entity may cure the noncompliance "based on the nature and extent of the failure to comply."

CMS recognizes that transactions often require the participation of two covered entities and that noncompliance by one covered entity may put the second covered entity in a difficult position. Therefore, during the period immediately following the compliance date, CMS intends to look at both covered entities' good faith efforts to come into compliance with the standards in determining, on a case-by-case basis, whether reasonable cause for the noncompliance exists and, if so, the extent to which the time for curing the noncompliance should be extended.

CMS will not impose penalties on covered entities that deploy contingencies (in order to ensure the smooth flow of payments) if they have made reasonable and diligent efforts to become compliant and, in the case of health plans, to facilitate the compliance of their trading partners. Specifically, as long as a health plan can demonstrate to CMS its active outreach/testing efforts, it can continue processing

*HIPAA Compliance after the October 16, 2003, Implementation Deadline (continued)*

payments to providers. In determining whether a good faith effort has been made, CMS will place a strong emphasis on sustained actions and demonstrable progress.

Indications of good faith might include, for example, such factors as:

- Increased external testing with trading partners.
- Lack of availability of, or refusal by, the trading partner(s) prior to October 16, 2003, to test the transaction(s) with the covered entity whose compliance is at issue.
- In the case of a health plan, concerted efforts in advance of the October 16, 2003, and continued efforts afterwards to conduct outreach and make testing opportunities available to its provider community.

While there are many examples of complaints that CMS may receive, the following is one example that illustrates how CMS expects the process to work.

**Example:** A complaint is filed against an otherwise-compliant health plan that accepts and processes both compliant and non-compliant transactions while working to help its providers achieve compliance.

In this situation, CMS would 1) notify the plan of the complaint, 2) based on the plan's response to the notification, evaluate the plan's efforts to help its noncompliant providers come into compliance, and 3) if it determined that the plan had demonstrated good faith and reasonable cause for its non-compliance, not impose a penalty for the period of time CMS determines is appropriate, based on the nature and extent of the failure to comply.

For example, CMS would examine whether the health plan undertook a course of outreach actions to its trading partners on awareness and testing, with particular focus on the actions that occurred prior to October 16. Similarly, health care providers should be able to demonstrate that they took actions to become compliant prior to October 16. If CMS determines that reasonable and diligent efforts have been made, the cure period for noncompliance would be extended at the discretion of the government. Furthermore, CMS will continue to monitor the covered entity to ensure that their sustained efforts bring progress towards compliance. If continued progress is not made, CMS will step up their enforcement efforts towards that covered entity.

Organizations that have exercised good faith efforts to correct problems and implement the changes required to comply with HIPAA should be prepared to document them in the event of a complaint being filed. This flexibility will permit health plans to mitigate unintended adverse effects on covered entities' cash flow and business operations during the transition to the standards, as well as on the availability and quality of patient care.

**Corrective Action Plan (CAP)** – After October 16, 2003, in addition to possible fines and penalties imposed, CMS will expect non-compliant covered entities to submit plans to achieve compliance in a manner and time acceptable to the Secretary. More detailed information on CAPs will be forthcoming.

## Working Toward Compliance

In the few remaining months before the October 16 deadline, HHS encourages health plans and providers to intensify their efforts toward achieving transaction and code set compliance. In addition, HHS encourages health plans to assess the readiness of their provider communities to determine the need to implement contingency plans to maintain the flow of payments while continuing to work toward compliance. Although transaction and code set compliance is a huge undertaking, the result will be greatly enhanced electronic communication throughout the health care community. Successful implementation will require the attention and cooperation of all health plans and clearinghouses, and of all providers that conduct electronic transactions. There is considerable industry support for transaction and code sets, and we all look forward to realizing the many advantages of its successful implementation.

Source: CMS Web site posting, July 24, 2003

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# ELECTRONIC DATA INTERCHANGE

## Remittance Advice Remark and Reason Code Update

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

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

The following list summarizes changes made through February 28, 2003 and is effective **October 1, 2003.**

### New Remark Codes

| Code | Current Narrative |
|---|---|
| N157* | Transportation to and from this destination is not covered. |
| N158* | Transportation in a vehicle other than an ambulance is not covered. |
| N159* | Payment denied/reduced because mileage is not covered when the patient is not in the ambulance. |
| N160* | The beneficiary/patient must choose an option before this procedure/equipment/supply/servic e can be covered. |
| N161* | This drug/service/supply is covered only when the associated service is covered. |
| N162* | This is an alert. Although your claim was paid, you have billed for a test/specialty not included in your Laboratory Certification. Your failure to correct the laboratory certification information will result in a denial of payment in the near future. |
| N163* | Medical record does not support code billed per the code definition. |
| *N164** | *Transportation to/from this destination is not covered.* |
| *N165** | *Transportation in a vehicle otherthan an ambulance is not covered.* |
| *N166** | *Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.* |
| N167* | Charges exceed the post-transplant coverage limit. |
| *N168** | *The beneficiary must choose an option before a payment can be made for this procedure/equipment/supply/servic e.* |
| *N169** | *This drug/service/supply is covered only when the associated service is covered.* |
| N170* | A new/revised/renewed certificate of medical necessity is needed. |

*** Medicare Initiated**

| Code | Current Narrative |
|---|---|
| N171* | Payment for repair or replacement is not covered or has exceeded the purchase price. |
| N172 | The patient is not liable for the denied/adjusted charge(s) for receiving any updated service/item. |
| N173* | No qualifying hospital stay dates were provided for this episode of care. |
| N174* | This is not a covered service/procedure/ equipment/ bed, however patient liability is limited to amounts shown in the adjustments under group "PR". |
| N175* | Missing/incomplete/invalid Review Organization Approval. |
| N176* | Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, a doctor licensed to practice in the United States must provide the service. |
| N177* | We did not send this claim to beneficiary's other insurer. They have indicated no additional payment can be made. |
| N178* | Missing/invalid/incomplete pre- operative photos or visual field results. |
| N179 | Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information. |
| N180 | This item or service does not meet the criteria for the category under which it was billed. |
| N181 | Additional information has been requested from another provider involved in the care of this member. The charges will be reconsidered upon receipt of that information. |
| N182 | This claim/service must be billed according to the schedule for this plan. |

*** Medicare Initiated**

*Remittance Advice Remark and Reason Code Update (continued)*

| Code | Current Narrative |
|---|---|
| N183 | This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits. |
| N184 | Rebill technical and professional components separately. |
| N185 | Do not resubmit this claim/service. |
| N186 | Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance. |
| N187 | You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents. |
| N188 | The approved level of care does not match the procedure code submitted. |
| N189 | This service has been paid as a one-time exception to the plan's benefit restrictions. |
| N190 | Missing/incomplete/invalid contract indicator. |
| N191 | The provider must update insurance information directly with payer. |
| N192 | Patient is a Medicaid/Qualified Medicare Beneficiary. |
| N193 | Specific federal/state/local program may cover this service through another payer. |
| N194 | Technical component not paid if provider does not own the equipment used. |
| N195 | The technical component must be billed separately. |
| N196 | Patient eligible to apply for other coverage which may be primary. |
| N197 | The subscriber must update insurance information directly with payer. |
| N198 | Rendering provider must be affiliated with the pay-to provider. |
| N199 | Additional payment approved based on payer-initiated review/audit. |
| N200 | The professional component must be billed separately. |
| N201 | A mental health facility is responsible for payment of outside providers who furnish these services/ supplies to residents. |

**Note:** Codes N157, N158, N159, N160 and N161 are used in lieu of codes N164, N165, N166, N168 and N169 that will be deactivated in the next update.

## Modified Remark Codes

| Code | Current Modified Narrative |
|---|---|
| M19 | Missing/incomplete/invalid oxygen certification/re-certification. |
| M20 | Missing/incomplete/invalid HCPCS. |
| M21 | Missing/incomplete/invalid place of residence for this service/item provided in a home. |
| M22 | Missing/incomplete/invalid number of miles traveled. |
| M23 | Invoice needed for the cost of the material or contrast agent. |
| M24 | Missing/incomplete/invalid number of doses per vial. |
| M29 | Missing/incomplete/invalid operative report. |
| M30 | Missing/incomplete/invalid pathology report. |
| M31 | Missing/incomplete/invalid radiology report. |
| M33 | Missing/incomplete/invalid UPIN for the ordering/ referring/performing provider. |
| M34 | Claim lacks the CLIA certification number. |
| M35 | Missing/incomplete/invalid pre-operative photos or visual field results. |
| M44 | Missing/incomplete/invalid condition code. |
| M45 | Missing/incomplete/invalid occurrence codes or dates. |
| M46 | Missing/incomplete/invalid occurrence span code or dates. |
| M47 | Missing/incomplete/invalid internal or document control number. |
| M49 | Missing/incomplete/invalid value code(s) or amount(s). |
| M50 | Missing/incomplete/invalid revenue code(s). |
| M51 | Missing/incomplete/invalid procedure code(s) and/ or rates. |
| M52 | Missing/incomplete/invalid "from" date(s) of service. |
| M53 | Missing/incomplete/invalid days or units of service. |
| M54 | Missing/incomplete/invalid total charges. |
| M56 | Missing/incomplete/invalid payer identifier. |
| M57 | Missing/incomplete/invalid provider identifier. |
| M58 | Missing/incomplete/invalid claim information. Resubmit claim after corrections. |
| M59 | Missing/incomplete/invalid "to" date(s) of service. |
| M62 | Missing/incomplete/invalid treatment authorization code. |
| M64 | Missing/incomplete/invalid other diagnosis. |
| M67 | Missing/incomplete/invalid other procedure code(s) and/or date(s). |
| M68 | Missing/incomplete/invalid attending or referring physician identification. |
| M76 | Missing/incomplete/invalid diagnosis or condition. |
| M77 | Missing/incomplete/invalid place of service. |
| M78 | Missing/incomplete/invalid HCPCS modifier. |
| M79 | Missing/incomplete/invalid charge. |

***Remittance Advice Remark and Reason Code Update (continued)***

| Code | Current Narrative |
|---|---|
| M81 | Patient's diagnosis in a narrative form is not provided on an attachment or diagnosis code(s) is truncated, incorrect or missing; you are required to code to the highest level of specificity. |
| M99 | Missing/incomplete/invalid Universal Product Number/Serial Number. |
| M108 | Missing/incomplete/invalid provider identifier for the provider who interpreted the diagnostic test. |
| M110 | Missing/incomplete/invalid provider identifier for the provider from whom you purchased interpretation services. |
| M119 | Missing/incomplete/invalid National Drug Code (NDC). |
| M120 | Missing/incomplete/invalid provider identifier for the substituting physician who furnished the service(s) under a reciprocal billing or locum tenens arrangement. |
| M122 | Missing/incomplete/invalid level of subluxation. |
| M123 | Missing/incomplete/invalid name, strength, or dosage of the drug furnished. |
| M124 | Missing/incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply. |
| M125 | Missing/incomplete/invalid information on the period of time for which the service/supply/ equipment will be needed. |
| M126 | Missing/incomplete/invalid individual lab codes included in the test. |
| M127 | Missing/incomplete/invalid patient medical record for this service. |
| M128 | Missing/incomplete/invalid date of the patient's last physician visit. |
| M129 | Missing/incomplete/invalid indicator of X-ray availability for review. |
| M130 | Missing/incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used. |
| M131 | Missing/incomplete/invalid physician financial relationship form. |
| M132 | Missing/incomplete/invalid pacemaker registration form. |
| M135 | Missing/incomplete/invalid plan of treatment. |
| M136 | Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician. |
| M141 | Missing/incomplete/invalid physician certified plan of care. |
| M142 | Missing/incomplete/invalid American Diabetes Association Certificate of Recognition. |
| MA06 | Missing/incomplete/invalid beginning and/or ending date(s). |

| Code | Current Narrative |
|---|---|
| MA27 | Missing/incomplete/invalid entitlement number or name shown on the claim. |
| MA29 | Missing/incomplete/invalid provider name, city, state, or zip code. |
| MA30 | Missing/incomplete/invalid type of bill. |
| MA31 | Missing/incomplete/invalid beginning and ending dates of the period billed. |
| MA32 | Missing/incomplete/invalid number of covered days during the billing period. |
| MA33 | Missing/incomplete/invalid noncovered days during the billing period. |
| MA34 | Missing/incomplete/invalid number of coinsurance days during the billing period. |
| MA35 | Missing/incomplete/invalid number of lifetime reserve days. |
| MA36 | Missing/incomplete/invalid patient name. |
| MA37 | Missing/incomplete/invalid patient's address. |
| MA38 | Missing/incomplete/invalid birth date. |
| MA39 | Missing/incomplete/invalid gender. |
| MA40 | Missing/incomplete/invalid admission date. |
| MA41 | Missing/incomplete/invalid admission type. |
| MA42 | Missing/incomplete/invalid admission source. |
| MA43 | Missing/incomplete/invalid patient status. |
| MA48 | Missing/incomplete/invalid name or address of responsible party or primary payer. |
| MA49 | Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services. |
| MA50 | Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services. |
| MA51 | Missing/incomplete/invalid CLIA certification number for laboratory services billed by laboratory services billed by physician office laboratory. |
| MA52 | Missing/incomplete/invalid date. |
| MA58 | Missing/incomplete/invalid release of information indicator. |
| MA60 | Missing/incomplete/invalid patient relationship to insured. |
| MA61 | Missing/incomplete/invalid social security number or health insurance claim number. |
| MA63 | Missing/incomplete/invalid principal diagnosis. |
| MA65 | Missing/incomplete/invalid admitting diagnosis. |
| MA66 | Missing/incomplete/invalid principal procedure code or date. |
| MA69 | Missing/incomplete/invalid remarks. |

*Remittance Advice Remark and Reason Code Update (continued)*

| Code | Current Narrative |
|---|---|
| MA70 | Missing/incomplete/invalid provider representative signature. |
| MA71 | Missing/incomplete/invalid provider representative signature date. |
| MA75 | Missing/incomplete/invalid patient or authorized representative signature. |
| MA76 | Missing/incomplete/invalid provider identifier for HHA or hospice when physician is performing care plan oversight services. |
| MA81 | Missing/incomplete/invalid provider/supplier signature. |
| MA82 | Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number. |
| MA86 | Missing/incomplete/invalid group or policy number of the insured for the primary coverage. |
| MA87 | Missing/incomplete/invalid insured's name for the primary payer. |
| MA88 | Missing/incomplete/invalid insured's address and/or telephone number for the primary payer. |
| MA89 | Missing/incomplete/invalid patient's relationship to the insured for the primary payer. |
| MA90 | Missing/incomplete/invalid employment status code for the primary insured. |
| MA92 | Missing/incomplete/invalid primary insurance information. |
| MA95 | De-activate and refer to M51. (Modified 2/28/03) |
| MA97 | Missing/incomplete/invalid Medicare Managed Care Demonstration contract number. |
| MA99 | Missing/incomplete/invalid Medigap information. |
| MA100 | Missing/incomplete/invalid date of current illness, injury or pregnancy. |
| MA102 | Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider. |
| MA104 | Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician. |
| MA105 | Missing/incomplete/invalid provider number for this place of service. |
| MA110 | Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim. |
| MA111 | Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address. |
| MA112 | Missing/incomplete/invalid group practice information. |
| MA114 | Missing/incomplete/invalid information on where the services were furnished. |
| MA115 | Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA). |
| MA120 | Missing/incomplete/invalid CLIA certification number. |
| MA121 | Missing/incomplete/invalid date the X-Ray was performed. |
| MA122 | Missing/incomplete/invalid initial date actual treatment occurred. |
| MA128 | Missing/incomplete/invalid six-digit FDA approved, identification number identification number. |
| MA129 | This provider was not certified for this procedure on this date of service. |
| N1 | You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents. |
| N3 | Missing/incomplete/invalid consent form. |
| N4 | Missing/incomplete/invalid prior insurance carrier EOB. |
| N6 | Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B. |
| N24 | Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information. |
| N26 | Missing/incomplete/invalid itemized bill. |
| N27 | Missing/incomplete/invalid treatment number. |
| N29 | Missing/incomplete/invalid documentation/orders/notes/sum mary/report/invoice. |
| N31 | Missing/incomplete/invalid prescribing/referring/attending provider license number. |
| N37 | Missing/incomplete/invalid tooth number/letter. |
| N38 | Missing/incomplete/invalid place of service. |
| N40 | Missing/incomplete/invalid X-ray. |
| N50 | Missing/incomplete/invalid discharge information. |
| N53 | Missing/incomplete/invalid point of pick-up address. |
| N56 | Procedure code billed is not correct/valid for the services billed or the date of service billed. |
| N57 | Missing/incomplete/invalid prescribing/dispensed date. |
| N58 | Missing/incomplete/invalid patient liability amount. |
| N65 | Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider. |

*Remittance Advice Remark and Reason Code Update (continued)*

| Code | Current Narrative |
|---|---|
| N66 | Missing/incomplete/invalid documentation. |
| N70 | Home health consolidated billing and payment applies. |
| N71 | Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claim. |
| N73 | A Skilled Nursing Facility is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents. |
| N75 | Missing/incomplete/invalid tooth surface information. |
| N76 | Missing/incomplete/invalid number of riders. |
| N77 | Missing/incomplete/invalid designated provider number. |
| N80 | Missing/incomplete/invalid prenatal screening information. |
| N95 | This provider type/provider specialty may not bill this service. |
| N103 | Social Security records indicate that this beneficiary was a prisoner when the service was rendered. This payer does not cover items and services furnished to beneficiaries while they are in State or local custody under a penal authority, unless under state or local law, the beneficiary is personally liable for the cost of his or her health care while incarcerated and the state or local government pursues such debt in the same way and with the same vigor as any other debt. |
| N108 | Missing/incomplete/invalid upgrade information. |

### Retired Remark Codes

| Code | Current Narrative Comment |
|---|---|
| M72 | Did not enter full 8-digit date (MM/DD/CCYY). **Note: Effective October 16, 2003,** code M72 will be replaced with code MA52. |
| MA05 | Incorrect admission date patient status or type of bill entry on claim. **Note: Effective October 16, 2003,** code MA05 will be replaced with code MA30, MA40, or MA43. |
| MA98 | Claim Rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary. **Note: Effective October 16, 2003,** code MA98 will be replaced with code MA97. |
| N41 | Authorization request denied. **Note: Effective October 16, 2003,** code N41 will be replaced with claim adjustment reason code 39. |
| N44 | Payer's share of regulatory surcharges, assessments, allowances or health care-related taxes paid directly to the regulatory authority. **Note: Effective October 16, 2003,** code N44 will be replaced with claim adjustment reason code 137. |

### X12 N 835 Health Care Claim Adjustment Reason Codes

The Health Care Code Maintenance Committee maintains the health care claim adjustment reason codes. An updated list is posted three times a year after each X12 trimester meeting at *http://www.wpcedi.com/hipaa/*. The committee did not approve any reason code change in February 2003. The current reason code set was installed April 1, 2003. ❖

Source: CMS Transmittal AB-03-095, CR 2788

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## NEW! — Call One Phone Number for Assistance with DDE and Medicare A EDI Transactions

Providers and senders who use Direct Data Entry (DDE) or Medicare EDI Transactions can now call one phone number for any electronic claims needs they have.

All Medicare A Electronic Senders and DDE customers should now call **1-904-791-8131**. Callers will be routed to the area in Medicare EDI that can assist them based on the option they choose.

The following is the message and options that callers will hear:

"Thank you for calling Medicare Part A EDI.

- If you know your party's 5-digit extension, please press 8.
- For DDE assistance or for the 270/271-eligibility transaction, press 1.
- For Medicare A electronic transactions or remittance advise assistance, press 2.
- For DDE password resets, press 3.
- For electronic claims transmission acknowledgements or to have remittance advice reloaded to your mailbox, press 4.
- For all other assistance, please remain on the line."

Please make a note of the telephone number change. ❖

# GENERAL INFORMATION

## Patient Status Code Update

Form locator 22, patient status, on Form UB-92 CMS 1450 or the electronic equivalent, is a required field for all Part A inpatient, skilled nursing facility (SNF), hospice, home health agency (HHA), and outpatient hospital services, and indicates a patient's status as of the "through" date of the billing period.

### Addition of Patient Status Code 43

Effective for discharges **on or after October 1, 2003,** the National Uniform Billing Committee (NUBC) has approved a new patient status code 43 (discharged/transferred to a federal hospital). CMS intends to use this code to track the frequency of discharges and transfers to government-owned hospitals such as Veteran's Administration and Department of Defense hospitals. This code is to be used whenever the destination at discharge is a federal hospital, whether the patient lives there or not. The use of patient status code 43 will not have any affect on payment to hospitals, SNFs, HHAs, or hospices, but these facilities are required to use this code when discharging a patient to a federal hospital.

### Deletion of Patient Status Codes 71 and 72

**Effective October 1, 2003,** the NUBC and CMS are discontinuing patient status codes 71 and 72 (discharged/transferred/referred for outpatient services specified by the discharge plan of care).

### Information on New Patient Status Code 65

Effective for *discharges* **on or after April 1, 2004,** the NUBC has approved a new patient status code 65 (discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital).

In summary:

- Providers shall begin using patient status code 43 for discharges/transfers to federal hospitals for discharges on or after October 1, 2003.
- Providers shall discontinue using patient status code 71 when discharging/transferring/referring patients to another institution for outpatient services when specified by the discharge plan of care.
- Providers shall discontinue using patient status code 72 when discharging/transferring/referring patients within their institution for outpatient services when specified by the discharge plan of care.
- Providers are not required to use new patient status code 65 until April 1, 2004. CMS will issue a separate instruction on new patient status code 65 closer to implementation.

Source: CMS Transmittal A-03-059, CR 2638

## Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment

*The following article is being published as a request from CMS.*

This article provides guidance for physicians, providers, and suppliers regarding overpayment recovery activities that the Centers for Medicare & Medicaid Services (CMS) will undertake connected to erroneous approvals for payment of fee-for-service (FFS) claims during periods of Managed Care enrollment.

The 1999 Balanced Budget Reconciliation Act (BBRA) requires "current month enrollment," which means that the effective date of enrollment is based upon the date a beneficiary signs an application for enrollment in a Medicare + Choice Organization (M+CO). The effective date of enrollment, as well as the date the M+CO is responsible for providing Medicare services to the beneficiary, is the first day of the month following receipt of the beneficiary's completed, signed application for enrollment in the M+CO.

The CMS electronic data systems may experience time lags, during which time Medicare services and items are paid twice: through the FFS Medicare contractor and the Managed Care Payment systems in the monthly capitation rate for the beneficiary. When the electronic data systems recognize that a beneficiary has enrolled in a M+CO, the M+CO receives capitation payments for the beneficiary, retroactive to the effective date of enrollment. During the period of time between the effective date of enrollment and when the CMS electronic data system updates, physicians, providers, and suppliers may not be aware of the beneficiary's enrollment in the M+CO and bill the Medicare FFS system for services and items provided to that beneficiary.

**Effective October 1, 2003,** CMS contractors will initiative overpayment recovery procedures to retract original Part A and Part B payments and generate adjustments to update or cancel claims connected to erroneous approvals for payment of FFS claims during periods of Managed Care enrollment.

For questions about this article, please contact our customer services representatives at 1-877-602-8816. ❖

Source: CMS Notification Dated June 24, 2003

## Frequency of Billing Revision

Section 3603 of the Medicare Intermediary Manual (MIM), Frequency of Billing, has been amended to include more information specific to the frequency of bill acceptance and will assist providers in billing other insurers more timely. Common working file (CWF) edits regarding outpatient services and inpatient hospital and skilled nursing facility (SNF) stays are being modified. These guidelines are effective for admissions submitted on types of bill 112 and 212 with a date received **on or after October 1, 2003,** and for outpatient claims received **on or after October 1, 2003.**

Providers affected by these changes are:

1. PIP (periodic interim payment) providers can now interim bill using the rules appropriate to their type of facility.
2. PPS hospitals will submit interim bills in intervals that are at least 60 days long; subsequent claims will be submitted as adjustments.
3. TEFRA hospitals (psychiatric hospitals or units, cancer and children's hospitals), skilled nursing facilities and Maryland waiver hospitals will submit interim bills once every month unless one of the following occurs:
   - The beneficiary's benefits are exhausted
   - The beneficiary's need for care changes
4. All providers will submit a bill/adjustment when the beneficiary is discharged.

### Inpatient Billing

Inpatient services in TEFRA hospitals will be billed:

- Upon discharge of the beneficiary,
- When the beneficiary's benefits are exhausted,
- When the beneficiary's need for care changes, or
- On a monthly basis

Providers will submit a bill to Medicare when a beneficiary in a SNF ceases to need active care (occurrence code 22), or a beneficiary in one of these hospitals ceases to need hospital level care (occurrence code 31). Do not separate the occurrence code 31 and occurrence span code 76 on two different bills.

Each bill must include all applicable diagnoses and procedures. However, interim bills are not to include charges billed on an earlier claim since the "From" date on the bill must be the day after the "Thru" date on the earlier bill. No-payment bills should be submitted until the beneficiary is discharged.

Inpatient acute-care PPS hospitals, inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs) may interim bill in at least 60-day intervals. Subsequent bills must be in the adjustment bill format. Each bill must include all applicable diagnoses and procedures.

LTCHs will also submit a bill when the beneficiary's benefits exhaust. This permits these providers to bill a secondary insurer when Medicare ceases to make payment.

Initial inpatient acute care prospective payment system (PPS) hospital, inpatient rehabilitation facility, and long term care hospital interim claims must have a patient status code of 30 (still patient). When processing interim PPS hospital bills, providers use the bill designation of 112 (interim bill – first claim). Upon receipt of a subsequent bill, the first bill will be cancelled and replaced with one of the following bill designations:

- A 117 bill for hospitals with a patient status of 30 (still patient), or
- A 117 discharge bill for hospitals with a patient status of one of the following:

  01 Discharged to home or self care

  02 Discharged/transferred to another short-term general hospital

  03 Discharged/transferred to SNF

  04 Discharged/transferred to an ICF

  05 Discharged/transferred to another type of institution (including distinct part), or referred for outpatient services to another institution

  06 Discharged/transferred to home under care of an organized home health service organization

  07 Left against medical advice

  08 Discharged/transferred to home under care of a home IV drug therapy provider

  20 Expired (or did not recover – religious non-medical health care institution patient)

  43 Discharged/transferred to a federal hospital

  50 Hospice – home

  51 Hospice – medical facility

  61 Discharged/transferred within institution to swing bed

  62 Discharged to another IRF or IRF unit (January 1, 2002)

  63 Discharge to a long-term care hospital (January 1, 2002)

  64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare

For interim hospital PPS bills, a debit only will be send to CWF to adjust the prior bill with a bill type designation of 117 and an action code of 3, with the following:

- A 117 bill for hospitals with a patient status of 30 (still patient), and an action code of 1, or
- A 117 discharge bill for hospitals with an action code of 1 and a patient status of one of the following:

  01 Discharged to home or self care

  02 Discharged/transferred to another short-term general hospital

  03 Discharged/transferred to SNF

  04 Discharged/transferred to an ICF

*Frequency of Billing Revision (continued)*

05 Discharged/transferred to another type of institution (including distinct parts), or referred for outpatient services to another institution

06 Discharged/transferred to home under care of an organized home health service organization

07 Left against medical advice

08 Discharged/transferred to home under care of a home IV drug therapy provider

20 Expired (or did not recover – religious non-medical health care institution patient)

43 Discharged/transferred to a federal hospital

50 Hospice – home

51 Hospice – medical facility

61 Discharged/transferred within institution to swing bed

62 Discharged to another IRF or IRF unit (January 1, 2002)

63 Discharge to a long-term care hospital (January 1, 2002)

64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare

All inpatient providers will submit bills when any of the following occur, regardless of the date of the prior bill (if any):

- Benefits are exhausted
- The beneficiary ceases to need a hospital level of care (all hospitals)
- The beneficiary falls below a skilled level of care (SNFs and hospital swing beds)
- The beneficiary is discharged

These instructions for hospitals and SNFs apply to all providers, including those receiving periodic interim payments (PIP). Continue submitting no pay bills until discharge.

### Outpatient Billing

Repetitive Part B services to a single individual must be billed monthly (or at the conclusion of treatment). These instructions also apply to home health agency (HHA) and hospice services billed under Part A. By doing so, bill processing costs are reduced for relatively small claims and in instances where bills are held for monthly review.

Examples of repetitive Part B services and HHA and hospice services billed under Part A with applicable revenue codes include:

| Type of Service | Revenue Codes |
|---|---|
| DME rental | 290-299 |
| Therapeutic radiology | 330-339 |
| Therapeutic nuclear medicine | 342 |
| Respiratory therapy | 410-419 |
| Physical therapy | 420-429 |
| Occupational therapy | 430-439 |
| Speech pathology | 440-449 |
| Home health visits | 550-599 |
| Kidney dialysis treatments | 820-859 |
| Cardiac rehabilitation services | 482, 943 |
| Psychological Services | 910-919 (in a psychiatric facility) |

Where there is an inpatient stay, or outpatient surgery, or outpatient hospital services subject to outpatient PPS, during a period of repetitive outpatient services, providers may submit one bill for the entire month if they use an occurrence span code 74 to encompass the inpatient stay, day of outpatient surgery, or outpatient hospital services subject to outpatient PPS. Providers should bill other one-time Part B services upon completion of the service.

Bills for outpatient hospital services subject to outpatient PPS must contain, on a single bill, all services provided on the same day except claims containing condition codes 20, 21, or G0 (zero) or kidney dialysis services, which are billed on a 72x bill type. If an individual outpatient PPS service is provided on the same day as an outpatient PPS repetitive service, the individual outpatient PPS service must be billed on the outpatient PPS monthly repetitive claim. Indian Health Service hospitals, Maryland hospitals, as well as hospitals located in Saipan, Guam, American Samoa, and the Virgin Islands are not subject to outpatient PPS. In addition, hospitals that furnish only inpatient Part B services are also exempt from outpatient PPS. Bills for ambulatory surgery in these hospitals must contain on a single bill all services provided on the same day as the surgery except kidney dialysis services, which are billed on a 72x bill type. (Non-outpatient PPS hospitals services furnished on a day other than the day of surgery must not be included on the outpatient surgical bill.) ❖

Source: CMS Transmittal 1892, CR 2838

## Clarification on Mammography Computer Aided Detection Equipment

The Centers for Medicare & Medicaid Services has clarified that mammography-related computer-aided detention (CAD) equipment does not require Food and Drug Administration (FDA) certification. Certification from the FDA is needed only for screening and diagnostic mammograms (film and digital). The CAD add-on codes involved in this process are 76085 and G0236.

The CAD process can provide either digitization of film radiographic images with computer analysis **or** computer analysis of direct digital mammography. ❖

Source: CMS Transmittal AB-03-072, CR 2743

## New Condition and Value Codes Effective October 16, 2003

The National Uniform Billing Committee (NUBC) has approved new condition codes for form locator (FL) 24 and new value codes for FL 39. The effective date for these codes is **October 16, 2003,** which coincides with the implementation of the HIPAA 837 institutional guide. The Medicare Intermediary Manual, section 3604 – Review of Form UB 92 CMS-1450 for Inpatient and Outpatient Bills has been updated. In addition, crosswalks have been provided under the revenue codes section for the new list of patient status codes, which are also effective **October 16, 2003.**

All of the updates may not apply to Medicare but because of the HIPAA legislation, the Centers for Medicare & Medicare Services must accept all valid codes in order to pass the codes on to another payer, for possible coordination of benefits.

### New Condition Codes – FL 24

**Effective October 16, 2003:**

| Code | Title | Description |
|---|---|---|
| AK | Air Ambulance Required | For ambulance claims. Air ambulance required – time needed to transport poses a threat. |
| AL | Specialized Treatment/Bed Unavailable | For ambulance claims. Specialized treatment/bed unavailable. Transported to alternate facility. |
| AM | Nonemergency Necessary Medically Stretcher Transport Required | For ambulance claims. Non-emergency medically necessary stretcher transport required. |
| B3 | Pregnancy Indicator | Indicates patient is pregnant. Required when mandated by law. The determination of pregnancy should be completed in compliance with applicable law. |

### New Value Codes – FL 39

**Effective October 16, 2003:**

| Code | Title | Description |
|---|---|---|
| AA | Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer A | The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. |
| AB | Other Assessments or Allowances (e.g., Medical Education) Payer A | The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. |
| BA | Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer B | The amount of regulatory surcharges, assessments, or allowances or health care related taxes pertaining to the indicated payer. |
| BB | Other Assessments or Allowances (e.g., Medical Education) Payer B | The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. |
| CA | Regulatory Surcharges, Other Assessments or Allowances (e.g., Medical Education) Payer A | The amount of regulatory surcharges, assessments, Assessments, Allowances or allowances or health care related taxes pertaining Health Care Related Taxes to the indicated payer. |
| CB | Other Assessments or Allowances (e.g., Medical Education) Payer C | The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. |
| EA | Regulatory Surcharges, Assessments, Allowances Health Care Related Taxes Payer D | The amount of regulatory surcharges, assessments, or allowances or health care related taxes pertaining to the indicated payer. |
| EB | Other Assessments or Allowances (e.g., Medical Education) Payer D | The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. |
| FA | Regulatory Surcharges, Assessments, Allowances Health Care Related Taxes Payer E | The amount of regulatory surcharges, assessments, or allowances or health care related taxes pertaining to the indicated payer. |
| FB | Other Assessments or Allowances (e.g., Medical Education) Payer E | The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. |
| GA | Regulatory Surcharges, Assessments, Allowances Health Care Related Taxes Payer F | The amount of regulatory surcharges, assessments, or allowances or health care related taxes pertaining to the indicated payer. |
| GB | Other Assessments or Allowances (e.g., Medical Education) Payer F | The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. |

*New Condition and Value Codes Effective October 16, 2003 (continued)*

## Patient Relationship to Insured Codes – FL 59A, B and C

These codes indicate the relationship of the patient to the identified insured. The codes on the first list are effective until October 15, 2003. The codes on the second list are effective **on or after October 16, 2003.** Crosswalks to the corresponding lists of patient relationship codes are provided.

**List I –** Patient relationship codes **effective until October 15, 2003:**

| Code | Title | Description | Map to List II |
|---|---|---|---|
| 01 | Patient Is Insured | Self-explanatory | 18 |
| 02 | Spouse | Self-explanatory | 01 |
| 03 | Natural Child/Insured Financial Responsibility | Self-explanatory | 19 |
| 04 | Natural Child/Insured Does not Have Financial Responsibility | Self-explanatory | 43 |
| 05 | Step Child | Self-explanatory | 17 |
| 06 | Foster Child | Self-explanatory | 10 |
| 07 | Ward of the Court | Patient is ward of the insured as a result of a court order. | 15 |
| 08 | Employee | Patient is employed by the insured. | 20 |
| 09 | Unknown | Patient's relationship to the insured is unknown. | None |
| 10 | Handicapped Dependent | Dependent child whose coverage extends beyond normal termination age limits as result of laws or agreements extending coverage. | 22 |
| 11 | Organ Donor | Code is used in cases where bill is submitted for care given to organ donor where such care is paid by the receiving patient's insurance coverage. | 39 |
| 12 | Cadaver Donor | Code is used where bill is submitted for procedures performed on cadaver donor where such procedures are paid by the receiving patient's insurance coverage. | 40 |
| 13 | Grandchild | Self-explanatory | 05 |
| 14 | Niece/Nephew | Self-explanatory | 07 |
| 15 | Injured Plaintiff | Patient is claiming insurance as a result of injury covered by insured. | 41 |
| 16 | Sponsored Dependent | Individual not normally covered by insurance coverage but coverage has been specially arranged to include relationships such as grandparent or former spouse that would require further investigation by the payer. | 23 |
| 17 | Minor Dependent of a Minor Dependent | Code is used where patient is a minor and a dependent of another minor who in turn is a dependent (although not a child) of the insured. | 24 |
| 18 | Parent | Self-explanatory | None |
| 19 | Grandparent | Self-explanatory | 04 |
| 20 | Life Partner | Patient is covered under insurance policy of his/her life partner (or similar designation, e.g., domestic partner, significant other) | 29*, 53* |

*New Condition and Value Codes Effective October 16, 2003 (continued)*

**List II** – Patient relationship codes **effective on or after October 16, 2003:**

| Code | Title | Map to List I |
|---|---|---|
| 01 | Spouse | 02 |
| 04 | Grandfather or Grandmother | 19 |
| 05 | Grandson or Granddaughter | 13 |
| 07 | Nephew or Niece | 14 |
| 10 | Foster Child | 06 |
| 15 | Ward of the Court<br>**Note:** This code indicates that the patient is a ward of the insured as a result of a court order. | 07 |
| 17 | Stepson or Stepdaughter | 05 |
| 18 | Self | 01 |
| 19 | Child | 03 |
| 20 | Employee | 08 |
| 21 | Unknown | 09 |
| 22 | Handicapped Dependent | 10 |
| 23 | Sponsored Dependent | 16 |
| 24 | Dependent of Minor Dependent | 17 |
| 29 | Significant Other | None* |
| 32 | Mother | None |
| 33 | Father | None |
| 36 | Emancipated Minor | None |
| 39 | Organ Donor | 11 |
| 40 | Cadaver Donor | 12 |
| 41 | Injured Plaintiff | 15 |
| 43 | Child Where Insured Has No Financial Responsibility | 04 |
| 53 | Life Partner | None* |
| G8 | Other Relationship | None |

* No 1:1 map for Significant Other and Life Partner.❖

Source: CMS Transmittal 1881, CR 2655

## National Participating Physician Directory

*The following article is being published per request from the Centers for Medicare & Medicaid Services.*

The National Participating Physician Directory contains valuable information about Medicare participating physicians for the use of beneficiaries, their families, and their caregivers. In order to ensure that the Directory includes the most up-to-date information, practicing physicians should check the accuracy of their listings and use the feedback tool on our web site to notify CMS about any information that is incorrect, has changed, or to advise us if you are not listed in the Directory.

### Information Included in the Directory

The following information is available regarding Medicare participating physicians (those who have agreed to always accept assignment):

- Name and address (including a mapping feature)
- Medical specialty
- Business telephone number
- Medical school and year of graduation
- Board certification in a medical specialty
- Gender
- Hospital affiliation
- Foreign language
- Residency and internship program (coming soon)
- Sanctions against individual physicians (coming soon)
- Whether accepting new Medicare patients (coming soon)

### How to Check Accuracy of Your Information

The accuracy of your listing can be checked by clicking on the "Participating Physician Directory " from the home page of *www.medicare.gov*. Our feedback tool is available to correct any information that is incorrect, has changed, or to advise us if you are not listed in the Directory. The Directory will be updated on a monthly basis. For additional information about the Directory, click on "Physician Note" at the bottom of the page. You may also link to the Directory from the CMS web site at *www.cms.hhs.gov/physicians* (under "Participation").

**Note:** Only participating physicians who have agreed to accept assignment on all Medicare claims and covered services are included in the Directory. Assignment does not apply to Medicare managed care or private fee-for-service plans. ❖

Source: CMS Notification Dated June 9, 2003

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## Termination Date Change for 2003 Discontinued HCPCS Codes

The Centers for Medicare & Medicaid Services (CMS) has notified fiscal intermediaries that claims submitted for payment by institutional providers for services furnished in January and February 2003 cannot be processed for payment if the claim contains a 2002 Health Care Procedural Coding System (HCPCS) code that was discontinued and replaced with a new 2003 HCPCS code. This is a result of the 2003 MPFS update which delayed payment of new HCPCS codes, usually submitted for processing from January until March, and it affects claims that were not submitted by March 31, 2003.

The HCPCS code files have been updated to allow the processing of claims containing discontinued 2002 HCPCS codes for dates of service from January 1, 2003, through February 28, 2003, regardless of their receipt date.

### Action Required by Providers

Provider may resubmit for payment any returned claim that contained 2002 discontinued HCPCS codes. Reimbursement for the 2002 HCPCS codes will be made at the 2002 payment rate.

For a list of discontinued codes for 2003 and their crosswalk replacement codes, see the January 2003 *Medicare A Bulletin* Special Issue (pages 9-10). ❖

Source: CMS Notification Dated July 17, 2003

## Quarterly Update of HCPCS Codes Home Health Consolidated Billing

In April 2001, CMS established the process of periodically updating the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the home health prospective payment system (HH PPS). Services appearing on this list submitted on claims to both Medicare fiscal intermediaries (FIs) and carriers, including durable medical equipment regional carriers (DMERCs), will not be paid on dates when the beneficiary for whom such a service is being billed is in a home health episode. A home health care episode means that the beneficiary is 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.

Updates to the HH consolidated billing code master list are issued quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes). These temporary codes may describe services subject to consolidated billing in addition to the permanent list of HCPCS codes that is updated annually. This is the third quarterly HH consolidated billing update for calendar year 2003. The second update occurred in April 2003; there was no update in July 2003.

Three nonroutine supply codes have been added to the list of codes subject to consolidated billing. Two codes that are no longer valid for Medicare billing have been removed form the master list. These changes are effective for services provided **and or after October 1, 2003.**

The new codes added are:

K0614 chem/antiseptic solution, 8oz
K0620 tubular elastic dressing
K0621 gauze, non-impreg pack strip

The codes removed are:

A4421 Ostomy Supply misc
*97014 Electric stimulation therapy*

The next update to the list of codes subject to consolidated billing will be the calendar year 2004 annual update.

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.

The complete master list of codes subject to HH consolidated billing is available at *cms.hhs.gov/medlearn/refhha.asp*. ❖

Source: CMS Transmittal AB-03-096

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## Appeal Requests Submitted with Appropriate Supporting Documentation

The Centers for Medicare & Medicaid Services (CMS) has provided guidance to Medicare contractors relative to processing appeals, reconsiderations, reviews, hearing officer and administrative law judge hearings, and agency referrals.

In an effort to manage workload requests with the given resources, incoming appeal requests submitted **without** necessary supporting documentation will be given secondary priority to appeal requests submitted **with** appropriate documentation. Consequently, determinations or decisions on appeal requests that are submitted without appropriate documentation to support the contention that the initial determination was incorrect could possibly be delayed. ❖

Source: CMS Transmittal AB-03-052, CR 2330

## CMS Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all nonregulatory changes to Medicare including Program Memoranda, manual changes and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program.
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions.
- Ensure that providers have time to react and prepare for new requirements.
- Announce new or changing Medicare requirements on a predictable schedule.
- Communicate the specific days that CMS business will be published in the *Federal Register.*

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update listserv (electronic mailing list at *http:list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1*.

The Quarterly Provider Update can be accessed at *http://www.cms.gov/providerupdate*.

We encourage you to bookmark this Web site and visit it often for this valuable information.

Source: CMS Transmittal AB-03-075, CR 2686

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# OUTPATIENT REHABILITATION SERVICES

## Delay in Implementation of the Financial Limitation for Outpatient Rehabilitation Services

**The financial limitation for outpatient rehabilitation services scheduled for implementation on July 1, 2003 has been delayed**. Effective for services furnished **on or after September 1, 2003,** Medicare coverage for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) will be limited. For the period September 1, 2003, through December 31, 2003, the limits are $1,590 for PT and SLP combined, and $1,590 for OT alone. These limits do not apply to therapy provided in a hospital outpatient department, unless the beneficiary is a resident of and occupies a Medicare-certified bed in a skilled nursing facility. Only the date of implementation has been change in this initiative. ❖

Source: CMS Transmittal AB-03-097, CR 2837

## Financial Limitation of Claims for Outpatient Rehabilitation Services

*This article, published at a request from the Centers for Medicare & Medicaid Services (CMS), addresses the implementation of the financial limitation for outpatient rehabilitation services including physical therapy (PT), speech language pathology (SLP), and occupational therapy (OT) claims submitted with dates of service* ***on and after September 1, 2003.*** *This article contains additional important information related to "Beneficiary Notification" not published in previous notifications.* ***The implementation date has been corrected from July 1, 2003, to September 1, 2003, based on CMS decision to delay the implementation of the physical therapy limitation.***

Financial limits on outpatient physical therapy services provided in private practice settings began in 1972, and included occupation therapy services provided in private practice settings in 1987. The Balanced Budget Act of 1997 expanded the caps to include all PT, SLP, and OT services in every outpatient setting except outpatient hospital. These caps were effective in 1999, but were not fully implemented due to Y2K issues. The Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act of 2000 suspended the caps for the years 2000, 2001, and 2002. The moratorium expired on December 31, 2002.

### Description

The caps apply to outpatient rehabilitation (PT, SLP, and OT) services provided by any provider/supplier except outpatient therapy services provided by:

1) a hospital to an outpatient or to an inpatient who has exhausted Part A benefits
2) another entity under an arrangement with a hospital to provide the same services to the same beneficiaries.

**Note:** Only services billed by the hospital as type of bill (TOB) 12x or 13x are exempt from limitations on therapy services.

*Financial Limitation of Claims for Outpatient Rehabilitation Services (continued)*

For skilled nursing facilities (SNFs), this limitation does apply to rehabilitation services furnished to those SNF residents in noncovered stays (TOB 22x) who are in a Medicare-certified section of the facility – i.e., one that is either certified by Medicare alone or is dually certified (by Medicare as a SNF and by Medicaid as a nursing facility (NF)). For SNF residents, consolidated billing requires all outpatient rehabilitation services be billed to Part B by the SNF. If a resident has reached the financial limitation and remains in the Medicare-certified section of the SNF, no further payment will be made to the SNF or any other entity. Therefore, SNF residents who are subject to consolidated billing may not obtain services from an outpatient hospital after the cap has been exceeded.

Once the financial limitation has been reached, SNF residents who are in a non-Medicare certified section of the facility – i.e., one that is certified only by Medicaid as a NF or that is not certified at all by either program – use TOB 23x (see CR 2674). For SNF residents in non-Medicare certified portions of the facility and SNF non-residents who go to the SNF for outpatient treatment (TOB 23x) medically necessary outpatient therapy may be covered at an outpatient hospital facility after the financial limitation has been exceeded.

Limitations do not apply to SNF residents in a covered Part A stay, including swing beds. Rehabilitation services are included within the global Part A per diem payment that the SNF receives under the PPS for the covered stay. Similarly, limitations do not apply to any therapy services billed under PPS home health or inpatient hospitals, including critical access hospitals.

The limits apply to outpatient rehabilitation therapy services provided by:

- Physicians
- Nurse practitioners
- Clinical nurse specialists
- Physician's assistants
- Physical therapists
- Occupational therapists
- Speech-language pathologists.

Settings affected by the caps consist of all settings paid using the Medicare physician fee schedule except the outpatient hospital setting including:

- Comprehensive outpatient rehabilitation facilities
- Outpatient physical therapy providers, e.g., outpatient rehabilitation facilities/rehabilitation agencies
- Part B services in skilled nursing facilities (see above details for SNF settings)
- Home health agencies providing therapies to patients who are not homebound
- Physician offices
- Non-physician practitioner offices
- Physical and occupational therapist private practices.

The 2003 limits per beneficiary per year are:

- $1590 for PT and SLP combined; and
- $1590 for OT.

In 2003, the caps will be implemented beginning with claims submitted for dates of service on and after September 1, 2003. Due to systems limitations, the caps could not be implemented between January 1, 2003 and June 30, 2003. The full $1590 limit is available for beneficiary use between September 1, 2003 and December 31, 2003. In 2004 and subsequent years, the caps will apply to the entire year.

## Billing Instructions

Therapy services, no matter who performs them, must meet the standards and conditions that apply to therapy services. For example, there must be an appropriate plan of care and documentation that supports medical necessity whenever therapy services are billed to Medicare.

Deductibles and co-insurance are subtracted from the allowed amount. For example, if the deductible for the year has been met and services are received that total $1590 (the limit of the allowed amount), Medicare pays 80 percent of the allowed amount ($1272) and the beneficiary pays $318 in co-insurance.

Providers/suppliers must continue to add a modifier (GP, GN, GO) to claims, which identify the type of service (PT, SLP, OT) that represents the therapy plan of care. A therapy plan of care is required whenever therapy services, represented by therapy codes noted below, are billed to Medicare.

Therapy service claims without modifiers on applicable *CPT*/HCPCS or revenue codes will be returned.

**Note:** For the first time, these limits will be tracked for all provider/supplier types, including physicians' and non-physician practitioners' (NPP) claims. Claim payment depends on the use of the modifier. Therefore everyone, including physicians and NPPs who provide these services, should make certain that the appropriate modifier (GN, GO or GP) is included on each code for therapy services. Modifiers should reflect the plan of care under which the service is provided, rather than the specialty of the person who provides the service.

Certain *CPT*/HCPCS codes may be used under more than one type of plan of care (PT, OT, SLP), in which case the physician or NPP should chose the appropriate modifier for their plan. Failure to include one of these code modifiers for these services will result in the claim/service being returned as unprocessable.

## Applicable Outpatient Rehabilitation *CPT*/ HCPCS Codes

The following codes apply to each financial limitation except as noted below. These codes supersede the codes listed in section 3653 of the Medicare Intermediary Manual, Part 3: (**Note:** listing of the following codes does not imply that services are covered.)

| | | | |
|---|---|---|---|
| *29065** | *29075** | *29085** | *29086** |
| *29105** | *29125** | *29126** | *29130** |
| *29131** | *29200* | *29220* | *29240* |
| *29260* | *29280* | *29345** | *29355** |
| *29365** | *29405** | *29425** | *29445** |
| *29505** | *29515** | *29520* | *29530* |
| *29540* | *29550* | *29580** | *29590* |
| *64550* | *90901* | *90911* | *92506* |
| *92507* | *92508* | *92526* | *92597* |
| *92601*** | *92602*** | *92603*** | *92604*** |

***Financial Limitation of Claims for Outpatient Rehabilitation Services (continued)***

| | | | |
|---|---|---|---|
| *92607* | *92608* | *92609* | *92610* |
| *92611* | *92612* | *92614* | *92616* |
| *95831* | *95832* | *95833* | *95834* |
| *95851* | *95852* | *96000* | *96001* |
| *96002* | *96003* | *96105* | *96110* |
| *96111* | *96115* | *97001* | *97002* |
| *97003* | *97004* | *97012* | *97016* |
| *97018* | *97020* | *97022* | *97024* |
| *97026* | *97028* | *97032* | *97033* |
| *97034* | *97035* | *97036* | *97039* |
| *97110* | *97112* | *97113* | *97116* |
| *97124* | *97139* | *97140* | *97150* |
| *97504* | *97520* | *97530* | *97532* |
| *97533* | *97535* | *97537* | *97542* |
| *97601** | *97703* | *97750* | *97799* |
| V5362 | V5363 | V5364 | G0279 |
| G0280 | G0281 | G0283 | *0020T* |
| *0029T* | | | |

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

* These codes for casts and splints will not apply to the financial limitations when billed by physicians and nonphysician practitioners, as appropriate. When these codes are billed by Part A providers (TOB 22x, 23x, 34x, 74x, and 75x), or other Part B providers/suppliers, physical therapists or occupational therapists in private practice, specialty codes "65" and "67," they must be billed with a GO or GP modifier. Specialty codes 73 and 74 were not included because they are no longer applicable.

** If an audiology procedure code is performed by an audiologist, the modifiers GN, GO and GP should not be reported, as these procedures are not subject to the financial limitation. When these 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.

## Beneficiary Notification

Providers/suppliers will be denied payment for services that exceed the limitations. Therefore, it is recommended that they make every effort to learn if prior therapy was performed before a patient is accepted for treatment. Since CMS can only report claims that have been submitted, providers/suppliers should track expenditures in their own facility or office and inform beneficiaries when they may become liable for payment. Providers and suppliers are encouraged to inform beneficiaries that they will be responsible for 100 percent of therapy costs after the limit has been met unless additional services are furnished directly or under arrangement by a hospital. It is recommended that they notify beneficiaries about this responsibility at the first therapy encounter, thereby allowing beneficiaries to make informed decisions regarding their continued care and financial responsibility.

CMS developed the Notice of Exclusion from Medicare Benefits (NEMB) (Form No. CMS-20007 and Formulario No. CMS-20007) to assist in informing beneficiaries that the services they are receiving are excluded from Medicare benefits. Use of the NEMB form is optional.

Providers/suppliers may develop their own process to communicate to beneficiaries that they will be billed for services over the cap. (Do not use the Advance Beneficiary Notice form.) **The NEMB form can be found at:** *http://www.cms.hhs.gov/medlearn/refabn.asp*. (Page down twice for both English and Spanish versions.)

On the NEMB, check Box #1 and write a reason for the limitations as follows: "Medicare will not pay for physical therapy and speech-language pathology over $1590 (including dates of service from September 1, 2003 through December 31, 2003)." Substitute "occupational therapy services" in place of PT and SLP for patients under an OT plan of care.

Beginning on September 1, 2003, CMS will include a generic message on each Medicare summary notice (MSN) containing therapy services which states that Medicare provides up to $1590 a year for PT and SLP services combined and up to $1590 for OT services and that additional medically necessary services over these limits are covered only in a hospital outpatient department. CMS will track the total dollar amount of allowed costs for therapy services reported for payment. Beneficiaries will receive a message on the MSN indicating when the caps have been exceeded and payment is denied.

Beginning October 1, 2003, CMS plans to include an MSN message that informs beneficiaries of the amount of allowed cost that has accrued during this calendar year toward the cap. Providers (facilities) with access to HIQA may obtain the accrued amounts for beneficiaries from this database.

When HIPAA goes into effect, (planned for October 2003) the accrued therapy amounts will be available on the ELGA and ELGB screens. Beneficiaries and providers without access to this information may contact the call center at their intermediary or carrier to obtain these amounts.

## Appeals

Beneficiaries may appeal claims denied due to exceeding therapy caps. The beneficiary is to be advised of his or her appeal rights set forth in 42 CFR Part 405, subpart G. Physicians, therapists, and other suppliers who accept assignment may also appeal denials. Physicians, therapists and other suppliers who do not accept assignment, and institutional providers do not have the right to appeal.

For additional information about the financial limitation for outpatient rehabilitation services, refer to CR 2709 which can be accessed at *http://www.cms.hhs.gov/manuals/memos/comm_date_dsc.asp*.

A PowerPoint presentation that CMS developed to assist providers in understanding these financial limits is available at *http://www.cms.hhs.gov/medlearn/therapy*. ❖

Source: CMS Transmittal AB-03-073, CR 2603

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# AMBULANCE SERVICES

## Third Clarification Regarding Ambulance Fee Schedule Implementation

*This is a reminder of current Medicare policy regarding the ambulance fee schedule, which was implemented on April 1, 2002. It is **not** intended to replace previously issued instructions and does **not** encompass all issues that have been addressed to date.*

During the implementation of the ambulance fee schedule, issues concerning the interpretation of Medicare policy have arisen which require clarification. This is the third set of instructions to provide additional guidance on issues related to the implementation of the ambulance fee schedule, and supplements previously issued instructions regarding this implementation.

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

### Ambulance Fee Schedule Appeals

A fee schedule for the payment of ambulance services under the Medicare program was implemented for claims with dates of service on or after April 1, 2002. The final rule established a five-year transition period, during which time payment will be based on a blended amount, based in part on the ambulance fee schedule and in part on reasonable cost or reasonable charge, as applicable. In accordance with section 1834(l)(5) of the Social Security Act and 42 CFR section 414.625, ambulance providers/ suppliers may not appeal the fee schedule amounts.

### Inherent Reasonable (IR) Adjustments

The final rule implementing inherent reasonable (IR) adjustments to Medicare payment allowances was published in the **Federal Register** on December 13, 2002 (67 FR 76684). The criteria for applying IR, specified in the final rule, includes a threshold of 15 percent that must be met before IR adjustments may be made. That is, if a payment allowance is determined to be either deficient or excessive by an amount that is less than 15 percent, then no IR adjustment may be made. Prospective payment systems, including the Ambulance Fee Schedule, are exempt from IR. Therefore, IR applies only to the reasonable charge portion of the blended payment for ambulance services during the transition period.

The CMS has not yet developed contractor processes for applying IR. Until these processes are in place, contractors may not make any IR adjustments. Therefore, carriers that receive requests for IR adjustments to the reasonable charge portion of the blended payment for ambulance services may not make any such adjustments until CMS issues further guidance on how to implement IR. Carriers that receive requests for IR adjustments to the Ambulance Fee Schedule portion of the blended payment must deny any such requests.

### Supplier Requests to Change Billing Methods During the Transition Period

Ambulance suppliers were instructed to elect a single billing method by March 31, 2002. In the absence of any election, carriers were required to convert suppliers using multiple billing methods to billing Method 2. During the transition period, April 1, 2002 through December 31, 2005, a supplier may not change its billing method. Carriers will deny any such requests from a supplier. Effective with the full implementation of the ambulance fee schedule beginning January 1, 2006, all ambulance suppliers will be converted to billing method 2.

### Advance Beneficiary Notice Requirements

**ABN Requirements for Non-Emergency Transports**

The ABN (form CMS-R-131) is a written notice a physician or provider/supplier gives to a Medicare beneficiary before items or services are furnished when the physician or provider/supplier believes that Medicare probably or certainly will not pay for some or all of the items or services on the basis of certain Medicare statutory exclusions.

An ABN is rarely used for ambulance services, and may only be issued for non-emergency transports. An ABN may not be used when a beneficiary is under great duress. A beneficiary is considered to be under great duress when his or her medical condition requires emergency care. Intermediaries and carriers will use the following guidelines to determine when it is appropriate for an ambulance provider/ supplier to issue an ABN for ambulance services.

An ABN may be needed and may be used for *non-emergency* transports in the following situations:

a. A transport by air ambulance when the transporting entity has a reasonable basis to believe that the transport can be done safely and effectively by ground ambulance transportation.

b. A level of care downgrade, e.g., from ALS-2 to ALS-1, or from ALS to Basic Life Support (BLS), when the transport at the lower level of care is a covered transport.

An ABN is not needed, and should not be used, in the following situations:

a. Any denial where the patient could be transported safely by other means (these are denials under section 1861(s)(7) of the Act).

b. Any denial that is based on not meeting an origin or destination requirement (these denials are based on 42 CFR 410.40 and generally also constitute section 1861(s)(7) denials).

c. A denial for mileage that is beyond the nearest appropriate facility (for the same reason as "b" above).

d. A denial where the PCS or accepted alternative (e.g., certified mail) is not obtained (for the same reason as "b" above).

*Third Clarification Regarding Ambulance Fee Schedule Implementation (continued)*

e. A convenience discharge, e.g., where the patient is an inpatient at one hospital that can care for their needs, but wants to be transferred to a second hospital to be closer to family (for the same reason as "b" above).

The Notice of Exclusions from Medicare Benefits (NEMB, form CMS-20007) is an optional form that CMS developed to assist suppliers and providers in informing beneficiaries that the services they are receiving are excluded from Medicare benefits. When an ABN is not appropriate to use because medical necessity is not the basis for the expected denial, an NEMB may be used. Ambulance providers/suppliers may develop their own process to communicate to beneficiaries that they will be billed for excluded services, for which the ABN is not appropriate.

The NEMB form CMS-20007 is available in English and Spanish online and can be accessed at the CMS Beneficiary Notices Initiative Web page at *http://www.cms.hhs.gov/medicare/bni/*.

In the case of the denials listed above for which an ABN is not appropriate, on the NEMB, check Box #1 and write the relevant reason in the "Medicare will not pay for" space (above check Box #1), for example: "ambulance transports that do not meet an origin or destination requirement" or "ambulance transports where the patient could be transported safely by other means" or "personal convenience transports."

The following table summarizes situations when an ABN is applicable regarding ambulance services:

| Situation | Statutory Provision | ABN Applicable | Limitation On Liability Applicable | Payment Responsibility |
|---|---|---|---|---|
| Other means of transportation not contraindicated | 1861(s)(7) – Benefit Category | **No** An NEMB may be used | **No** | Beneficiary |
| Air to ground down coding | 1862(a)(1)(A) – Reasonable and Necessary | **Yes **** | **Yes** | Supplier/provider or beneficiary if ABN is signed |
| ALS to BLS down coding | 1862(a)(1)(A) – Reasonable & Necessary | **Yes **** | **Yes** | Supplier/provider or beneficiary if ABN is signed |
| Mileage partial denial | 1861(s)(7) – Benefit Category | **No** An NEMB may be used | **No** | Beneficiary |

** Indicates that an ABN is applicable. However, if it is an emergency transport, ABNs cannot be used, since beneficiaries are considered under great duress in such situations.

**ABN Requirements for International Flights**

Absent the rare circumstance of coverage of an ambulance service under section 1814(f) of the Act, services outside the United States furnished to a Medicare beneficiary are statutorily excluded from Medicare coverage under section 1862(a)(4) of the Act. Thus, when the point of pickup is outside the United States, including a point of pickup outside of the U.S. territories, then the transport from the point of pickup to the nearest U.S. point of entry is statutorily excluded. The use of an ABN is not indicated but the beneficiary should be informed that Medicare will not pay for the international portion of the flight. An NEMB may be used, in which case, on the NEMB, check Box #2 and the sixth box in the left column ("Health care received outside of the USA") and write the relevant reason in the "Medicare will not pay for" space (above check Box #1), for example: "ambulance transports outside of the USA." If the beneficiary (or his/her representative) desires a formal Medicare determination on a claim for a transport originating outside the U.S., then the transporting entity must file a claim to Medicare.

Following the international portion of a flight, if the beneficiary is then transported from the nearest point of entry by ambulance, including the same aircraft used to transport the beneficiary on the international flight, then standard Medicare rules apply. If the beneficiary is transported from the nearest point of entry to the nearest appropriate facility, then, assuming all other Medicare rules are met, the transport would be covered and payable. If the transporting entity has a reasonable basis to believe that the domestic portion of a non-emergency flight would not be covered because it is not reasonable and necessary under Medicare rules, then use of an ABN is indicated for non-emergency ambulance transports.

## Physician Certification Statement Requirements

**PCS Requirements for Emergency Transports**

The regulations governing PCS requirements are specified at 42 CFR section 410.40(d). As stated in previously issued instructions, a PCS is not required if the transport is an emergency transport. This instruction applies to providers submitting ambulance claims to intermediaries as well as suppliers submitting ambulance claims to carriers. Under Medicare regulations, an emergency response is defined as a BLS or ALS-1 level of service provided in immediate response to a 911 call or the equivalent. The patient's diagnosis, and whether the transport is documented as an "emergency" due to the patient's condition, is not relevant to this determination. See item h. for more information concerning the Medicare definition of "emergency."

*Third Clarification Regarding Ambulance Fee Schedule Implementation (continued)*

**PCS Requirements for Repetitive Ambulance Services**

The regulations governing PCS requirements for repetitive, scheduled, non-emergency ambulance services are specified at 42 CFR section 410.40(d)(2). A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished three or more times during a ten-day period or at least once per week for at least three weeks. Dialysis and respiratory therapy are types of treatments for which repetitive ambulance services are often necessary. However, the requirement for submitting the PCS form for repetitive, scheduled, non-emergency ambulance services is based on the quantitative standard (three or more times during a ten-day period or at least once per week for at least three weeks). Similarly, regularly scheduled ambulance services for follow-up visits, whether routine or unexpected, are not "repetitive" for purposes of this requirement unless one of the quantitative standards is met. PCS requirements for other types of ambulance transports are specified in PM AB-03-007.

**Computer Generated PCS Forms and Electronic Signatures**

Providers/suppliers may use computer-generated PCS forms and computerized physician signatures to meet the PCS requirements of 42 CFR section 410.40(d).

**Proof of Mailing When a PCS Cannot Be Obtained**

When a PCS cannot be obtained in accordance with section §410.40(d)(3)(iv), a provider/supplier may send a letter via U.S. Postal Service (USPS) certified mail with a return receipt proof of mailing or other similar commercial service demonstrating delivery of the letter as evidence of the attempt to obtain the PCS. Providers/suppliers may also use the U.S. Postal Service Certificate of Mailing, Form 3817 as an acceptable alternative to certified mail.

## Billing for Air Mileage

Claims for air transports may account for all mileage from the point of pickup, including where applicable: ramp to taxiway, taxiway to runway, takeoff run, air miles, roll out upon landing, and taxiing after landing.

## Unsuccessful ALS Interventions

An ALS intervention is a procedure that is, in accordance with state and local laws, beyond the scope of practice of an emergency medical technician-basic (EMT-Basic). An unsuccessful attempt to perform an ALS intervention (e.g., endotracheal intubation was attempted, but was unsuccessful) may qualify the transport for billing at the appropriate ALS level provided that the intervention would have been reasonable and necessary had it been successful.

## Establishing an ALS Transport Based on an ALS Assessment

When a BLS ambulance is dispatched and an ALS assessment is performed, the transport may be billed as ALS only for emergency transports. Medicare pays the BLS-level rate for non-emergency transports regardless of whether an ALS assessment is performed.

For Medicare program purposes, an emergency level of ambulance services depends upon how the ambulance was dispatched and how it responded. Emergency status does not depend upon whether an assessment was furnished after the ambulance arrived. Medicare defines "emergency response" as a BLS or ALS-1 level of service that has been provided in immediate response to a 911 call or the equivalent". An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call. An emergency is determined based on the information available to the dispatcher at the time of the call, based on standard dispatch protocols. Medicare also specifies that an ALS assessment is relevant only with respect to payment for an ALS emergency transport. That is, the ALS assessment may be relevant to determine whether an emergency transport is payable at the BLS or ALS level. However, an ALS assessment has no bearing on whether the transport qualifies for emergency-level payment. Furthermore, identifying a service as an emergency response has no bearing on its status under SSA 1861(s)(7), i.e., whether transportation by other means is feasible.

## Mandated ALS Response

During the transition period, Medicare allows the ALS-level payment for emergency and non-emergency transports when an ALS vehicle is used but no ALS service is furnished in areas where an ALS-only response is mandated. As stated in previously issued instructions, two temporary Healthcare Common Procedure Coding System (HCPCS) codes have been established to allow billing for these services during the transition period. HCPCS code Q3019 applies when an ALS vehicle is used for an emergency transport, but no ALS-level service is furnished. HCPCS code Q3020 applies when an ALS vehicle is used for a non-emergency transport, but no ALS level service is furnished. The fee schedule portion of the blended payment is based on the emergency or non-emergency BLS level, as applicable, and the reasonable charge portion of the blended payment is the ALS emergency/non-emergency rate.

The use of an ALS vehicle to furnish only BLS-level services would most often occur in local jurisdictions that mandate all ambulances to be ALS. However, a contract with a government agency to furnish general ambulance services in one or more specific political jurisdictions may also qualify as a "mandated ALS response" if the terms of the contract require an ALS-only response for all requests for service. For example, in a locality where there is no ordinance requiring an "ALS only" EMS response, but there is a contract with a supplier for 911 services that requires an ALS response to all requests for services, the contractual requirement to provide such services may qualify as a "mandated ALS response". The intermediary or carrier must determine whether, in the totality of the circumstances, any particular contractual requirement is tantamount to a "mandated ALS response". However, a contractual requirement for ALS-only service in a contract either with a private entity, or with a government agency for less than general, jurisdiction-wide ambulance services, would not qualify as a "mandated ALS response". Note that the ALS vehicle must meet the crew requirements specified in 42 CFR section 410.41.

*Third Clarification Regarding Ambulance Fee Schedule Implementation (continued)*

The policy of paying according to the medically necessary services actually furnished continues under the ambulance fee schedule. That is, payment is based on the level of service provided, not on the vehicle used. Even if a local government requires an ALS response for all calls, Medicare pays only for the level of service provided, and then only when the service is medically necessary. The use of Q3019 and Q3020 described in this instruction, and in previous notifications, is effective only during the transition period.

### Intra-facility Transports

An intra-facility transport, i.e., a transport within the certified campus of a facility, is not within the scope of the Medicare ambulance benefit because it fails to meet Medicare origin and destination requirements. (See CFR section 413.65(a)(2) for a definition of "certified campus.") Medicare payment to a facility for the cost of facility-based treatment includes an allowance for intra-facility movement of the beneficiary. No separate Medicare payment may be made for such a transport. Moreover, it is improper for a provider to bill Medicare for an intra-facility transport to receive a Medicare denial since the Medicare facility payment constitutes payment in full for all medically necessary, Medicare-covered services furnished to the beneficiary while undergoing treatment at the facility. As such, billing the beneficiary or another insurer for such included services would be similarly improper.

### Physician Services Provided During an Ambulance Transport

Under the ambulance fee schedule, payment for all ambulance-related items and services (including ambulance services that happen to be furnished by a physician) is included in the base payment for the ambulance transport. Therefore, under the ambulance fee schedule, there is no separate payment for these services. However, if, during an ambulance transport, a physician furnishes a service(s) that is covered as a physician's service, and not covered under the Medicare ambulance benefit, then the physician may bill and be paid separately from the ambulance fee schedule payment for such a service.

### Billing the Beneficiary for Non-covered Services

When a provider/supplier issues an ABN because the service is not reasonable and necessary, it may only collect upfront the coinsurance amount and deductible from the beneficiary. If a transport is clearly statutorily excluded for another reason (e.g., it originates outside the United States), or if there is no benefit category for the service, the provider/supplier may charge the individual its full fee and collect the fee at a time of its choosing. In this situation, the provider/supplier may wish to advise the beneficiary, in advance of furnishing the service, that such transportation is not covered under Medicare. (An NEMB may be used, since an ABN is not appropriate.)

Source: CMS Transmittal AB-03-106, CR 2770

## Clarification on Providing Advance Beneficiary Notices

CMS has provided clarification to the fiscal intermediary regarding when an ambulance supplier must provide Medicare beneficiaries with an advance beneficiary notice (ABN) (Form CMS-R-131).

An ABN is not needed, and should not be used, in the following situations:

- Any denial where the patient could be transported safely by other means (these are denials under section 1861(s)(7) of the Social Security Act (the Act).
- Any denial that is based on not meeting an origin or destination requirement. *
- A denial for mileage that is beyond the nearest appropriate facility. *
- A denial where the Physician Certification Statement or accepted alternative (e.g., certified mail) is not obtained. *
- A convenience discharge, for example, where the patient is an inpatient at one hospital that can care for their needs, but wants to be transferred to a second hospital to be closer to family. *

***Note:** These denials are inconsistent with 42 CFR 410.40 and generally also constitute section 1861(s)(7) denials.

Any denial based on medical necessity, i.e., where the patient could be transported safely by other means, are section 1861(s)(7) denials. Reference to "medical necessity" is incorrect in this context. Section 1862(a)(1) sets forth the Medicare statutory exclusion for services that are not considered reasonable and necessary – commonly referred to as "medical necessity" – which is the statutory trigger for the section 1879 Limitation On Liability provision that entails the use of ABNs. Denials under section 1861(s)(7) are not "medical necessity" denials under section 1862(a)(1) of the Act.

The ABN may not be used in any emergency transport situation. This was clearly conveyed in Program Memorandum (PM) AB-02-114, Section I.2.B. This memorandum specified that physicians and suppliers may not use ABNs to shift financial liability to beneficiaries in emergency care situations. Ambulance companies may not give ABN-Gs to beneficiaries or their authorized representatives in any emergency transport because such beneficiaries are under "great duress".

An ABN may be needed and may be used for non-emergency transports in the following situations:

- A transport by air ambulance when the transporting entity has a reasonable basis to believe that the transport can be done safely and effectively by ground ambulance transportation.
- A level of care downgrade, for example, from advance life support (ALS)-2 to ALS-1, or from ALS to basic life support (BLS), when the transport at the lower level of care is a covered transport.
- A transport from a residence to a hospital for a service that can be performed more economically in the beneficiary's home.
- A transport of a skilled nursing facility (SNF) patient to a hospital or to another SNF for a service that can be performed more economically in the first SNF.

The above guidelines will be applied on reconsiderations for ambulance services requested on or after September 1, 2003. ❖

Source: CMS Transmittal AB-02-114

# Local Medical Review Policies

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

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

## Effective and Notice Dates

Effective dates are provided in each policy, and are based on the date claims are processed, not the date of service, unless otherwise noted in the policy. Medicare contractors are required to offer a 45-day notice period for LMRPs; the date the LMRP is posted to the provider education Web site is considered the notice date.

## Electronic Notification

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

## More Information

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

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

## Medical Policy Table of Contents


**New Local Medical Review Policy Implementation**

*55700:* Biopsy of Prostate Using Image Guidance ... 33
*70540:* Magnetic Resonance Imaging of the Orbit, Face, and Neck ... 33
*73218:* Magnetic Resonance Imaging of Upper Extremity ... 33
*76536:* Ultrasound, Soff Tissues of Head and Neck ... 33
*90804:* Interactive Psychotherapy ... 34
*90810:* Interactive Individual Psychotherapy ... 34
*90853:* Group Psychotherapy ... 34
*90857:* Interactive Group Psychotherapy ... 34
*92506:* Speech-Language Pathology Services ... 35
*96000:* Comprehensive Motion Analysis Studies ... 35
AOOS: Outpatient Observation Services ... 35
J0880: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) ... 35
J1955: Levocarnitine (Carnitor®, L-caritine®) ... 36

**Additions/Revisions to Previously Published Medical Policies**

*11600:* Excision of Malignant Skin Lesions ... 36
*70544:* Magnetic Resonance Angiography (MRA) ... 36
*70551:* Magnetic Resonance Imaging of the Brain ... 36
*72141:* Magnetic Resonance Imaging of the Spine ... 36
*72192:* Computed Tomography of the Pelvis ... 37
*74150:* Computed Tomography of the Abdomen ... 37
*78267:* Breath Test for Helicobacter Pylori (H. PYLORI) ... 37
*93350:* Stress Echocardiography ... 37
*93784:* Ambulatory Blood Pressure Monitoring (ABPM) ... 37
C9119: Pegfilgrastim (Neulasta™) ... 38
G0245: Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes ... 38
J0150: Adenosine (Adenocard®, Adenoscan®) ... 38
J1563: Intravenous Immune Globulin ... 38
J1950: Leuprolide Acetate ... 38
J9999: Antinpeoplastic Drugs ... 38
Q0136: Non-ESRD Epoetin (Procrit®) ... 39
Q9920: Chronic Renal Failure Erythropoietin (EPOGEN®) ... 39

**Clarification and Other Information on Medical Review Policies**

Hand Carried Ultrasound (Hand Held Ultrasound) ... 39
Investigational Device Exemption Revised Requirements ... 40
Medicare Payment for Uterine Artery Embolization ... 41

**Comprehensive Data Analysis**

*77417:* Therapeutic Radiology Port Film ... 41
Ambulatory Payment Classification (APC) Codes 0610, 0611 and 0612 ... 41


**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*.**

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# New LMRP Implementation

## 55700: Biopsy of Prostate Using Image Guidance—New Policy

*CPT 55700* describes *a biopsy of the prostate; needle or punch, single or multiple, any approach.* The digital rectal exam (DRE) and prostate specific antigen (PSA) blood test are two ways to detect changes in the prostate gland. However, they cannot determine if the changes are due to prostate cancer or to a noncancerous condition. A prostate biopsy must be performed in order to make a definitive diagnosis of prostate cancer. Using statistical medical data obtained for dates of service from January 1, 2002 to June 30, 2002, the use of *CPT* code *55700* was found to have an aberrancy ratio of 1.67 per 1000 enrollees. Due to these findings, a policy has been developed to define the indications and limitations of coverage, establish a procedure to diagnosis application, and clarify the appropriate use of a biopsy of prostate using image guidance (procedure codes *55700* and *76942*).

The full text LMRP is available on the provider education Web site *www.floridamedicare.com*.

### Effective Date

Implementation of this policy is effective for services processed **on or after September 29, 2003**. ❖

## 73218: Magnetic Resonance Imaging of Upper Extremity—New Policy

Magnetic resonance imaging (MRI) is a noninvasive imaging technique used for a variety of diagnostic visualizations. Unlike computed tomography (CT) scanning, MRI does not make use of ionizing radiation or require iodinated contrast material to distinguish normal from pathologic tissue. Rather, the process employs the magnetic properties of the hydrogen nucleus (proton) and its interaction with strong external magnetic fields and radio frequency signal, which is processed by a computer to produce an image.

MRI provides superior tissue contrast when compared to CT, is able to image in multiple planes, is not affected by bone artifact, provides vascular imaging capability, and makes use of safer contrast media. Its major disadvantages over CT include longer scanning times, which make MRI less useful in emergency evaluation. The use of MRI on certain soft tissue structures for the purpose of detecting disruptive, neoplastic, degenerative, or inflammatory lesions has now become established in medical practice.

The full text LMRP is available on the provider education Web site *www.floridamedicare.com*.

### Effective Date

Implementation of this policy is effective for services processed **on or after September 29, 2003**. ❖

## 70540: Magnetic Resonance Imaging of the Orbit, Face, and Neck—New Policy

*CPT* code *70540* was chosen for a comprehensive data analysis for fiscal year 2002 based on the January through June 2001 data revealing an aberrancy ratio of 3.12 per 1000 enrollees. Based on the conclusion of the findings, the performance of this service was considered a widespread problem; therefore, a probe was conducted to determine the medical conditions for which the service was being performed. Using the results of the widespread probe, a local medical review was developed to address the indications and limitations of coverage, establish a procedure to diagnosis application, and clarify the appropriate use of procedure code *70540*.

The full text LMRP is available on the provider education Web site *www.floridamedicare.com*.

### Effective Date

Implementation of this policy is effective for services processed **on or after September 29, 2003**. ❖

## 76536: Ultrasound, Soft Tissues of Head and Neck—New Policy

*CPT* code *76536* was chosen for a comprehensive data analysis for fiscal year 2002 based on the January 2001 through June 2001 data revealing an aberrancy ratio of 2.25 per 1000 enrollees. Based on the conclusion of the findings, the performance of this service was considered a widespread problem; therefore, a probe was conducted to determine the medical conditions for which the service was being performed. Using the results of the widespread probe, a local medical review policy was developed to address the indications and limitations of coverage, establish a procedure to diagnosis application, and clarify the appropriate use of procedure code *76536*.

The full text LMRP is available on the provider education Web site *www.floridamedicare.com*.

### Effective Date

Implementation of this policy is effective for services processed **on or after September 29, 2003**. ❖

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## 90804: Interactive Psychotherapy—New Policy

Psychotherapy is the treatment of mental illness and behavior disturbances in which the physician establishes a professional contact with the patient and through therapeutic communication and techniques, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development.

Individual psychotherapy is utilized when the physician needs to establish contact with the patient on a one on one basis.

The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

### Effective Date

Implementation of this policy is effective for services processed **on or after September 29, 2003**. ❖

## 90853: Group Psychotherapy—New Policy

Psychotherapy is the treatment of mental illness and behavior disturbances in which the clinician establishes a professional contact with the patient and through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development.

Group psychotherapy is administered in a group setting with a trained group leader in charge of several patients. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction and support.

The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

### Effective Date

Implementation of this policy is effective for services processed **on or after September 29, 2003**. ❖

## 90810: Interactive Individual Psychotherapy—New Policy

Psychotherapy is the treatment of mental illness and behavior disturbances in which the clinician establishes a professional contact with the patient and through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development.

Interactive individual psychotherapy is used when the patient does not have the ability to interact by ordinary verbal communication; therefore, non-verbal communication skills are employed, or an interpreter may be necessary. Interactive procedures are distinct forms of diagnostic procedures and psychotherapeutic procedures which predominately use non-verbal communication (sign interpreters, visual aids, computer monitors, etc.) and physical aids (dolls, toys, inanimate objects) to overcome barriers to therapeutic interaction between the physician and the patient who has lost or who has not yet developed either the expressive language communication skills to explain his/her symptoms and response to treatment or the receptive communication skills to understand the physician if he/she were to use verbal communication.

The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

### Effective Date

Implementation of this policy is effective for services processed **on or after September 29, 2003**. ❖

## 90857: Interactive Group Psychotherapy—New Policy

Psychotherapy is the treatment of mental illness and behavior disturbances in which the clinician establishes a professional contact with the patient and through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development.

Interactive group psychotherapy is used when patients in a group setting do not have the ability to interact by ordinary verbal communication; therefore, non-verbal communication skills are employed, or an interpreter may be necessary. Interactive procedures are distinct forms of diagnostic procedures and psychotherapeutic procedures which predominately use non-verbal communication (sign interpreters, visual aids, computer monitors, etc.) and physical aids (dolls, toys, inanimate objects to overcome barriers to the therapeutic interaction between the physician and the patient who has lost or who has not yet developed either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the physician if he/she were to use verbal communication.

The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

### Effective Date

Implementation of this policy is effective for services processed **on or after September 29, 2003**. ❖

## 92506: Speech–Language Pathology Services—New Policy

This local medical review policy describes the services that may be furnished under the Medicare Part B benefit by or under the supervision of speech-language pathologists. Speech-language pathology services are those services necessary for the diagnosis and treatment of speech-language disorders that result in communication disabilities, and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability.

This policy applies to all services speech-language pathologists furnish regardless of whether they are employees of or subcontractors to institutions (e.g., hospitals, skilled nursing facilities), or whether they are providers the services incident to a physician's services in a doctor's practice. This policy includes reference to medical equipment/supplies that may be related to the speech/language pathology plan of treatment. This policy does not address dysphagia (swallowing) services rendered by speech-language pathologists.

The full text LMRP is available on the provider education Web site *www.floridamedicare.com*.

### Effective Date

Implementation of this policy is effective for services processed **on or after September 29, 2003**. ❖

## 96000: Comprehensive Motion Analysis Studies—New Policy

Comprehensive computer-based motion analysis is the quantification and evaluation of human motion, which includes measurement of muscle activity, joint motion and forces, and pressure under the feet during walking.

Motion analysis has been used to evaluate walking, primarily in children with neuromuscular disorders such as cerebral palsy or meningomyelocele. A dedicated facility-based motion analysis laboratory uses a computer-based analysis of videotaping and 3-D kinematics, tracking retroreflective markers along the legs. Surface electromyography is also used to assess the tibialis posterior muscle, which is a deep muscle far from the skin surface. Plantar pressure and footplate devices are able to measure the pressure distribution on the foot and the direction of force, while walking and during stance phase. The entire gait laboratory analysis may take 2-3 hours.

The full text LMRP is available on the provider education Web site *www.floridamedicare.com*.

### Effective Date

Implementation of this policy is effective for services processed **on or after September 29, 2003**. ❖

## AOOS: Outpatient Observation Services—New Policy

Outpatient observation services are defined as the use of a bed and periodic monitoring by nursing or other ancillary staff, which are reasonable and necessary to evaluate the patient's condition for possible need of an inpatient admission. These services are only considered reimbursable when performed under a specific order of a physician (pr under the order of another person who is authorized by state statute and the hospital's bylaws to admit patients or order outpatient testing). The order must be based on the physician's expectation of the care that the patient will require.

Outpatient observation services are not to be used as a substitute for medically necessary inpatient admissions. Outpatient observation services are not to be used for the convenience of the hospital, its physicians, patient, or patient's families, or while awaiting placement to another facility.

In general, a patient is considered an inpatient if he has been formally admitted to a hospital with the physician expectation that he will need hospital care for 24 hours or longer or needs services only available in an inpatient environment. Admission to the intensive care level of service does not fit the criteria for observation. This level of care and observation is not reimbursable as outpatient observation services.

Outpatient observation services must be patient specific. Outpatient observation services, generally, do not exceed 24 hours. Some patients may require a second day of observation and only in rare and exceptional cases do observation services span more than 48 hours.

The full text LMRP is available on the provider education Web site *www.floridamedicare.com*.

### Effective Date

Implementation of this policy is effective for services processed **on or after September 29, 2003**. ❖

## J0880: Darbepoetin alfa (Aranesp®)(novel erythropoiesis stimulating protein [NESP])—New Policy

Darbepoetin alfa, produced under the name Aranesp®, is a modified form of recombinant human erythropoietin. The Food and Drug Administration approved this drug for the treatment of anemia associated with chronic renal failure and chemotherapy induced anemia associated with malignancy. To ensure access to care and to communicate the covered indications, a policy was developed.

The full text LMRP is available on the provider education Web site *www.floridamedicare.com*.

### Effective Date

Implementation of this policy is effective for services processed **on or after September 29, 2003**. ❖

## J1955: Levocarnitine (Carnitor®, L-caritine®)—New Policy

Per Program Memorandum AB-02-165, Change Request 2438, a national coverage decision expanded coverage for levocarnitine for use in the treatment of carnitine deficiency in ESRD patients. A local medical review policy for Levocarnitine-J1955 has been developed to communicate the coverage guidelines per the above Program Memorandum and to define the appropriate diagnoses for this procedure.

The full text LMRP is available on the provider education Web site *www.floridamedicare.com*.

### Effective Date

Implementation of this policy is effective for services processed **on or after September 29, 2003**. ❖

# Addition/Revisions to Existing LMRPs

## 11600: Excision of Malignant Skin Lesions—Addition to Policy

The local medical review policy for excision of malignant skin lesions has been revised. The following ICD-9-CM codes have been added to the to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy.

- ICD-9-CM codes 198.2 and 198.81 for *CPT* code range *11600-11606*
- ICD-9-CM codes 198.2 and 198.82 for *CPT* code range *11620-11626*

### Effective Date

This addition is effective for services processed **on or after June 27, 2003**. ❖

## 70551: Magnetic Resonance Imaging of the Brain—Addition to Policy

The LMRP for magnetic resonance imaging of the brain has been revised. ICD-9-CM diagnosis codes 389.10-389.18 and 389.2 for procedures codes *70551*, *70552* and *70553* have been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy.

### Effective Date

These additions are effective for services processed **on or after July 11, 2003**. ❖

## 70544: Magnetic Resonance Angiography (MRA)—Addition to Policy

The LMRP for magnetic resonance angiography (MRA) was published in the Second Quarter 2001 Medicare A Bulletin (pages 28-30). Since that time, additional indications and additional ICD-9-CM codes have been added for MRA of the abdomen for procedure codes *74185*, C8900, C8901, C8902. Added diagnosis codes are:

Abdomen (procedure codes *74185*, C8900, C8901, C8902)

| | |
|---|---|
| 151.0-151.9 | Malignant neoplasm of stomach |
| 152.0-152.9 | Malignant neoplasm of small intestine, including duodenum |
| 153.0-153.9 | Malignant neoplasm of colon |
| 154.0 | Malignant neoplasm of rectosigmoid junction |
| 155.0-155.2 | Malignant neoplasm of liver and intrahepatic bile ducts |
| 156.0-156.9 | Malignant neoplasm of gallbladder and extrahepatic bile ducts |
| 157.0-157.9 | Malignant neoplasm of pancreas |
| 158.0-158.9 | Malignant neoplasm of retroperitoneum and peritoneum |
| 159.0-159.9 | Malignant neoplasm of other and ill |
| 188.0-189.9 | Malignant neoplasm of bladder, kidney, and other and unspecified urinary organs |

### Effective Date

These additions are effective for services processed **on or after June 25, 2003**. ❖

## 72141: Magnetic Resonance Imaging of the Spine—Addition to Policy

The local medical review policy for magnetic resonance imaging of the spine has been revised. ICD-9-CM code 721.0 (Cervical spondylosis without myelopathy) has been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy. Additionally, type of bill code 71x (rural health clinic) has been removed and type of bill code 85x (critical access hospital) has been added to the policy.

### Effective Date

This addition is effective for services processed **on or after May 27, 2003**. ❖

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

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## 72192: Computed Tomography of the Pelvis—Addition to Policy

The LMRP for computed tomography of the pelvis was published in the First Quarter 2002 *Medicare A Bulletin* (pages 26-27). Since that time, the following ICD-9 CM codes have been added to the policy for procedure codes 72192, 72193, and 72194:

| | |
|---|---|
| 016.00-016.06 | Tuberculosis of genitourinary system |
| 171.5 | Malignant neoplasm of connective and other soft tissues, abdomen |
| 189.0-189.1 and 189.4 | Malignant neoplasm of kidney and other and unspecified urinary organs |
| 195.2 | Malignant neoplasm of abdomen |
| 197.4 | Secondary malignant neoplasm, of small intestine, including duodenum |
| 197.5 | Secondary malignant neoplasm of large intestine and rectum |
| 215.5 | Other benign neoplasm of abdomen |
| 215.7 | Other benign neoplasm of trunk, unspecified |

### Effective Date

These additions are effective for services processed **on or after June 2, 2003**. ❖

## 74150: Computed Tomography of the Abdomen—Addition to Policy

The LMRP for computed tomography of the abdomen was published in the Fourth Quarter 2001 *Medicare A Bulletin*. Since then, diagnosis code 996.62 for infection and inflammatory reaction due to other vascular device, implant, and graft has been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy.

### Effective Date

This addition is effective for services processed **on or after May 1, 2003**. ❖

## 78267: Breath Test for Helicobacter Pylori (H. PYLORI)—Revision to Policy

The local medical review policy for breath test for helicobacter pylori (H. PYLORI) was published in *December 1999 Special Issue Bulletin.* Since then, revenue code 34x has been removed from the policy as a payable revenue code.

### Effective Date

These revisions are effective for services processed **on or after May 5, 2003**. ❖

## 93350: Stress Echocardiography—Addition to Policy

The local medical review policy for stress echocardiography was published in the First Quarter 2002 *Medicare A Bulletin* (pages 54-55). Since that time, type of bill 85x has been added to this policy and types of bill 21x and 71x have been removed from this policy.

### Effective Date

These additions are effective for services processed **on or after May 29, 2003**. ❖

## 93784: Ambulatory Blood Pressure Monitoring (ABPM)—Addition to Policy

The local medical review policy for ABPM was published in the Fourth Quarter 2002 *Medicare A Bulletin* (pages 76-77). Since that time, transmittal 168, dated March 28, 2003, was issued to specify that a physician is required to perform the interpretation of the data obtained through ambulatory blood pressure monitoring, but that there are no requirements regarding the setting in which the interpretation is performed.

### Effective Date

This addition is effective for services processed **on or after July 1, 2003**. ❖

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

## C9119: Pegfilgrastim (Neulasta™)—Revision to Policy

The local medical review policy for pegfilgrastim (Neulasta™) was published in the Third Quarter 2003 *Medicare A Bulletin!* (page 40). Since that time, the policy has been revised based on CMS Program Memorandum A-03-051 (CR 2771) dated June 13, 2003. The HCPCS code for pegfilgrastim has been changed to Q4053 (Injection, pegfilgrastim, 1 mg), replacing HCPCS code C9119. The policy number has also been changed to Q4053. Additionally, the CPT/HCPCS section and Benefit Category has been changed to Drugs and Biologicals.

### Effective Date

This addition is effective for services furnished **on or after July 1, 2003**. ❖

## J0150: Adenosine (Adenocard®, Adenoscan®)—Revision to Policy

The local medical review policy for adenosine (Adenocard®, Adenoscan®) has been revised to reflect hospital outpatient prospective payment system for calendar year 2003 changes. HCPCS code J0150 (Adenosine, 6 mg) has been assigned a status indicator of N (Items and services packaged into APC rate). Providers can no longer receive separate payment for J0150. Providers may bill and receive payment for HCPCS code J0151 (Adenosine, 12 mg), which has been assigned a status indicator of K (Non pass-through drug/biological, certain brachytherapy seeds).

In addition, the number of the policy has been changed from J0150 to J0151.

### Effective Date

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

## G0245: Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes—Revision to Policy

The local medical review policy for peripheral neuropathy with LOPS was published in its entirety in the Fourth Quarter 2002 *Medicare A Bulletin* (pages 86-87). A revision has been made to the "*CPT*/HCPCS Codes" section of the LMRP. The descriptor for procedure code G0247 has been revised as follows:

> Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include if present, at least the following:
> (1) local care of superficial (i.e., wounds superficial to fascia and muscle) wounds,
> (2) debridement of corns and calluses, and
> (3) trimming and debridement of nails.

### Effective Date

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

Source: CMS Transmittal AB-03-070, CR 2734

## J1563: Intravenous Immune Globulin—Revision to Policy

The local medical review policy for intravenous immune globulin (IVIG) has been revised based on CMS Program Memorandum A-03-020 (CR 2671) dated April 2, 2003. Instructions have been added to the "Coding Guidelines" section of the policy.

### Effective Date

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

## J1950: Leuprolide Acetate—Revision to Policy

The local medical review policy for leuprolide acetate has been revised. Leuprolide acetate is not separately reimbursed when provided in a skilled nursing facility. Therefore, type of bill code 21x (skilled nursing facility) has been removed from the policy. Additionally, type of bill code 71x (rural health clinic) has been removed and type of bill code 85x (critical access hospital) has been added to the policy.

### Effective Date

This revision is effective for services processed **on or after May 22, 2003**. ❖

## J9999: Antineoplastic Drugs—Revision to Policy

The local medical review policy for antineoplastic drugs has been revised. The following chemotherapy agents have been added to the LMRP:

### Fulvestrant (Faslodex®) C9120

Fulvestrant is an estrogen receptor antagonist without known agonist effects. The Food and Drug Administration (FDA) approved Fulvestrant for the treatment of hormone receptor positive metastatic breast cancer in postmenopausal women with disease progression following antiestrogen therapy.

### Oxaliplatin (Eloxatin™) C9205

Oxaliplatin is a chemotherapeutic agent. The FDA approved Oxaliplatin for injection with infusional 5-Fluorouracil/Leucovorin (5FU/LV) for the treatment of patients with metastatic carcinoma of the colon or rectum whose disease has recurred or progressed during or within six months of completion of first line therapy with the combination of bolus 5-FU/LV and Irinotecan.

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

*J9999: Antineoplastic Drugs—Revision to Policy (continued)*

### Floxuridine (FUDR) J9200

Floxuridine (FUDR) is an antimetabolite of the pyrimidine analog type. The monophosphat of the drug, 5-fluoro-2'-deoxyuridine-5'-phosphate (FUDR-MP), inhibits thymidylate synthetase, thus inhibiting methylation of deoxyuridylic acid to thymidylic acid, thereby, interfering with the synthesis of DNA. Floxuridine, given by continuous intra-arterial infusion, is FDA approved for the palliative management of colorectal carcinoma metastatic to the liver that has not responded to other treatment. Intra-arterial Floxuridine is also indicated for the palliative treatment of primary and secondary carcinomas of the liver.

The full-text LMRP is available on the provider education Web site *www.floridamedicare.com*.

### Effective Date

This revision is effective for services processed **on or after September 29, 2003**. ❖

## Q0136: Non-ESRD Epoetin (Procrit®)—Revision to Policy

The local medical review policy for non-ESRD Epoetin (Procrit®) has been revised based on CMS Program Memorandum A-01-106 (CR 1839) dated August 24, 2001. The following revisions have been made:

- An indication for anemia associated with chronic renal failure (patients not on dialysis), has been added to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy.
- ICD-9-CM code 585 (chronic renal failure) has been added to the "ICD-9-CM Codes that Support Medical Necessity"
- Information has been added to the "Coding Guidelines" section of the policy.
- Type of bill code 71x (rural health clinic) has been removed and type of bill code 85x (critical access hospital) has been added to the policy
- Revenue codes 634 (Erythropoietin [EPO] less than 10,000 units) and 635 (Erythropoietin [EPO] 10,000 or more units) have been removed from the policy.
- The policy title has been changed to Q0136 – Epoetin (Procrit®).

### Effective Date

These revisions are effective for dates of service **on or after August 24, 2001**. ❖

## Q9920: Chronic Renal Failure Erythropoietin (EPOGEN®)—Revision to Policy

The local medical review policy for chronic renal failure erythropoietin (EPOGEN®) has been revised based on CMS Program Memorandum A-01-106 (CR 1839) dated August 24, 2001. The following revisions have been made:

- The indication for patients with chronic renal failure who are not on a regular course of dialysis was removed from the policy.
- Type of bill 85x – critical access hospital, has been added to the policy and type of bill 71x – rural health clinic, has been removed from this policy.

### Effective Date

These revisions are effective for dates of service **on or after August 24, 2001**. ❖

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

# ADDITIONAL INFORMATION ON LMRPs

## Hand Carried Ultrasound (Hand Held Ultrasound)

Medical equipment described as "hand carried ultrasound (HCU)" or "hand held ultrasound" ranges in complexity and capability from lightweight pocket-sized units completely contained within the examiner's hand, to complex equipment systems where only the probe itself is hand-held. The equipment used does not determine the appropriate use of a specific ultrasound *CPT* code, but rather by the extent, quality, completeness and documentation of the procedure.

Providers should only use a *CPT* code where they have performed the full extent, quality, completeness and documentation necessary for the use of that code. Studies that are significantly more limited in scope or quality, are less well-documented, or performed in any less comprehensive or less skilled manner than the full study described by an accepted *CPT* code should not be billed under traditional diagnostic ultrasound *CPT* codes (*93303-93350, 93875-93990 or 76506-76999*).

For example, an emergency room "quick look" ultrasound to briefly assess a chest for the presence of fluid, blood, pus or a foreign body, should not be coded as *CPT 76604 (Ultrasound, chest, B-scan [includes mediastimum] and/or real time with image documentation)*, since it has not met the full extent quality, completeness and documentation of that procedure. Instead, until more limited, specific codes are available such study is bundled into the reimbursement for the physical examination.

***Hand Carried Ultrasound (Hand Held Ultrasound) (continued)***

Consistent with this policy, *CPT 51798 (Measurement of post voiding residual urine and/or bladder capacity by ultrasound, non-imaging)* – formerly HCPCS G0050 – describes a limited, specific procedure, which may be performed by either comprehensive or more limited-capability ultrasounds.

*CPT 51798* may be separately covered as long as all of the criteria and documentation referenced in the code are fulfilled. ❖

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## Investigational Device Exemption Revised Requirements

In an effort to decrease the administrative burden on providers wishing to apply for Medicare coverage of category B investigational devices, First Coast Service Options, Inc., is reducing the documentation required to approve investigational device exemption (IDE) requests.

Effective August 1, 2003, any provider participating in a clinical study involving a FDA investigational device exemption (IDE) who submits claims for these services must furnish only the following information **before claims can be submitted:**

1. Provider name and provider number.
2. Number of cases the institution is planning to perform.
3. A narrative description of the device sufficient to make a payment determination (including planned diagnosis and procedure codes and charges as relevant).
4. A statement indicating how the device is similar to and/ or different from other comparable products.
5. A signed copy of the FDA approval letter demonstrating category B, IDE status and approval from the FDA to the participating company or manufacturer (including the name and number of the device).
6. Revenue code and *CPT* code(s) as applicable. If using an unlisted *CPT* code(s) to report the service performed, identify the expected charges.
7. Attestation of having the following:

   The manufacture's or primary investigator's letter containing the most current approved number of institutions and subjects, and the number of cases the institution is planning to perform.

All information specified above must be submitted to this contractor in the form of a letter. The required information must be received before claims may be submitted.

The following items must be **maintained by the provider and readily available upon request** if more information about the IDE is needed to evaluate for coverage:

1. The protocol for performing the procedure utilizing the category B, IDE device and a summary of the results of patients who have undergone the procedure(s) described within the protocol.
2. The agreement between the company or manufacturer and the provider, furnishing the details of provider participation in the study.
3. At least two peer-reviewed publications (abstracts are not acceptable) addressing the topic of the study.
4. Any product literature illustrating the device and/or the procedure.
5. The protocol used for obtaining informed consent from beneficiaries for their participation in the study.
6. An institutional review board approval letter or a statement from the provider assuring that approval has been obtained from the study institution.
7. A signed copy of the FDA approval letter demonstrating Category B, IDE status and approval from the FDA to the participating company or manufacturer.
8. The manufacture's or primary investigator's approval letter containing the most current approved number of institutions and subjects, and the number of cases the institution is planning to perform.

When filing claims for the IDE and related services to the fiscal intermediary on Form UB-92 CMS 1450 or electronic equivalent, use revenue code **642** in form locator 42.

**Note:** Revenue code 624 is only applicable for medical investigational devices and procedures with FDA approved IDE's for clinical trial.

Reimbursement for a device will be limited to what Medicare would have paid for a comparable approved device. Medicare does not cover costs associated with the investigational protocol, which are for research purposes and are not reasonable and necessary for the management of the patient.

Should the protocol for this investigation be altered or should the sponsor lose its category B status or violates FDA requirements, please notify us in writing at:

Medical Policy and Procedures Department
P.O. Box 2078
Jacksonville, Florida 32231-0048. ❖

## Medicare Payment for Uterine Artery Embolization

Uterine artery embolization (UAE) is an existing technology that represents a fundamentally new approach to the treatment of symptomatic fibroid disease. Medicare considers the UAE procedure to be medically reasonable and necessary for the treatment of symptomatic uterine fibroids.

The UAE procedure is usually done in the hospital with an overnight stay post-procedure. Initially, a needle is used to enter the femoral artery to provide access for the catheter. The catheter is advanced over the branch of the aorta and into the uterine artery on the side opposite the puncture. An arteriogram is performed to provide a road map of the blood supply to the uterus and fibroids. After the arteriogram, particles of polyvinyl alcohol (PVA) are injected slowly with X-ray guidance. Because fibroids are very vascular, the particles flow to the fibroids first and wedge in the vessels. Over several minutes the arteries are slowly blocked and the embolization is continued until there is complete blockage of flow to the fibroids. After the embolization, another arteriogram is performed to confirm the completion of the procedure. It would be expected that this procedure would be billed under *CPT* code *37204 (Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostatis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck*). Codes for catheter placement and the radiologic supervision and interpretation should also be reported, in addition to the code(s) for the therapeutic aspect of the procedure. ❖

# COMPREHENSIVE DATA ANALYSIS

## 77417:Therapeutic Radiology Port Film—Widespread Probe Review Referral

The Statistical and Medical Data Analysis department conducted an analysis of *CPT* code *77417* –Therapeutic radiology port film(s). A total of 9,236 claims representing 26,576 units were reimbursed for $430,414 during January to June 2002. Based on in-depth data analysis, it has been concluded that the fiscal intermediary is reimbursing for services when the medical necessity is often not clear, that exceed the expected utilization pattern, and may be improperly appended with modifiers 76 and/or 59.

A widespread probe has been recommended as a result of these findings. This service-specific probe review generally will not exceed evaluating 100 claims distributed among the identified provider universe. The purpose of the review is to determine if services billed to Medicare were documented as having been performed, and to determine the medical necessity of initial and repeat port films. The information found from the widespread probe will be evaluated in terms of the need for local medical review policy enhancement. ❖

## Ambulatory Payment Classification (APC) Codes 0610, 0611, and 0612

The Statistical and Medical Data Analysis department conducted an analysis of claims billed for the following APC codes:

- 0610 – low level emergency visits (*CPT* codes *99281* and *99282*)
- 0611 – mid level emergency visits (*CPT* code *99283*)
- 0612 – high level emergency visits (*CPT* codes *99284* and *99285*).

A total of 235,076 claims representing 245,781 units were reimbursed for $16,393,503 during January 2002 to June 2002. While the low level visits decreased three percent, the mid-level and high-level emergency visits increased 11 percent and 19 percent respectively.

One unexpected observation from the claims data was the utilization of an emergency room (ER) for follow-up care involving surgical dressings/suture removal, as well as using the ER for repetitive delivery of outpatient intravenous antibiotics. According to the Intermediary Manual, Section 3604, ancillary revenue code 45x would contain charges for emergency treatment to those ill and injured persons who require immediate unscheduled medical and surgical care. The data also identified a handful of Medicare beneficiaries as high ER utilizers. These specific Medicare recipients were under the age of 65 and visited a range from five to twenty-two unique facility ERs during this six-month time period.

The hospital outpatient prospective payment system instructions stated that providers are required to bill medical visits to emergency rooms using a range of *CPT* codes that define the intensity of the visits. CMS instructed hospitals to develop an internal system for mapping provided services or combination of services to the different levels of effort represented by the *CPT* codes. Each facility is held accountable for following its own *CPT* assignment system. CMS stated that a facility would be in compliance if: the services furnished are documented and medically necessary; the facility is following its own system; and the facility's system reasonably relates the intensity of hospital resources to the different levels of *CPT* codes. Our medical review experience to date demonstrates that hospital providers are billing for medically necessary services utilizing the proper *CPT* codes suggested via their mapping systems. There is a concern that the mapping systems allow the billing of high-level ER visits that do not reasonably relate to the intensity of the hospital resources utilized. We all await CMS's promised release of further instructions specific to outpatient hospital coding for overhead resource expenditures. ❖

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# GENERAL COVERAGE

## 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), effective March 21, 2002. The *Current Procedural Terminology* (*CPT*) codes for these new tests must have the modifier QW to be recognized as a waived test.

| *CPT* Code | Test Name | Manufacturer | Effective Date | Use |
|---|---|---|---|---|
| *81003QW* | Hypoguard Diascreen® Urine Chemistry Analyzer | Hypoguard USA, Inc. | 12/6/02 | Screening of urine to monitor/ diagnose various diseases/ conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections. |
| *82273QW* | Aerscher Hemaprompt FG | Aerscher Diagnostics | 2/11/03 | Rapid screening test to detect the presence of gastric occult blood. |
| *83036QW* | Bio-Rad Micromat II Hemoglobin A1c Prescription Home Use Test | Bio-Rad Laboratories | 12/17/02 | Measures the percent concentration of hemoglobin A1c in blood, which is used in monitoring the long-term care of people with diabetes |
| *86701QW* | OraSure Technologies OraQuick Rapid HIV-1 Antibody Test | OraSure Technologies, Inc. | 1/31/03 | Qualitative immunoassay to detect antibodies to human immunodeficiency virus type 1 (HIV-1) in fingerstick whole blood specimens. |
| *87880QW* | Immunostics Immuno/Strep A Detector | ACON Laboratories, Inc. | 2/13/03 | 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. |
| *87880QW* | Stanbio QuStick Strep A | Stambio Laboratory | 3/5/03 | 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. |

There is a national coverage determination (NCD) for glycated hemoglobin and for immunoassays performed by multiple step methods for HIV-1. These NCDs will be applied to claims for *CPT* code *83036*QW and *86701*QW.

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

Source: CMS Transmittal AB-03-056, CR 2685

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## Revision to Electrical Stimulation for the Treatment of Wounds

The Centers for Medicare & Medicaid Services (CMS) has added type of bill 85x for critical access hospitals to the list of acceptable types of bill for electrical stimulation for the treatment of wounds for services furnished **on or after April 1, 2003.** Coverage and billing guidelines for this service were published in the Second Quarter 2003 *Medicare A Bulletin* (page 13). ❖

Source: CMS Transmittal AB-03-093, CR 2733

## July 2003 Update to the Laboratory National Coverage Determination Edit Software

Changes to the national uniform edit software that was developed for processing clinical diagnostic laboratory services subject to one of the 23 national coverage determinations (NCDs) will be implemented in the July 2003 release. The following changes to the edit module are effective for services furnished **on or after July 1, 2003**.

1. The following procedure codes, which were added to the *Current Procedure Terminology (CPT)* beginning in January 1, 2003, will be added to the blood count NCD:

*85004 Blood count automated differential white blood cell (WBC) count*
*85032 Manual cell count (erythrocyte, leukocyte, or platelet) each*
*85049 Platelet, automated*

CMS has determine that these codes are essentially the same codes that were originally included in the blood count NCD as negotiated by the rulemaking committee.

2. Under the blood glucose testing NCD, ICD-9-CM code range 730.07-730.27 was erroneous described as osteomyelitis of the tarsal bones. This range is corrected by the following ICD-9-CM diagnosis codes, which reflect more accurately the intent of the committee to include osteomyelitis of the ankle and foot:

730.07 Acute osteomyelitis of ankle and foot
730.17 Chronic osteomyelitis of ankle and foot
730.27 Unspecified osteomyelitis of ankle and foot.

3. In the NCD coding manual issued for the January and April software releases, the ICD-9-CM diagnosis code 136.2 was inadvertently repeated in the list of covered diagnoses for HIV testing. The descriptions of the codes and the software implementing the NCD edits remained accurate. Thus, CMS is changing the NCD coding manual only to show the correct ICD-9-CM diagnosis code 136.3 for pneumocystosis. ❖

Source: CMS Transmittal AB-03-084, CR 2737

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## October 2003 Update to the Laboratory National Coverage Determination Edit Software

Changes to the national uniform edit software that was developed for processing clinical diagnostic laboratory services subject to one of the 23 national coverage determinations (NCDs) will be implemented in the October 2003 release. The laboratory edit module for the NCDs is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCD policies developed through the NCD process.

The following changes to the edit module are effective for services furnished **on or after October 1, 2003**.

1. In accordance with the decision memorandum published on the coverage Internet site on July 17, 2003, (see *http://cms.hhs.gov/ncdr/memo.asp?id=94*), Medicare is adding diagnosis code 401.1, benign essential hypertension, to the list of ICD-9-CM codes covered by Medicare for lipid testing. Hypertension may be viewed as a cause of atherosclerosis that requires tighter management when accompanied by dyslipidemia.
2. ICD-9-CM codes are updated annually. New ICD-9-CM codes can render some of the presently covered codes inappropriate. Most commonly, codes are expanded so that additional digits are necessary. For example, a code that presently is displayed as four digits may be expanded to require five digits. The coding changes below are considered ministerial in that Medicare is merely replacing existing codes within the NCD with the more current code structure or adding new codes that are within an existing covered range. Medicare is making the following specific changes to the NCDs and edit module. However, because Medicare provides a 90-day grace period for new ICD-9-CM codes for Part B services, the codes will not be removed from the edit module until the January 2004 release.

- In the serum iron studies NCD list of covered diagnoses,
  - ICD-9-CM code 282.4 has been removed and replaced with ICD-9-CM codes 282.41, 282.42 and 282.49.
  - ICD-9-CM code V43.2 has been has been removed and replaced with ICD-9-CM codes V43.21 and V43.22.
  - New ICD-9-CM diagnosis codes 282.64, 282.68, and 289.52 have been added.
- In the urine culture bacterial NCD list of covered diagnoses,
  - ICD-9-CM code 600.0 has been removed and replaced with ICD-9-CM codes 600.00 and 600.01.
  - ICD-9-CM code 600.1 has been removed and replaced with ICD-9-CM codes 600.10 and 600.11.
  - ICD-9-CM code 600.2 has been removed and replaced with ICD-9-CM codes 600.20 and 600.21.
  - ICD-9 CM code 600.9 has been removed and replaced with ICD-9-CM codes 600.90 and 600.91.
  - New ICD-9-CM diagnosis codes 780.93, 780.94, 785.52, and 788.63 have been added to the NCD.

***October 2003 Update to the Laboratory National Coverage Determination Edit Software (continued)***

- In the human immunodeficiency virus testing (diagnosis) NCD list of covered diagnoses,
  - ICD-9-CM diagnosis code 348.3 has been removed and replaced with ICD-9-CM codes 348.30 and 348.39.
  - ICD-9-CM code 530.2 has been removed and replaced with ICD-9-CM codes 530.20, 530.21 and 530.85.
  - New ICD-9-CM diagnosis code 331.19 has been added.
- In the blood counts NCD list of ICD-9-CM codes that do **not** support medical necessity,
  - ICD-9-CM code 600.0 has been removed and replaced with ICD-9-CM codes 600.00 and 600.01.
  - ICD-9-CM code 600.1 has been removed and replaced with ICD-9-CM codes 600.10 and 600.11.
  - ICD-9-CM code 600.2 has been removed and replaced with ICD-9-CM codes 600.20 and 600.21.
  - ICD-9-CM code 600.9 has been removed and replaced with ICD-9-CM codes 600.90 and 600.91.
  - ICD-9-CM code V04.8 has been removed and replaced with ICD-9-CM codes V04.81, V04.82 and V04.89.
  - ICD-9-CM code V53.9 has been removed and replaced with ICD-9-CM codes V53.90, V53.91 and V53.99.
  - ICD-9-CM code V54.0 has been removed and replaced with ICD-9-CM codes V54.01, V54.02 and V54.09.
  - New ICD-9-CM diagnosis codes 799.81, V25.03, V45.85, and V65.46 have been added.
- In the partial thromboplastin time NCD list of covered diagnoses, ICD-9-CM code 767.1 has been removed and replaced with ICD-9-CM codes 767.11.
- In the prothrombin time NCD list of covered diagnoses,
  - ICD-9-CM code 767.1 has been removed and replaced with ICD-9-CM codes 767.11.
  - ICD-9-CM code V43.2 has been removed and replaced with ICD-9-CM codes V43.21 and V43.22.
  - New ICD-9-CM diagnosis code 414.07 has been added.
- In the collagen cross-links NCD list of covered diagnoses, new ICD-9-CM diagnosis code V58.65 has been added.
- In the blood glucose NCD list of covered diagnoses,
  - ICD-9-CM code 790.2 has been removed and replaced with ICD-9-CM codes 790.21, 790.22 and 790.29.
  - ICD-9-CM 348.3 has been removed and replaced with ICD-9-CM codes 348.31.
  - New ICD-9-CM diagnosis codes 414.07, V58.63, V58.64, and V58.65 have been added.
- In the glycated hemoglobin NCD list of covered diagnoses, ICD-9-CM code 790.2 has been removed and replaced with ICD-9-CM codes 790.21, 790.22 and 790.29.
- In the thyroid testing NCD list of covered diagnoses,
  - ICD-9-CM code 331.1 has been removed and replaced with ICD-9-CM codes 331.11 and 331.19.
  - New ICD-9-CM diagnosis codes 728.87, 780.93 and 780.94 have been added.
- In the lipid testing NCD list of covered diagnoses, ICD-9-CM diagnosis codes 414.07, V58.63, and V58.64 have been added.
- In the prostate specific antigen NCD list of covered procedures, new ICD-9-CM diagnosis code 788.63 has been added.
- In the gamma glutamyl transferase NCD list of covered diagnoses, new ICD-9-CM diagnosis codes 282.64, 282.68, 289.52, V58.63, and V58.64 have been added.
- In the fecal occult blood NCD list of covered diagnoses,
  - ICD-9-CM code 530.2 has been removed and replaced with ICD-9-CM codes 530.20, 530.21 and 530.85.
  - New ICD-9-CM diagnosis codes V58.63, V58.64 and V58.65 have been added.
- In the list of ICD-9-CM codes denied that are applicable to all 23 NCDs, ICD-9-CM code V65.1 has been removed and replaced with ICD-9-CM codes V65.11 and V65.19. ❖

Source: CMS Transmittal AB-03-104, CR 2814

## Ambulatory Blood Pressure Monitoring—Revision to National Coverage Determination

Effective July 1, 2003, section 50-42 of the Medicare Coverage Issues Manual (CIM) is revised to specify that a physician is required to perform the interpretation of the data obtained through ambulatory blood pressure monitoring, but that there are no requirements regarding the setting in which the interpretation is performed. Everything else in this NCD remains unchanged. ❖

Source: CMS Transmittal 168, CR 2625 (CIM section 50-42)

## Revision to Coverage of Hyperbaric Oxygen Therapy for the Treatment of Diabetic Wounds of the Lower Extremities

The Centers for Medicare & Medicaid Services (CMS) has revised the national coverage decision for hyperbaric oxygen (HBO) therapy for the treatment of diabetic wounds of the lower extremities. Changes have been made to the ICD-9-CM codes and types of bill on this policy effective for services furnished **on or after April 1, 2003.**

The following ICD-9-CM codes have been updated to the fifth level of specificity:

- 250.7 to 250.70
- 250.8 to 250.83
- 707.1 to 707.10, 707.12, 707.13, 707.14, 707.15 and 707.19
- ICD-9-CM category 707 has been removed since this is the title of a category not a valid ICD-9-CM code.
- Type of bill 22x has been added to the policy.

All other information and instructions published in the Second Quarter 2003 *Medicare A Bulletin* (page 14) and the local medical review policy (LMRP) for Hyperbaric Oxygen Therapy (HBO Therapy) – C1300 remain in effect. The LMRP reflecting these changes will be revised in the near future.

Source: CMS Transmittal AB-03-102, CR 276

## Diagnosis Code for Screening Pap Smear and Pelvic Examination Services

Effective for services rendered **on or after October 1, 2003,** Medicare has added two new diagnosis codes, ICD-9-CM V76.47 and V76.49, to report Pap smear and pelvic examinations for low-risk patients. Diagnosis code V76.49 has been added for providers to use for women without a cervix.

### 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

## Psychiatric Diagnostic Interview Examination—Telehealth Services

Psychiatric diagnostic interview examination as identified by *CPT* code *90801* was added to the list of Medicare telehealth services through the physician fee schedule for calendar year 2003 final rule. The final rule is effective for services furnished **on or after March 1, 2003**. Therefore, the effective date for payment of the psychiatric diagnostic interview examination as a telehealth service (*CPT 90801* with modifier GT) is March 1, 2003.

Prior to the delay of the 2003 Medicare physician fee schedule, CMS had indicated that the addition of the psychiatric diagnostic interview examination to the list of Medicare telehealth services was effective January 1, 2003.

Payment for psychiatric diagnostic interview examination telehealth services will be made at the 2003 payment rates for claims with dates of service beginning **on or after March 1, 2003.**

Telehealth services provided by the physician or practitioner at the distant site are billed to the Medicare carrier, except in situations where a critical access hospital (CAH) has elected payment method II and reimbursement will be made by the CAH fiscal intermediary based on instructions stated in section 415.22 of the Medicare Hospital Manual.

Psychiatric diagnostic interview examination telehealth claims with dates of service **prior to March 1, 2003,** will be rejected with an indication that the procedure code billed is not correct/valid for the services billed or the date of service billed. ❖

Source: CMS Transmittal AB-03-070, CR 2734

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## Expanded Coverage of Positron Emission Tomography Scans

Positron emission tomography (PET) is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images, which are obtained from positron emitting radioactive tracer substances (radiopharmaceuticals) such as 2-(F-18) fluoro-D-glucose (FDG), that are administered intravenously to the patient.

Medicare has expanded coverage for PET scans for fluoro-D-glucose (FDG) PET for thyroid cancer and perfusion of the heart using ammonia N-13. This expanded coverage is effective for claims with dates of service **on or after October 1, 2003.**

### Thyroid Cancer

For services provided **on or after October 1, 2003,** Medicare covers the use of FDG PET for thyroid cancer only for restaging of recurrent or 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.

**Limitations:** All other uses of FDG PET in the diagnosis and treatment of thyroid cancer remain noncovered.

**HCPCS Code**

A new HCPCS code has been assigned to thyroid cancer management for services provided **on or after October 1, 2003**:

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.

### Perfusion of the Heart Using Ammonia N-13

Effective for service provided **on or after October 1, 2003,** PET scans performed at rest or with pharmacological stress used for noninvasive imaging of the perfusion of the heart for the diagnosis and management of patients with known or suspected coronary artery disease using the FDA-approved radiopharmaceutical ammonia N-13 are covered, provided the following requirements are met.

- The PET scan, whether at rest alone, or rest with stress, is performed in place of, but not in addition to, a single photon emission computed tomography (SPECT); or
- The PET scan, whether at rest alone or rest with stress, is used following a SPECT that was found to be inconclusive. In these cases, the PET scan must have been considered necessary in order to determine what medical or surgical intervention is required to treat the patient. For the purposes of this requirement, an inconclusive test is a test, whose results are equivocal, technically uninterpretable, or discordant with a patient's other clinical data and must be documented in the beneficiary's file.

**HCPCS Code**

A new temporary HCPCS code has been assigned to identified ammonia N-13 tracer for services provided **on or after October 1, 2003**:

Q4078 Supply of radiopharmaceutical diagnostic imaging agent, ammonia N-13, per dose.

Effective for service provided **on or after October 1, 2003,** only two tracers are covered for PET scans for the perfusion of the heart, for HCPCS code range G0030-G0047:

- Code Q3000, which identifies the tracer rubidium 82; and
- New code Q4078, which identifies the tracer ammonia N-13.

### Claim Processing Requirements

Claims for PET scan services must be billed on Form UB-92 CMS-1450, or electronic equivalent with the appropriate HCPCS and diagnosis codes. **The electronic equivalent formats other than the HIPAA format are effective through October 16, 2003. After October 16, 2003 the X12N 837 version 4010A1 is the only acceptable format.** The X12N 837 version 4010 (HIPAA) to UB-92 version 6.0 mapping is at *http://cms.hhs.gov/providers/edi/hipaadoc.asp*. The 837 versions 4010 and 4010A1 can be downloaded at *www.wpc-edi.com*.

PET scan services are billed under revenue code 404 for the following bill types:

12x 13x 14x 22x 23x 85x

These HCPCS codes represent the technical component costs associated with these identified PET procedures when furnished to hospital outpatients and are payable under the outpatient prospective payment system. Claims submitted for services provided by critical access hospitals are paid on a reasonable cost basis.

The new HCPCS codes will be added to the October 2003 quarterly update of the outpatient code editor (OCE). ❖

Source: CMS Transmittal AB-03-092, CR 2687

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# INPATIENT HOSPITAL SERVICES

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

An article addressing the three-day payment window under the short-term hospital inpatient prospective payment system (IPPS) was published in the Third Quarter 2003 *Medicare A Bulletin* (pg. 33). Since then, CMS has revised the list of revenue codes for diagnostic services, and has defined the terms "short-term" and "excluded" hospital and units as used in that article.

### Revised Revenue Code List

The following revenue codes, formerly identified as diagnostic, are to be treated as therapeutic (also known as nondiagnostic) for purposes of the Common Working File (CWF) edits for the three-day DRG (diagnosis related group) payment window:

51X – Clinic
52X – Free-standing clinic
71X – Recovery room
75X – Gastrointestinal services

Services in these centers may be either diagnostic or therapeutic, and cannot be easily differentiated in the CWF. Therefore, for electronic editing purposes, services in these centers will be treated as therapeutic. However, providers are responsible for billing properly according to the three-day payment window provisions specified in CFR sections 412.2(c)(5) and 413.40(c)(2), and the February 11, 1998, *Federal Register* (63 FR 6864).

### Term Clarification

Reference to "short-term" hospitals refers to those entities for which Medicare pays for services under the hospital IPPS, in accordance with section 1886(d) of the Social Security Act (the Act).

Additionally, the reference to "excluded" hospitals and units refers to those entities specified under section 1886(d)(1)(B) of the Act. These hospitals and units are: psychiatric hospitals and units, inpatient rehabilitation facilities and units, long-term care hospitals, children's hospitals, and cancer hospitals. Critical access hospitals are not subject to the three-day (nor one-day) DRG payment window. ❖

Source: CMS Transmittal A-03-054, CR 2803

## Clarification on Existing Policies Affecting Long-Term Care Hospitals

*The Centers for Medicare & Medicaid Services (CMS) has provided the following clarifications on existing policies affecting long-term care hospitals (LTCHs).*

### LTCHs Co-located With Other Medicare Providers: Onsite Discharge and Readmission Policy

All discharges from LTCHs immediately followed by an admission to an acute care hospital, an inpatient rehabilitation facility (IRF) or a skilled nursing facility (SNF), and then a readmission to the same LTCH are subject to the interrupted stay policy. Under this policy, unless the stay at the intervening provider exceeds nine days for the acute care hospital, 27 days for the IRF, and 45 days for the SNF, if the patient is readmitted to the LTCH, the days prior to and subsequent to the interruption will count as only one complete episode of care at the LTCH.

LTCHs that are co-located with other Medicare providers (acute care hospitals, IRFs, SNFs) are subject to the interrupted stay policy but in addition, if such discharges and readmissions exceed five percent of the LTCH's total discharges during a cost reporting period, all such readmissions during that cost reporting period will be paid as one discharge, regardless of the time spent at the intervening facility. (One five percent calculation is applied to discharges to and readmissions from onsite acute care hospitals and a separate five percent calculation will be made for the combined discharges to and readmissions to the LTCH from onsite IRFs, SNFs, and psychiatric facilities.) Prior to triggering either of the five percent thresholds, such cases will be evaluated and paid under the interrupted stay policy. (Presently, there is no interrupted stay policy for psychiatric facilities, so in the case of a LTCH patient who is directly readmitted from a psychiatric facility, there will be two LTC-DRG payments unless and until the number of such readmissions (counted along with readmissions from an onsite IRF or SNF) reach the five percent threshold).

### Computation of the Greater Than 25-day Average Length of Stay (ALOS) Criteria

In calculating the greater than 25-day ALOS criteria necessary to qualify as a LTCH, the calculation will be made by dividing the days of care provided to Medicare patients included for the cost reporting period in which those days of care are actually provided, by the Medicare discharges occurring during that period. For payment purposes, it is standard policy, under a discharge-based PPS such as the LTCH PPS, for patient days to be counted during the cost reporting period of the discharge, regardless of whether or not the LTCH is being paid under the transition blend or has elected 100 percent based on the federal rate. For ALOS calculations, however, presently, patient days will only be counted during the cost reporting period that they occur. ❖

Source: CMS Transmittal A-03-056, CR 2807

## Assigning Liability for Line Items Excluded by Statute on Otherwise Covered Claims

The Centers for Medicare & Medicaid Services (CMS) has been notified of an existing problem in assigning liability to beneficiaries on line items for services excluded by statute, such as self-administered drugs, on claims that also contain other covered services. The billing systems of some hospitals cannot accommodate splitting covered and noncovered line items onto separate claims. Additionally, improper assignment of liability affects subsequent payer payment for such items, thereby negatively affecting beneficiaries.

### Action Required by Providers

The fiscal intermediary standard system (FISS) cannot process modifier GY with proper assignment of liability at this time, although use of this modifier is required by current instructions for laboratory and hospital outpatient prospective payment system services. Therefore, as a temporary work-around, providers on the FISS should submit both modifier GY (" item or service statutory excluded or does not meet the definition of Medicare benefit") and GA ("waiver of liability statement on file") on line items excluded by statute when these line items **must** be submitted on the same claim with other covered services. **Such line items must be submitted as covered charges.**

The FI has created a medical policy parameter in the FISS systems to suspend these line items when received. Charges will then be denied, and liability assigned to the beneficiary. CMS will facilitate the sharing of programming of enhanced claims editing tools, such as a "Superop event", by contacting FISS FIs through existing channels in order to automate this process subsequent to the setting of the parameter as much as possible.

Use of the modifier GA suggests notification is required, however, there is no **required** notice if beneficiaries elect to receive services that are excluded from Medicare by statute. Nonetheless, providers are advised to respect Medicare beneficiaries' right to information about their care by informing them of noncoverage for statutory exclusions prior to treatment. An explanation and sample notice suggested for this purpose can be found at the CMS Web site at *www.cms.hhs.gov/medlearn/refabn.asp*.

When possible, providers should still be splitting items not covered by statute onto separate no payment claims. These claims use the condition code 21, and all services on such claims must be submitted as noncovered. ❖

Source: CMS Notification Dated March 27, 2003, PCM # 0308501

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# Skilled Nursing Facility Services

## Clarification of Types of Bill 22x and 23x Submitted by Skilled Nursing Facilities

The Centers for Medicare & Medicaid Services has clarified when skilled nursing facilities (SNFs) should be reporting type of bill (TOB) 23x as opposed to TOB 22x, in those situations where the SNF elects to limit its Medicare participation to only a distinct part of the overall institution. TOB 23x is used for beneficiaries who are placed in the Medicare non-certified part of the institution. TOB 22x is used for those SNF residents who are in noncovered stays but are placed in the Medicare-certified distinct part of the institution. TOB 22x is subject to SNF consolidating billing edits, while TOB 23x is not.

Under the SNF consolidated billing legislation, a beneficiary was considered a "resident" of the SNF for consolidated billing purposes no matter where (certified or non-certified part of the institution) the beneficiary was placed. Subsequent legislation revised the "resident" definition to include only individuals who were actually placed in the Medicare-certified part of the institution. Because those individuals who are placed in the Medicare non-certified area of the institution are no longer considered SNF "residents," it is appropriate to use type of bill 23x (non-resident) rather than 22x (resident).

### Policy for SNF Certification

Regulations for certification of SNFs specify that for Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the "facility" is always the entity that participates in the program. Therefore, when the institution limits its Medicare SNF participation to a distinct part SNF, and moves a beneficiary who has exhausted Part A benefits from the Medicare-certified distinct part SNF to a Medicare non-certified area of the institution, the beneficiary has technically ceased to reside in the Medicare-certified SNF and, thus, is appropriately billed as a "non-resident" of the SNF using type of bill 23x.

### Billing Requirements

In situations where an institution limits its Medicare participation as a SNF to only a distinct part of the institution, TOB 23x rather than 22x is used for those beneficiaries who reside in the Medicare non-certified part of the institution. When TOB 22x is used for Part B services (e.g., lab tests, immunizations) furnished to such a beneficiary, it incorrectly identifies the beneficiary as a resident of the Medicare SNF. This, in turn, could inappropriately trigger SNF consolidated billing edits for therapy services that the beneficiary receives in the outpatient hospital setting. Instead, services furnished to SNF nonresidents (i.e., to beneficiaries residing in the Medicare non-certified part of the institution, as well as to outpatients) are billed using type of bill 23x. Section 560 of the Medicare SNF Manual (Pub. 12) classifies type of bill 22x as applying to Part B services furnished to SNF residents, and type of bill 23x as applying to Part B services furnished to non-residents of the SNF. ❖

Source: CMS Transmittal A-03-040, CR 2674

*Reference Regulation:* Section 4432(b) of the Balanced Budget Act (BBA) of 1997 (P.L. 105-33)
Section 313 of the Benefits Improvement and Protection Act of 2000, P.L. 106-554)
Title 42 of the Code of Federal Regulations (42 CFR), Part 483.5

## Quarterly Update for Skilled Nursing Facility Consolidated Billing

Under the consolidated billing requirement, skilled nursing facilities must submit Medicare claims to the fiscal intermediary for all the Part A and Part B services that its residents receive during the course of a covered Part A stay except for a small number of excluded services. For beneficiaries in a Part B stay, only physical, occupational and speech therapy services must be consolidated.

Effective March 1, 2003, the payment status on the Medicare physician fee schedule database for procedure code *92597 (Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech)*, changed from "Not valid for Medicare purposes" to "Active."

Effective for services rendered **on or after October 1, 2003,** procedure code *92597* is considered part of speech therapy services consolidated in either a Part A or Part B stay. ❖

Source: CMS Transmittal AB-03-094, CR 2781

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## Claim Submission after Skilled Level of Care Ended

The Centers for Medicare & Medicare Services is issuing a reminder to skilled nursing facilities and hospital swing bed providers of the need to submit a bill as soon as possible when the beneficiary ceases to need skilled care.

Once a beneficiary has exhausted his/her benefits, many SNFs are not submitting a bill to indicate when the beneficiary ceases to need skilled care. This notification serves to remind the above providers that a bill is required whenever the beneficiary ceases to need skilled care, whether or not said beneficiary has any Medicare benefits remaining. This is necessary for the common working file system to correctly calculate the spell of illness.

Instructions to this effect are in the Medicare SNF Manual in the second paragraph of section 527.

Providers are to show the end of the need for skilled care by using occurrence code (OC) 22 – date active care ended, in the appropriate form locator of a nonpayment inpatient SNF bill, as follows:

| | | |
|---|---|---|
| **Type of Bill** | = | 210 |
| **Date of Admission** | = | the date the beneficiary entered the SNF |
| **Patient Status** | = | 30, still patient |
| **OC A3, B3, or C3** | = | the date benefits were exhausted, which may or may not have already occurred and been reported. If benefits are not exhausted, this OC will not appear on the bill **and/or** |
| **OC 22** | = | the date the beneficiary ceased to need skilled care. ❖ |

Source: CMS Notification Dated June 9, 2003

# 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 July 1, 2003,** and represent the Medicare maximum reimbursement for separately billable ESRD drugs and/or pharmaceuticals.

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 | $ 2.08 |
| J0210* | Aldomet, methyldopate HCL, up to 250 mg | $11.88 |
| J2997 | Alteplase, recombinant, activase, 1 mg | $35.63 |
| 00047 | Amikin, Amikacin, 100 mg/2 cc | $30.88 |
| 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 | $ 1.74 |
| J3430 | Aquamephyton, phytonaidione (vitamin K), 1 mg | $ 2.42 |
| J0380* | Aramine, metaraminol bitartrate, 10 mg | $ 1.27 |
| J7504 | Atgam, lymphocyte immune globine, 250 mg | $290.31 |
| J2060 | Ativan, lorazepam, 2 mg | $ 3.14 |
| J0460 | Atropine sulfate, 0.3 mg | $ 0.83 |
| X0004 | Azactam, aztreonam, 1 gm | $17.94 |
| 00151 | Bactrim, 80 mg/ml-16 mg/ml, 5 cc | $ 3.07 |
| J0530 | Bicillin C-R, penicillin-G, 600,000 units | $10.64 |
| J0540 | Bicillin C-R, penicillin-G, 1,200,000 units | $23.40 |
| J0550 | Bicillin C-R, penicillin-G, 2,400,000 units | $44.75 |
| J0560 | Bicillin L-A,penicillin-G, 600,000 units | $ 9.89 |
| 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 | $ 0.97 |
| J0636 | Calcijex, calcitriol, 0.1 mcg | $ 1.38 |
| J0630 | Calcitonin-salmon, up to 400 units | NC |
| X0014 | Calcium chloride 10%, 10 cc | $2.05 |
| 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 | $10.60 |
| 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 | $3.56 |

*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 | $ 0.48 |
| J0800 | Corticotropin Acthar Gel 40 Units | $92.94 |
| J0835 | Cortrosyn, cosyntropin, 0.25 mg | $16.76 |
| J9070 | Cyclophosphamide, Cytoxan, 100 mg | $ 5.98 |
| J9080 | Cyclophosphamide, Cytoxan, 200 mg | $11.34 |
| J9090 | Cyclophosphamide, Cytoxan, 500 mg | $23.81 |
| J9091 | Cyclophosphamide, Cytoxan, 1 gm | $47.64 |
| J9092 | Cyclophosphamide, Cytoxan, 2 gm | $95.27 |
| 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 | $ 5.15 |
| J1080 | Depo-Testosterone, 1 cc, 200 mg | $ 8.94 |
| 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 | $ 1.49 |
| J1200* | Diphenhydramine HCL (Benadryl), up to 50 mg | $ 1.61 |
| X0023* | 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 | $13.35 |
| J9190 | Fluorouracil, 500 mg | $ 2.27 |
| X0100 | Folic Acid, 5 mg/cc | $1.28 |
| J0713 | Fortaz, ceftazidime, 500 mg | $ 6.75 |
| J1470 | Gamma globulin, 2 cc | $22.80 |
| J1550 | Gamma globulin, 10 cc | $114.00 |

| *CPT*/HCPCS CODE | NAME | PRICE |
|---|---|---|
| J1570 | Ganciclovir sodium, Cytovene, 500 mg | $35.25 |
| J1580 | Garamycin, gentamicin, 80 mg | $ 1.77 |
| J1630 | Haldol, haloperidol, 5 mg | $ 7.13 |
| J1644* | Heparin sodium 1000 units | $ 0.38 |
| 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 | $17.81 |
| J1720 | Hydrocortisone sodium succinate (Solu-Cortef), 100 mg | $ 1.73 |
| J3410 | Hydroxyzine HCL, 25 mg | $ 1.21 |
| J1561 | Immune globulin, Gammimune N, 5%, 500 mg) | $42.75 |
| J1563 | Immune globulin, intravenous, 1 gm | $55.20 |
| 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 | $ 4.01 |
| 90658 | Influenza virus vaccine, split virus, 3 years and above dosage | $ 4.01 |
| 90659 | Influenza virus vaccine, whole virus | $ 8.02 |
| 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 | $ 1.52 |
| J1940 | Lasix, furosemide, 20 mg | $1.01 |
| X0056 | Levophed bitartrate, Norepinephrine bitartrate 4 cc | $10.43 |
| X0043 | Levothyroxine, 0.2 mg | $24.85 |
| J1990 | Librium, chlordiazepoxide hydrochloride, 100 mg | $24.99 |
| J2000* | Lidocaine HCL, 50 cc | $ 1.18 |

*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 | $3.03 |
| J1051 | Medroxyprogesterone acetate, Depo-Provera, 50 mg | $ 4.98 |
| J0694 | Mefoxin, cefoxitin sodium, 1 gm | $10.69 |
| 00987 | Mezlin, Mezlocillin, 1 gm | $ 4.24 |
| J2270 | Morphine sulfate, 10 mg | $0.72 |
| J7505 | Muromonab-CD3, parenteral, 5 mg | $777.31 |
| 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 | $ 2.26 |
| J3260 | Nebcin, tobramycin sulfate, 80 mg | $ 6.38 |
| 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 | $ 9.05 |
| X0101 | Pentam, 300 mg | $93.81 |
| J2550 | Phenergan, promethazine HCL, 50 mg | $ 2.85 |
| J2560 | Phenobarbital sodium, 120 mg | $ 1.62 |
| 01231 | Pipracil, Piperacillin sodium, 1 gm | $ 7.01 |
| 90732 | Pneumovax, Pneumococcal vaccine 0.5 cc | $13.10 |
| J3480* | Potassium chloride, per 2 mEq/ml | $ 0.08 |
| J1410 | Premarin, estrogen congugated, 25 mg | $56.75 |
| J0743 | Primaxin-I.M., 500 mg | $29.86 |
| J0743 | Primaxin-I.V., 250 mg | $15.87 |
| J0780 | Prochlorperazine, Compazine, up to 10 mg | $ 2.45 |
| X0076 | Prolastin, 500 mg | $104.50 |
| J2680 | Prolixin Decanoate, fluphenazine, 25 mg | $13.89 |
| J2690* | Pronestyl, procainamide HCL, 1 gm | $11.03 |
| J2720* | Protamine sulfate, 10 mg | $0.76 |
| J2765 | Reglan, metoclorpramide HCL, 10 mg | $ 2.07 |
| J0696 | Rocephin, ceftriaxone sodium, 250 mg | $14.92 |

*This drug is included in the composite rate.

| *CPT*/HCPCS CODE | NAME | PRICE |
|---|---|---|
| 89991 | Sandoglobulin, 1gm | $86.81 |
| X0102 | Septra, 80 mg/ml-16 mg/ml, 5 ml | $3.07 |
| X0038 | Sodium bicarbonate 8.4%, 50 cc | $ 2.74 |
| 00515 | Sodium chloride 9%, 30 cc | $1.39 |
| 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 | $5.94 |
| J1720 | Solu Cortef, hydrocortisone sodium succinate 100 mg | $1.73 |
| X0040 | Solu Cortef 500 mg | $6.64 |
| J2920 | Solu-Medrol, methylprednisolone sodium succinate, up to 40 mg | $ 1.58 |
| J2930 | Solu-Medrol, methylprednisolone sodium succinate, up to 125 mg | $ 1.92 |
| 01478 | Stadol, 1 mg | $ 7.66 |
| 01479 | Stadol, 2 mg | $ 7.81 |
| J3010 | Sublimaze, fentanyl citrate, 2 cc | $ 0.93 |
| J3070 | Talwin Lactate, pentazocine HCL, 30 mg | $ 5.23 |
| 01601 | Talwin Lactate, 60 mg | $ 8.01 |
| J3120 | Testosterone enanthate, Delatestryl enanthate, up to 100 mg | $ 0.57 |
| J3130 | Testosterone enanthate, Delatestryl enanthate, up to 200 mg | $16.25 |
| J3150 | Testosterone propionate, up to 100 mg | $ 1.71 |
| 90703 | Tetanus toxoid, 1.ml | $14.37 |
| J3230 | Thorazine, chlorpromazine HCL, up to 50 mg | $ 3.97 |
| 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 | $26.80 |
| X0099 | Unasyn, 3 gm | $21.01 |
| J3360 | Valium, diazepam, 5 mg | $ 0.97 |
| J3370 | Vancocin, vancomycin HCL, 500 mg | $ 7.03 |
| W0233 | Venofer, 100 5 mg | $65.36 |

*End-Stage Renal Disease Drug Pricing Update (continued)*

| *CPT*/HCPCS CODE | NAME | PRICE |
|---|---|---|
| X0057* | Verapamil, 5 mg | $ 2.14 |
| J2250 | Versed, midazolam HCL, 1 mg | $ 1.15 |
| X0044 | Vibramycin, Doxycycline, 100 mg | $14.01 |
| J3420 | Vitamin B-12 cyanocobalamin, up to 1,000 mcg | $ 1.13 |
| 00522 | Water for injection, 30 cc | $ 1.90 |
| 00521 | Water for injection, 500 cc | $ 7.13 |
| J2501 | Zemplar, 1 mcg | $ 5.02 |
| J0697 | Zinacef, cefuroxime sodium, 750 mg | $6.42 |
| X0062 | Zofran, 2 mg/1 cc | $12.18 |
| 01958 | Zovirax, 500 mg | $46.55 |

* This drug is included in the composite rate.

## End Stage Renal Disease Reimbursement for Automated Multi-Channel Chemistry Tests

The Office of Inspector General (OIG) conducted several studies that identified ESRD laboratory related services were not paid in compliance with Medicare payment policy. In response to the payment vulnerabilities identified by the OIG, CMS has issued claim-processing instructions to implement changes to ensure that ESRD laboratory claims are paid in accordance with Medicare payment policy.

Medicare provides reimbursement for certain routine clinical diagnostic laboratory tests rendered to an ESRD beneficiary within the composite rate payment to the ESRD facility.

Medicare guidelines state that separate payment may be made for the clinical diagnostic laboratory test rendered on a particular date of service when 50 percent or more of the covered tests billed for that particular date of service are non-composite rate tests.

### Reimbursement Guidelines

Clinical diagnostic laboratory tests included under the composite rate payment are paid through the composite rate paid by the intermediary. To determine if separate payment is allowed for non-composite rate tests for a particular date of service, 50 percent or more of the covered tests must be non-composite rate tests.

Medicare will apply the following guidelines to automated multi-channel chemistry (AMCC) tests for ESRD beneficiaries:

1) Payment is at the lowest rate for services performed by the same provider, for the same beneficiary, for the same date of service.
2) Identify for a particular date of service the AMCC tests ordered that are included in the composite rate and those that are not included. The composite rate tests are defined for hemodialysis, intermittent peritoneal dialysis (IPD), continuous cycling peritoneal dialysis (CCPD), and hemofiltration (see table 1) and for continuous ambulatory peritoneal dialysis (CAPD) (see table 2).
3) If 50 percent or more of the covered tests are included under the composite rate payment, then all submitted tests are included within the composite payment. In this case, no separate payment in addition to the composite rate is made for any of the separately billable tests.
4) If less than 50 percent of the covered tests are composite rate tests, all AMCC tests submitted for that date of service are separately payable.
5) A non-composite rate test is defined as any test separately payable outside of the composite rate or beyond the normal frequency covered under the composite rate that is reasonable and necessary.

### Policy Implementation

Three pricing modifiers discretely identify the different payment situations for ESRD AMCC tests. The physician that orders the tests is responsible for identifying the appropriate modifier when ordering the tests.

**CD** AMCC test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable

**CE** AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity

**CF** AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable

ESRD clinical diagnostic laboratory tests identified with modifiers “CD”, “CE” or “CF” may not be billed as organ or disease panels. Effective for services furnished **on or after October 1, 2003,** all ESRD clinical diagnostic laboratory tests must be billed individually.

The intermediary standard system will calculate the number of AMCC tests provided for any given date of service. All AMCC tests with a CD modifier will be added and divided by the sum of all tests with a CD, CE and CF modifier for the same beneficiary and billing provider for any given date of service.

If the result of the calculation for a date of service is 50 percent or greater, Medicare will not pay the AMCC tests.

If the result of the calculation for a date of service is less than 50 percent, Medicare will pay for the AMCC tests.

All tests for a date of service must be billed on the monthly ESRD bill. Providers must send in an adjustment if they identify additional tests that have not been billed. ❖

***End Stage Renal Disease Reimbursement for Automated Multi-Channel Chemistry Tests (continued)***

**Table 1 – Automated Multi-Channel Chemistry Tests**

| Chemistry | *CPT* Code | Monthly Composite Rate Test |
|---|---|---|
| 1 Albumin | *82040* | Yes |
| 2 Alkaline phosphatase | *84075* | Yes |
| 3 ALT (SGPT) | *84460* | No |
| 4 AST (SGOT) | *84450* | Yes |
| 5 Bilirubin, total | *82247* | No |
| 6 Bilirubin, direct | *82248* | No |
| 7 Calcium | *82310* | Yes |
| 8 Chloride | *82435* | No |
| 9 Cholesterol | *82465* | No |
| 10 CK, CPK | *82550* | No |
| 11 $CO_2$ (bicarbonate) | *82374* | Yes |
| 12 Creatinine | *82565* | Yes |
| 13 GGT | *82977* | No |
| 14 Glucose | *82947* | No |
| 15 LDH | *83615* | Yes |
| 16 Phosphorus | *84100* | Yes |
| 17 Potassium | *84132* | Yes |
| 18 Protein, total | *84155* | Yes |
| 19 Sodium | *84295* | Yes |
| 20 Triglycerides | *84478* | No |
| 21 Urea nitrogen (BUN) | *84520* | Yes |
| 22 Uric Acid | *84550* | No |

**Table 2 – Automated Multi-Channel Chemistry Tests**

| Chemistry | *CPT* Code | Composite Rate Test |
|---|---|---|
| 1 Albumin | *82040* | Yes – Monthly |
| 2 Alkaline phosphatase | *84075* | Yes – Monthly |
| 3 ALT (SGPT) | *84460* | No |
| 4 AST (SGOT) | *84450* | Yes – Monthly |
| 5 Bilirubin, total | *82247* | No |
| 6 Bilirubin, direct | *82248* | No |
| 7 Calcium | *82310* | Yes – Monthly |
| 8 Chloride | *82435* | Yes – Monthly |
| 9 Cholesterol | *82465* | No |
| 10 CK, CPK | *82550* | No |
| 11 $CO_2$ (bicarbonate) | *82374* | Yes – Monthly |
| 12 Creatinine | *82565* | Yes – Weekly |
| 13 GGT | *82977* | No |
| 14 Glucose | *82947* | No |
| 15 LDH | *83615* | Yes – Monthly |
| 16 Phosphorus | *84100* | Yes – Monthly |
| 17 Potassium | *84132* | Yes – Monthly |
| 18 Protein, total | *84155* | Yes – Monthly |
| 19 Sodium | *84295* | No |
| 20 Triglycerides | *84478* | No |
| 21 Urea nitrogen (BUN) | *84520* | Yes – 13 x Quarter |
| 22 Uric Acid | *84550* | No |

Source: CMS Transmittal A-03-033, CR 2277
Reference: Provider Reimbursement Manual section 2711

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# CRITICAL ACCESS HOSPITAL SERVICES

## July 2003 Update to the Medicare Outpatient Code Edit

The Medicare outpatient code editor (OCE) specifications (version 18.2) have been updated with the July 2003 new additions, changes, and deletions to the *Current Procedural Terminology*/Healthcare Common Procedure Coding System (*CPT*/HCPCS) codes.

This OCE update is used to process bills from hospitals that are not paid under the outpatient prospective payment system. Below are the specifications to the July 2003 update to the Medicare OCE (version 18.2).

### Changes Retroactive to August 1, 2000

**Non-Covered List Changes**

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

*80050*

**Non-Reportable List Changes**

**Added** to the list of non-reportable procedures, effective August 1, 2000:

*99361* *99362*

### Changes Retroactive to January 1, 2003

**Non-Reportable List Changes**

**Removed** from the list of non-reportable procedures, effective January 1, 2003:

*92597*

**Questionable Covered List Changes**

**Removed** from the list of questionable covered procedures, effective January 1, 2003:

*90846*

### Changes Retroactive to April 1, 2003

**HCPCS Code Changes**

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

Q3031

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

G0025

### Changes Effective July 1, 2003

**Non-Reportable List Changes:**

**Added** to the list of non-reportable procedures, effective July 1, 2003:

*92510*

**Removed** from the list of non-reportable procedures, effective July 1, 2003:

G0290 G0291

**Non-Covered List Changes**

**Removed** from the list of non-covered procedures, effective July 1, 1, 2003:

*72198*

**HCPCS Code Changes**

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

K0606 K0607 K0608 K0609 K0610
K0611 K0612 K0613 K0614 K0615
K0616 K0617 K0618 K0619 K0620
K0621 Q4052 Q4053

**Note:** Claims for these services should be billed to durable medical equipment regional carrier.

**Deleted** from the list of valid HCPCS, effective July 1, 2003:

C1207 C9119

### Ambulatory Surgical Center (ASC) Code Changes

**Added** to the list of valid ASC procedures, **effective July 1, 2003:**

| Code | Group | Code | Group | Code | Group | Code | Group | Code | Group | Code | Group |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 10121 | 2 | 11010 | 2 | 11011 | 2 | 11012 | 2 | 15351 | 2 | 15401 | 2 |
| 15775 | 3 | 15776 | 3 | 15820 | 3 | 15821 | 3 | 15822 | 3 | 15823 | 5 |
| 15824 | 3 | 15825 | 3 | 15826 | 3 | 15828 | 3 | 15829 | 5 | 15831 | 3 |
| 15832 | 3 | 15833 | 3 | 15834 | 3 | 15835 | 3 | 15876 | 3 | 15877 | 3 |
| 15878 | 3 | 15879 | 3 | 19316 | 4 | 19324 | 4 | 19325 | 9 | 19355 | 4 |
| 20692 | 3 | 20693 | 3 | 21015 | 3 | 21029 | 2 | 21046 | 2 | 21047 | 2 |
| 21121 | 7 | 21122 | 7 | 21123 | 7 | 21127 | 9 | 21181 | 7 | 21295 | 1 |
| 21296 | 1 | 21336 | 4 | 21345 | 7 | 23031 | 3 | 24006 | 4 | 24305 | 4 |
| 24341 | 3 | 24345 | 2 | 25337 | 5 | 25830 | 5 | 26185 | 4 | 26546 | 4 |
| 26608 | 4 | 27067 | 5 | 27257 | 3 | 27329 | 4 | 27347 | 4 | 27357 | 5 |
| 27358 | 5 | 27496 | 5 | 27497 | 3 | 27498 | 3 | 27499 | 3 | 27594 | 3 |
| 27600 | 3 | 27601 | 3 | 27602 | 3 | 27647 | 3 | 27889 | 3 | 27892 | 3 |
| 27893 | 3 | 27894 | 3 | 28011 | 3 | 28022 | 2 | 28024 | 2 | 28052 | 2 |
| 28126 | 3 | 28153 | 3 | 28160 | 3 | 28234 | 2 | 28270 | 3 | 28289 | 3 |
| 28531 | 3 | 29800 | 3 | 29827 | 5 | 29848 | 9 | 29860 | 4 | 29861 | 4 |

***July 2003 Update to the Medicare Outpatient Code Edit (continued)***

| Code | Group | Code | Group | Code | Group | Code | Group | Code | Group | Code | Group |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 29862 | 9 | 29863 | 4 | 29891 | 3 | 29892 | 3 | 29893 | 9 | 29899 | 3 |
| 30460 | 7 | 30462 | 9 | 30465 | 9 | 30545 | 5 | 30930 | 4 | 31081 | 4 |
| 31085 | 4 | 31087 | 4 | 31400 | 2 | 31420 | 2 | 31623 | 2 | 31624 | 2 |
| 31643 | 2 | 33222 | 2 | 33223 | 2 | 35188 | 4 | 35207 | 4 | 35875 | 9 |
| 35876 | 9 | 36260 | 3 | 36488 | 1 | 36490 | 1 | 36831 | 9 | 36870 | 9 |
| 37607 | 3 | 37650 | 2 | 37790 | 3 | 38570 | 9 | 38571 | 9 | 38572 | 9 |
| 40700 | 7 | 40701 | 7 | 40720 | 7 | 40761 | 3 | 42226 | 5 | 42415 | 7 |
| 42820 | 3 | 42825 | 4 | 42830 | 4 | 42835 | 4 | 42890 | 7 | 42892 | 7 |
| 42972 | 3 | 43201 | 1 | 43205 | 1 | 43231 | 2 | 43232 | 2 | 43236 | 2 |
| 43240 | 2 | 43242 | 2 | 43244 | 2 | 43256 | 3 | 43653 | 9 | 44370 | 9 |
| 44376 | 2 | 44377 | 2 | 44378 | 2 | 44379 | 9 | 44383 | 9 | 45160 | 2 |
| 45190 | 9 | 45335 | 1 | 45340 | 1 | 45381 | 2 | 45386 | 2 | 46288 | 4 |
| 46615 | 2 | 46761 | 3 | 46762 | 7 | 46917 | 1 | 47511 | 9 | 47556 | 9 |
| 49422 | 1 | 49495 | 4 | 49496 | 4 | 49500 | 4 | 49501 | 9 | 49507 | 9 |
| 49521 | 9 | 49553 | 9 | 49557 | 9 | 49561 | 9 | 49566 | 9 | 49568 | 7 |
| 49572 | 9 | 49580 | 4 | 49582 | 9 | 49587 | 9 | 49600 | 4 | 50947 | 9 |
| 50948 | 9 | 51050 | 4 | 51065 | 4 | 51080 | 1 | 51520 | 4 | 51715 | 3 |
| 52282 | 9 | 52327 | 2 | 52341 | 3 | 52342 | 3 | 52343 | 3 | 52344 | 3 |
| 52345 | 3 | 52346 | 3 | 52355 | 4 | 52510 | 3 | 52647 | 9 | 52648 | 9 |
| 53080 | 3 | 53270 | 2 | 53850 | 9 | 54000 | 2 | 54111 | 2 | 54112 | 2 |
| 54150 | 1 | 54160 | 2 | 54304 | 3 | 54308 | 3 | 54312 | 3 | 54316 | 3 |
| 54318 | 3 | 54322 | 3 | 54324 | 3 | 54326 | 3 | 54328 | 3 | 54340 | 3 |
| 54344 | 3 | 54348 | 3 | 54352 | 3 | 54380 | 3 | 54385 | 3 | 54400 | 3 |
| 54401 | 3 | 54405 | 3 | 54406 | 3 | 54408 | 3 | 54410 | 3 | 54415 | 3 |
| 54416 | 3 | 54522 | 3 | 54690 | 9 | 55250 | 2 | 55550 | 9 | 55725 | 2 |
| 55859 | 9 | 57023 | 1 | 57289 | 5 | 57291 | 5 | 57415 | 2 | 57556 | 5 |
| 58350 | 3 | 58545 | 9 | 58546 | 9 | 58550 | 9 | 58560 | 3 | 58562 | 3 |
| 59160 | 3 | 59320 | 1 | 59812 | 5 | 59820 | 5 | 59821 | 5 | 59840 | 5 |
| 59841 | 5 | 59870 | 5 | 59871 | 5 | 61886 | 3 | 62281 | 1 | 62287 | 9 |
| 62355 | 2 | 64553 | 1 | 64573 | 1 | 64577 | 1 | 64580 | 1 | 64585 | 1 |
| 64821 | 4 | 64885 | 2 | 64886 | 2 | 65772 | 4 | 65775 | 4 | 66825 | 4 |
| 67027 | 4 | 67334 | 4 | 67335 | 4 | 67900 | 4 | 68115 | 2 | 68770 | 4 |
| 69300 | 3 | 69714 | 9 | 69715 | 9 | 69717 | 9 | 69718 | 9 | G0260 | 1 |

**Deleted** from the list of valid ASC procedures, **effective July 1, 2003:**

| Code | Group | Code | Group | Code | Group | Code | Group | Code | Group | Code | Group |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 15756 | 3 | 15757 | 3 | 15758 | 3 | 15842 | 4 | 16030 | 1 | 16035 | 2 |
| 19260 | 5 | 19364 | 5 | 20660 | 2 | 20661 | 3 | 20662 | 3 | 20663 | 3 |
| 20665 | 1 | 20955 | 4 | 20962 | 4 | 20969 | 4 | 20970 | 4 | 20972 | 4 |
| 20973 | 4 | 21343 | 5 | 21360 | 4 | 21365 | 5 | 21385 | 5 | 21386 | 5 |
| 21387 | 5 | 21390 | 7 | 21395 | 7 | 21406 | 4 | 21407 | 5 | 21422 | 5 |
| 21470 | 5 | 21495 | 4 | 21510 | 3 | 21550 | 1 | 21620 | 2 | 21810 | 2 |
| 21920 | 1 | 22100 | 3 | 22101 | 3 | 22102 | 3 | 22103 | 3 | 22325 | 3 |
| 22326 | 3 | 22327 | 3 | 22328 | 3 | 23065 | 1 | 24065 | 1 | 24150 | 3 |
| 24151 | 4 | 24152 | 3 | 24153 | 4 | 25065 | 1 | 25170 | 3 | 26035 | 4 |
| 26037 | 4 | 26551 | 4 | 26553 | 2 | 26554 | 2 | 26992 | 2 | 27030 | 3 |
| 27303 | 2 | 27440 | 5 | 27507 | 4 | 27511 | 4 | 27513 | 5 | 27524 | 3 |
| 27535 | 3 | 27613 | 1 | 27715 | 4 | 30124 | 1 | 31584 | 4 | 31600 | 2 |
| 31710 | 1 | 31715 | 1 | 31785 | 4 | 31800 | 2 | 32002 | 2 | 32005 | 2 |
| 32020 | 2 | 34101 | 3 | 38700 | 2 | 38790 | 1 | 40805 | 2 | 40806 | 1 |
| 40820 | 1 | 41000 | 1 | 41105 | 2 | 41110 | 1 | 41115 | 1 | 41805 | 1 |
| 41806 | 1 | 42104 | 2 | 42106 | 2 | 42160 | 1 | 42225 | 5 | 42281 | 3 |
| 42335 | 3 | 44345 | 4 | 44346 | 4 | 49000 | 4 | 49400 | 1 | 49425 | 2 |
| 50020 | 2 | 50040 | 3 | 50520 | 1 | 50570 | 1 | 50572 | 1 | 50574 | 1 |
| 50576 | 1 | 50578 | 1 | 50580 | 1 | 50684 | 1 | 50690 | 1 | 51005 | 1 |
| 51600 | 1 | 51605 | 1 | 51610 | 1 | 51725 | 1 | 51865 | 4 | 51900 | 4 |
| 51920 | 3 | 54125 | 2 | 55600 | 1 | 55605 | 1 | 55650 | 1 | 56405 | 2 |
| 56605 | 1 | 57310 | 3 | 57311 | 4 | 57320 | 3 | 57800 | 1 | 60220 | 2 |
| 60225 | 3 | 62256 | 2 | 62351 | 2 | 62367 | 2 | 62368 | 2 | 69424 | 1 |
| 69710 | 3 ❖ | | | | | | | | | | |

Source: CMS Transmittal A-03-050, CR 2768

# HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

## July 2003 Update to the Hospital Outpatient Prospective Payment System

CMS has issued changes to the hospital outpatient PPS for July 2003. The July 2003 update to the outpatient code editor (OCE) and the PRICER software systems reflects HCPCS and ambulatory payment classification (APC) addition, changes and revisions, identified in this notification. Unless otherwise noted, all changes discussed in this notification are effective for services furnished **on or after July 1, 2003.**

### New HCPCS Codes Under the Hospital OPPS

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

C1818 Integrated keratoprosthesis
**Assigned APC: 1818**

C8918 Magnetic resonance angiography with contrast, pelvis
**Assigned APC: 0284**

C8919 Magnetic resonance angiography without contrast, pelvis
**Assigned APC: 0336**

C8920 Magnetic resonance angiography without contrast, followed by with contrast, pelvis
**Assigned APC: 0337**

C9205 Injection, oxaliplatin, per 5 mg
**Assigned APC: 9205**

K0606 Automatic external defibrillator with integrated electrocardiogram analysis, garment type
**Assigned APC: Not Applicable (N/A)**

K0607 Replacement battery for automatic external defibrillator, each
**Assigned APC: N/A**

K0608 Replacement garment for use with automatic external defibrillator, each
**Assigned APC: N/A**

K0609 Replacement electrodes for use with automatic external defibrillator, each
**Assigned APC: N/A**

K0610 Peritoneal dialysis clamp, each
**Assigned APC: N/A**

K0611 Disposable cycler set used with cycler dialysis machine, each
**Assigned APC: N/A**

K0612 Drainage extension line, sterile, for dialysis, each
**Assigned APC: N/A**

K0613 Extension line with easy lock
**Assigned APC: N/A**

K0614 Chemicals/antiseptic solutions used to clean/sterilize dialysis equipment, per 8 ounces
**Assigned APC: N/A**

K0615 Speech generating device, digitized speech, using prerecorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time
**Assigned APC: N/A**

K0616 Speech generating device, digitized speech, using prerecorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time
**Assigned APC: N/A**

K0617 Speech generating device, digitized speech, using prerecorded messages, greater than 40 minutes recording time
**Assigned APC: N/A**

K0618 TLSO, sagittal-coronal control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphsis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment
**Assigned APC: N/A**

K0619 TLSO, sagittal-coronal control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphsis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment
**Assigned APC: N/A**

K0620 Tubular elastic dressing, any width, per linear yard
**Assigned APC: N/A**

K0621 Gauze, packing strips, nonimpregnated, less than or equal to 2 inches, per linear yard
**Assigned APC: N/A**

*July 2003 Update to the Hospital Outpatient Prospective Payment System (continued)*

Q4052 Injection, octreotide, depot form for intramuscular injection, 1 mg
**Assigned APC:** N/A

Q4053 Injection, pegfilgrastim, per 1 mg
**Assigned APC:** N/A

## Changes Affecting Drugs and Biologicals

**Deleted C-codes**

Effective for services furnished **on or after July 1, 2003,** the following C-codes are deleted and replaced with the following Q-codes:

| Deleted C-Code | Added Q-Code | Descriptor | APC |
|---|---|---|---|
| C1207 | Q4052 | Injection, octreotide, depot form for intramuscular injection, 1 mg | **1207** |
| C9119 | Q4053 | Injection, pegfilgrastim, per 1 mg | **9119** |

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

**Device Categories Eligible for Pass-Through Payment**

Below is a complete listing of the device categories that are eligible for pass-through payment under the OPPS, including one new category added **effective July 1, 2003.**

If a device is described by one of the existing device categories but is packaged as a component of a system, only the device that meets the pass-through criteria would be eligible for pass-through payment under the appropriate category.

| HCPCS | Category Long Descriptor | Effective Date |
|---|---|---|
| C1765 | Adhesion barrier | July 1, 2001 |
| C1783 | Ocular implant, aqueous drainage assist device | July 1, 2002 |
| C1814 | Retinal tamponade device, silicone oil | April 1, 2003 |
| **C1818*** | **Integrated keratoprosthesis** | **July 1, 2003** |
| C1884 | Embolization protective system | January 1, 2003 |
| C1888 | Catheter, ablation, non-cardiac, endovascular (implantable) | July 1, 2002 |
| C1900 | Lead, left ventricular coronary venous system | July 1, 2002 |
| C2614 | Probe, percutaneous lumbar discectomy | January 1, 2003 |
| C2618 | Probe, cryoablation | April 1, 2001 |
| C2632 | Brachytherapy solution, iodine – 125, per mCi | January 1, 2003 |

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

## Explanation of Terms/Definitions for Specific Category Codes

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

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

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

**Integrated keratoprosthesis (C1818)** – The device is composed of a flexible, one-piece biocompatible polymer. It is used to replace diseased corneas in conditions and patient states where traditional corneal transplantation is not indicated or possible. Implantation of the procedure is done in a two-stage surgical approach.

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

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

## Modifications to Existing HCPCS Codes and APC Groups

The following services are not payable under OPPS:

| *CPT*/HCPCS Code | Effective Date of Change |
|---|---|
| *0029T* | July 1, 2003 |
| *80050* | August 1, 2000 |
| *92510* | July 1, 2003 |
| *92597* | January 1, 2003 |
| K0552 | April 1, 2003 |

The following service is payable under OPPS:

| *CPT* Code | Effective Date of Change | APC Code |
|---|---|---|
| *0016T* | January 1, 2003 | 0235 |

**Modifications to APC Groups**

| APC Code | Effective Date of Change | Description |
|---|---|---|
| 1207 | July 1, 2003 | Octreotide injection, depot |
| 9119 | July 1, 2003 | Pegfilgrastim, per 1 mg |

## Billing and Payment Requirements for Observation Services

Medicare has previously instructed hospitals to use modifier 25 with HCPCS code G0263 (Direct admission of patient with diagnosis of congestive heart failure, chest pain or asthma for observation services that meet all criteria for G0244) in order to receive payment for G0244 (Observation care provided by a facility to a patient with CHF, chest pain, or asthma, minimum eight hours, maximum forty-eight hours). However, that instruction was incorrect. **Hospitals are not required to report modifier 25 with G0263.**

In addition, diagnostic services performed on the day before a patient is admitted to observation are not automatically allowed in meeting the requirement that certain

*July 2003 Update to the Hospital Outpatient Prospective Payment System (continued)*

diagnostic tests be performed in order to receive a separate payment for observation services. Hospitals must perform the specified diagnostic services during the period that begins with the date of the evaluation and management (E/M) visit, or the date the patient is admitted to critical care or directly admitted to observation, and ends when the patient has been in observation for 24 hours.

If the E/M visit that led to the observation is the day before, e.g., overnight ER visit leading to observation, any ancillary tests performed during that E/M visit are allowed toward the observation criteria. However, for patients who are direct admissions to observation from the physician's office, ancillary tests done the day before would be unrelated to the observation period and would not be counted toward meeting the observation criteria.

## Drug-Eluting Stents

The Food and Drug Administration (FDA) approved drug-eluting stents effective April 24, 2003.

This notification provides updated billing instructions for the placement of drug-eluting stents.

**Effective for Services Furnished on or after July 1, 2003**

Medicare is implementing payment under APC 0656, transcatheter placement of drug-eluting coronary stents, for two temporary HCPCS codes that describe drug-eluting stents and their placement. Hospitals may include the charge for the drug-eluting stent in the charge for G0290 and G0291. Alternatively, hospitals may bill separately for the stent using an appropriate revenue code, making certain that the charge for the HCPCS procedure code does not include the charge for the stent. Payment for placement of the stents, and the stents themselves, will be made under APC 0656.

| HCPCS Code | APC | Descriptor |
|---|---|---|
| G0290 | 0656 | Transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel |
| G0291 | 0656 | Transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel |

**For Services Furnished in an Outpatient Setting prior to July 1, 2003**

Hospitals should bill for the placement of drug-eluting stents using procedure codes *92980* and *92981*. Hospitals may include the charge for the drug-eluting stent in the charge for *92980* and *92981*. Alternatively, hospitals may bill separately for the stent using an appropriate revenue code, making certain that the charge for the HCPCS procedure code does not include the charge for the stent. Payment for placement of the stents, and the stents themselves, will be made under APC 0104.

## Coding Instructions for Oxaliplatin (Eloxatin)

These coding instructions only indicate the method by which Eloxatin is paid under the OPPS, if it is covered by the Medicare program when the fiscal intermediary has determined that the drug meets all program requirements for coverage such as the drug is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment because it is usually self-administered. These instructions do not represent a determination that the Medicare program covers the drug.

**Effective for Services Furnished on or after July 1, 2003**

Payment for HCPCS code C9205, injection, oxaliplatin, per 5 mg, is effective for services furnished **on or after July 1, 2003.** Hospitals should bill for Eloxatin using HCPCS code C9205 under APC 9205 to allow a transitional pass-through payment under the OPPS.

**For Services Furnished prior to July 1, 2003**

Hospitals should use HCPCS code J3490 (Unclassified drugs) to bill for Eloxatin furnished to a beneficiary in the hospital outpatient setting. Although no separate payment is allowed under the OPPS for a drug billed with HCPCS J3490, charges associated with J3490 are split proportionally among all the other payable APCs on the claim and are added to the original charges for those other APCs. The resulting charges are converted to cost and used in determining whether the threshold for outlier payment is met. If the outlier threshold is met, claims will generate an outlier payment in addition to APC payments.

## Billing Instructions for A9518

The dosage descriptor for A9518 (Supply of radiopharmaceutical therapeutic imaging agent, I-131 sodium iodide solution) was changed from per millicurie (mCi) to per microcurie (uCi). Coding per microcurie may be problematic for some hospital charge masters in that there may be insufficient coding space to accommodate a large number of units. Under these circumstances, hospitals may break down the number of units and bill for A9518 on multiple lines. ❖

Source: CMS Transmittal A 03-051, CR 2771

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# COST REPORTING ISSUES

## Revision to Suspension, Offset, and Recoupment of Medicare Payments to Providers and Suppliers of Services

Effective immediately, if a provider cannot submit its cost report by the due date, then the provider may contact its fiscal intermediary (FI) prior to the cost report due date and request a reduction in the rate of suspension.

If the FI receives a request for a reduction in the rate of suspension, and the FI believes the request should be approved, the FI will recommend to the CMS regional office (RO) that the provider's suspension rate be reduced to 50 percent for a 60-day period. If the RO concurs, then the FI will suspend 50 percent of the provider's payments for the first 60 days the cost report is late. On the 61st day, if the cost report has not been filed, the rate of suspension will change to 100 percent.

If a provider fails to request a reduction in the rate of suspension, or if the FI does not concur with the request for a reduced suspension rate, then 100 percent of the provider's payments will be suspended if the cost report is not filed timely. Payment due dates and interest assessments are still based on the due date of the cost report

Terminated providers will immediately have 100 percent of their payments suspended for failure to file a cost report in a timely manner.

These instructions **supercede** previous instructions given related to the suspension of payment for providers that do not file their cost reports timely. ❖

Source: CMS Transmittal A-03-042, CR 2677

## Change in Methodology for Determining Payment for Outliers Under the Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems

Regulations at 42 CFR section 412.84 describe the criteria and procedures for determining whether an acute care hospital subject to the inpatient prospective payment system (IPPS) qualifies for an additional payment for extraordinarily costly cases, known as high-cost outliers. Regulations at 42 CFR section 412.525 and section 412.529 describe the criteria and procedures for determining whether a long-term care hospital (LTCH) subject to the LTCH prospective payment system (PPS) qualifies for high cost outlier and short stay outlier payments, respectively. A final rule, published on June 9, 2003 (68 FR 34494) revised the regulations at section 412.84 for hospitals subject to the IPPS and at section 412.525 and section 412.529 for LTCHs subject to the LTCH prospective payment system.

Under the existing IPPS and LTCH PPS outlier methodologies, the cost-to-charge ratios (CCRs) from hospitals' latest settled cost reports are used in determining whether a case qualifies for payment as an outlier and the amount of any such payment. Based on the final rule published in the *Federal Register* on June 9, 2003, the Centers for Medicare & Medicaid Services (CMS) has provided instructions for applying CCRs for IPPS hospitals and LTCHs, including: the use of alternative CCRs when directed by CMS or at the request of the hospital and the use of CCRs based on tentative settlements of cost reports for discharges on or after October 1, 2003; use of the statewide average; the criteria for identifying hospitals to be subject to reconciliation; and notification to hospitals about those updates.

Under the new section 412.84(i)(1) implemented in the final rule published in the *Federal Register* on June 9, 2003, for discharges occurring on or after August 8, 2003, in the event more recent charge data indicate that a hospital's charges have been increasing at an excessive rate (relative to the rate of increase among other hospitals), CMS may direct the fiscal intermediary to change the hospital's operating and capital CCRs to reflect the high charge increases evidenced by the later data. A hospital may also request that its fiscal intermediary use a different (higher or lower) CCR based on substantial evidence presented by the hospital.

Before a change based on a hospital's request can become effective, the CMS Regional Office must approve the change.

Currently, hospitals are assigned a statewide average CCR if their actual operating or capital CCR falls outside three standard deviations from the respective national geometric mean CCR. Effective August 8, 2003, a hospital will no longer be assigned the statewide average CCR when the hospital has a CCR that falls below three standard deviations from the national mean. Hospitals will receive their actual CCRs, no matter how low their ratios fall.

The statewide average CCRs may still apply in those instances in which a hospital's operating or capital CCRs exceed the upper threshold. In addition, hospitals that have not yet filed their first Medicare cost report may still receive the statewide average CCRs. CMS will continue to set forth the upper threshold (i.e., three standard deviations above the national geometric mean CCR) and the statewide CCRs applicable to IPPS hospitals and LTCHs in each year's annual notice of prospective payment rates published in the **Federal Register**. ❖

Source: CMS Transmittal A-03-058, CR 2785

# EDUCATIONAL RESOURCES

## Medicare Medifest 2003
## "Tampa Florida"

First Coast Service Options, Inc., is proud to present this year's third Medicare Medifest event. This two-day symposium is structured to offer a variety of educational sessions, which allows you to enroll in courses of your choice. Medifest is open to all Florida providers and billing personnel.

This event is packed with everything needed to help optimize providers' performance. All participants will have an opportunity to participate in several interactive workshops designed with hands-on exercises that underscore the training and provide you with the necessary skills needed to bill your Medicare services.

**When**
**August 26- 27, 2003**

**Where**
**Marriott Tampa Airport**
**Tampa International Airport**
**Tampa, Florida 33607**

**Registration**
**Please complete the registration form and class schedule and fax to: (904)-791-6035.**
**or**
**Register on-line at www.floridamedicare.com**

You can't afford to miss this event. Some of the many benefits are:

- You'll gain strategies to improve reimbursement.
- You'll discover proven methods to resolve your Medicare denials.
- Medicare experts will be on hand to answer your questions.

***The Medicare Medifest is a one-of-a-kind event guaranteed to increase your Medicare knowledge!***

**Please utilize only one registration form per attendee.**

**August 26 – 27, 2003**
**Marriott Tampa Airport**
**Tampa International Airport**
**Tampa, FL 33607**
**Please contact hotel for directions and or reservations (813) 879-5151**

**ON-LINE REGISTRATION**

1. Register through the Web site. A computer generated confirmation will be sent via e-mail.
2. An invoice will be faxed or e-mailed to you.
3. Make checks payable to: **FCSO Account #700390**
4. Mail a copy of the invoice and the check to:
   **Medifest Registration**
   **P.O. Box 45157**
   **Jacksonville, FL 32231**
5. Bring your Medifest confirmation notice to the event.

**FAXED REGISTRATION**

1. Fax both registration form and class schedule(s) to (904) 791-6035.
2. A confirmation and invoice will be faxed or e-mailed to you.
3. Make checks payable to: **FCSO Account #700390**
4. Mail the forms (after you have faxed them) and payment to:
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   **P.O. Box 45157**
   **Jacksonville, FL 32231**
5. Bring your Medifest confirmation notice to the event.

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Provider's Name ______________________________________________

Street Address ______________________________________________

City, State, ZIP Code ______________________________________________

Phone (          ) _________________ Fax (          ) ______________E-mail ______________________

**Payment is being issued for:**

| Seminar Cost | Price (each) |
|---|---|
| **Medifest** | **$159.00** |

**Important Registration Information:**

| Substitutions | Confirmation Notice |
|---|---|
| If you are unable to attend, your company may send **one substitute** to take your place for the **entire seminar**. Once you have signed in at the registration desk, substitutions will not be permitted during the remainder of the event.<br><br>**Remember:** Registration must be informed of all changes in advance. | **Faxed registration**: A confirmation notice will be faxed or e-mailed to you within 14 days of receiving your registration form. If you do not receive a confirmation notice (not the confirmation form generated from your fax machine, but the confirmation notice provided by Medicare Education and Outreach), please contact us at **(904) 791-8103.**<br><br>**On-line registration:** When registering on-line for an education event, you will automatically receive your confirmation via email notification. |

*For registration information, please visit our Web site at www.floridamedicare.com or call our registration hotline at (904) 791-8103.*

***Registration Is on a First Come First Serve Basis. Please Register As Soon As Possible.***

# MEDIFEST Class Schedule

**The price for the MEDIFEST Event is $159 per person.**

**August 26 -27, 2003**
**Marriott Tampa Airport**
**Tampa International Airport**
**Tampa, FL 33607**
**Please contact hotel for directions and/or reservations (813) 879-5151**

***Select one class per session (time slot).***

## DAY 1
## Tuesday/August 26

**8:30AM - 10:00AM SESSION 1/DAY 1**
- ❑ E/M Documentation (B)
- ❑ Fraud & Abuse (A/B)
- ❑ HOPPS: Outpatient Coding (A)
- ❑ Inquiries, Appeals & Overpayments (B)
- ❑ Medicare Secondary Payer (B)

**10:30AM - 12:00PM SESSION 2/DAY 1**
- ❑ Global Surgery/Modifiers (B)
- ❑ HOPPS: Legislative Update (A)
- ❑ Medical Review/Data Analysis (A/B)
- ❑ Medicare Secondary Payer (A)
- ❑ Navigating FCSO's Web Site (A/B)

**1:30PM - 4:30PM SESSION 3/DAY 1**
- ❑ CMS-1500/EMC (B)
- ❑ CPT for Beginners (A/B)*
- ❑ E/M Coding/Primary Care (B)
- ❑ ICD-9-CM for Beginners (A/B)*
- ❑ UB-92/DDE (A)

**6:00PM - 7:30PM SESSION 4/DAY 1**
- ❑ E/M Documentation (B)♦

*♦This session is designed for physicians only. There is no charge to attend this session.*

## DAY 2
## Wednesday/August 27

**9:00AM – 12:00PM SESSION 1/DAY 2**
- ❑ CMS-1500/EMC (B)
- ❑ CPT for Beginners (A/B)*
- ❑ E/M Coding/Primary Care (B)
- ❑ ICD-9-CM for Beginners (A/B)*
- ❑ UB-92/DDE (A)

**1:30AM - 3:00PM SESSION 2/DAY 2**
- ❑ Fraud & Abuse (A/B)
- ❑ Global Surgery/Modifiers (B)
- ❑ Medicare Secondary Payer (B)
- ❑ Navigating FCSO's Web Site (A/B)
- ❑ Reimbursement Efficiency (A)

**3:30PM - 5:00PM SESSION 3/DAY 2**
- ❑ E/M Documentation (B)
- ❑ Inquiries, Appeals & Overpayments (B)
- ❑ Part A Modifiers (A)
- ❑ Provider Enrollment (B)
- ❑ Rehabilitative Services (A)

***Participants are required to bring their 2003 CPT and ICD-9-CM books.***

***For complete class descriptors, please visit our Web site at www.floridamedicare.com***

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| FAXED REGISTRATION | CONFIRMATION NOTICE |
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| 1. Fax both registration form and class schedule(s) to **(904) 791-6035.**<br>2. A confirmation and invoice will be faxed or e-mailed to you.<br>3. Make checks payable to: **FCSO Account #700390**<br>4. Mail the forms (after you have faxed them) and payment to:<br>**Medifest Registration**<br>**P.O. Box 45157**<br>**Jacksonville, FL 32231**<br>5. Bring your Medifest confirmation notice to the event. | **Faxed registration**: A confirmation notice will be faxed or e-mailed to you within 14 days of receiving your registration form. If you do not receive a confirmation notice (not the confirmation form generated from your fax machine, but the confirmation notice provided by Medicare Education and Outreach), please contact us at **(904) 791-8103.**<br><br>**On-line registration:** When registering on-line for an education event, you will automatically receive your confirmation via e-mail notification. |

# How Hospitals Can Bill Medicare for Inpatient Influenza and Pneumococcal Immunizations

Hospitals may bill Medicare for inpatient influenza and pneumococcal vaccines through their fiscal intermediaries. The billing method and information on what Medicare pays for are described below.

## Direct Data Entry (DDE) – Roster Billing

Hospitals may bill the intermediary by using DDE. The appropriate procedure and diagnosis codes must appear on the claim:

| | Vaccine | Administration | Diagnosis Code |
|---|---|---|---|
| Influenza Vaccine | 90657-90659 | G0008 | V04.8 |
| Pneumococcal Vaccine | 90732 | G0009 | V03.82 |

Roster billing is a simplified billing process that allows **mass immunizers** to submit one claim form with a list of immunized beneficiaries. Part A providers must submit roster bills via Electronic Media Claims (EMC) or Direct Data Entry. The roster must include the following:

- Receipt Date, Provider Number, Date of Service
- Type of Bill – This is only a two-digit field
- Revenue Code – Up to two revenue codes may be entered on a screen
- HCPCS Code
- Charges Per Beneficiary
- Health Insurance Claim Number
- Last Name, First Name, Middle Initial
- Date of Birth, Sex

## What Medicare Pays For

Medicare pays for one influenza vaccination each season (not every twelve months) and one pneumococcal vaccine per lifetime. The pneumococcal vaccine may be administered more than once for persons with chronic health problems and for patients unsure of their vaccination status.

## Additional Information

Hospital staff should reference section 3660.7 of the Medicare Hospital Manual at **www.cms.hhs.gov** for detailed billing procedures.

The fiscal intermediary may be contacted directly at the following address and phone number:

First Coast Service Options, Inc.
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231
1-877-602-8816 (Toll Free)

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

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

## New Releases

Pages within the site containing information of immediate interest.

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

## Content–Part A and B

Both areas contain the following:

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

### Part A

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

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

### Part B

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

- ***Crossovers/Medigap* -** A listing of Medigap insurers and supplemental insurers (automatic crossover), and other helpful information.

### MCS

- Contains publications relative to FCSO's conversion to the Multi-Carrier System (MCS). Also includes the Part B System Issues Log.

## Shared Content

Provides information shared by Part A and Part B providers.

- ***Education & Training* -** Educational resources and calendar of events featuring online registration capabilities.
- ***Electronic Data Interchange (EDI)* -** Publications/news, forms/ applications, specification manuals for programmers and guidelines relevant to electronic transactions.
- ***FAQs* -** Providers' most frequently asked questions and answers.
- ***Fee Schedules* -** Medicare physicians fee schedule files and links to CMS files for download for Medicare payment systems.
- ***Forms* -** Various FCSO and CMS enrollment applications and forms.
- ***General Info* -** Information about other Medicare topics (not inclusive):
  - ***COB/MSP* -** Coordination of Benefits/Medicare Secondary Payer.
- ***Medicare Enrollment* -** Medicare provider enrollment applications and forms with instructions, which include paper and electronic versions of the CMS-855s.
- ***MEDPARD* -** Medicare Participating Physician and Supplier Directory.
- ***UPIN* -** Access to FCSO and national UPIN (unique physician identification number) directories.

## Extras

- ***eNews* -** FCSO electronic mailing list. Sign up to receive automatic email notification when new or updated information is posted to Florida Medicare's provider education Web site.
- ***Search* -** Enables visitors to search the entire site or individual areas within the site for specific topics or subjects.
- ***Links* -** Valuable links to resources on other Web sites.
- ***Contact Us* -** Important telephone numbers and addresses.

# Reader Survey—*Medicare A Bulletin*

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**Please complete the questions below and return your reply to us by September 30, 2003.**

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**On a scale of 5 to 1, with 5 being very satisfied and 1 being very dissatisfied**, how satisfied are you with the publication overall? Please ***circle*** the number that best applies.

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**5 4 3 2 1**

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"The *Medicare A Bulletin* assists me in performing my job."

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"The *Medicare A Bulletin* is arranged in a manner that makes it easy to find the information I need."

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# ORDER FORM - PART A MATERIALS

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# A


Actinic Keratosis, Treatment of .......................... 2nd Qtr 2002 12
Additional Documentation Request Requirements
for Ordering Providers of Laboratory Services ... 3rd Qtr 2003 7
Advance Beneficiary Notice Initiative ................. 1st Qtr 2003 14
Advance Beneficiary Notices for Services for
which Institutional Part B Claims Are Processed
by Fiscal Intermediaries ................................. 2nd Qtr 2002 7
***Ambulance Services***
Air Transportation of Deceased Beneficiary,
Payment for ............................................... 3rd Qtr 2002 5
Applicable Types of Bill .................................... 1st Qtr 2003 17
Claims with Modifier QL ................................. 3rd Qtr 2003 20
Clarification of Medicare Policy Regarding Fee
Schedule Implementation .............................. 1st Qtr 2003 15
Second Clarification Regarding Fee Schedule
Implementation ........................................... 2nd Qtr 2003 7
Definitions of Ambulance Services ................... 1st Qtr 2003 18
Multiple Patient Transport ............................... 2nd Qtr 2003 11
Multiple Patient Transport—Value Code 32 ...... 3rd Qtr 2003 21
Noncovered Miles .......................................... 2nd Qtr 2003 11
Noncovered Miles—Instruction Rescinded ....... 3rd Qtr 2003 20
Transition Schedule for Fee Schedule
Implementation ............................................. 1st Qtr 2003 17
Ambulatory Blood Pressure Monitoring .............. 2nd Qtr 2002 11
Appeal Documentation, Medicare Part A ............ 3rd Qtr 2002 5
Appeal Form for Part A Claims is Now Available ... 3rd Qtr 2003 17
Appeal Provisions, Implementation of Certain
Initial Determination ........................................ 1st Qtr 2003 8
Appeal Time-Frame Extension Criteria .............. 3rd Qtr 2003 8
Audiologists, Payment for Services Furnished by 4th Qtr 2002 12


# B


Blood Clotting Factors, 2003 Fees .................... 2nd Qtr 2003 20
Blood Clotting Factor Administered to
Hemophilia Inpatients, Payment for ................. 1st Qtr 2002 22
Breast Prosthesis, Lifetime Expectancy ............ 1st Qtr 2002 16


# C


***Certified Registered Nurse Anesthetist***
Cost-Based Payment Services Furnished by
OPPS Hospital ............................................... 1st Qtr 2003 27
***CLIA Waived Tests, New***
..................................................................... 3rd Qtr 2003 30
..................................................................... 2nd Qtr 2003 16
..................................................................... 4th Qtr 2002 12
..................................................................... 3rd Qtr 2002 10
..................................................................... 2nd Qtr 2002 12
..................................................................... 1st Qtr 2002 14
***Clinical Diagnostic Laboratory Services***
Based on the Negotiated Rulemaking .............. 1st Qtr 2003 5
List of Policies ............................................... 1st Qtr 2003 6
Questions and Answers ................................. 1st Qtr 2003 6
Administrative Policies for .............................. 3rd Qtr 2002 9
Clinical Trial Routine Care Services, Revised
Diagnosis Coding Requirements .................... 1st Qtr 2002 10
Colorectal Cancer Screening Awareness for
Health Care Providers ................................... 3rd Qtr 2003 10
Colorectal Cancer Screening Publications ......... 3rd Qtr 2003 15
Coordination of Benefits–Trading Partners Update 1st Qtr 2003 15
..................................................................... 3rd Qtr 2002 7
Contractor Operations, Current Status ............... 1st Qtr 2002 8
Correct Coding Initiative Questions, Responses
to Provider ..................................................... 4th Qtr 2002 10


*C (continued)*


***Critical Access Hospitals***
Exempt from Ambulance Fee Schedule .......... 2nd Qtr 2002 19
January 2003 Update to the Medicare
Outpatient Code Editor ................................ 3rd Qtr 2003 48
Medicare OCE, January 2003 Update ............ 2nd Qtr 2003 18
October 2002 Update .................................. 1st Qtr 2003 46
Update to the Medicare OCE .......................... 4th Qtr 2002 20
Crossover Updates ......................................... 1st Qtr 2002 9


# D


Deep Brain Stimulation for Essential Tremor and
Parkinson's Disease ..................................... 3rd Qtr 2003 27
Deductible and Coinsurance for Calendar
Year 2002, Medicare ......................................... Jan 2003 21
Deported Medicare Beneficiaries ..................... 2nd Qtr 2003 6
Deported Medicare Beneficiaries Article,
Correction .................................................. 3rd Qtr 2003 7
***Diabetes Self-Management Training***
Clarification Regarding Nonphysician Practitioners
Billing on Behalf of ...................................... 2nd Qtr 2003 12
Correction of Payment ................................... 1st Qtr 2002 9
Fee Schedule Payment ................................. 1st Qtr 2003 11
Payment ........................................................ 4th Qtr 2002 6
Diagnosis Coding for the UB-92 Form .............. 2nd Qtr 2002 12
Direct Data Entry – HIPAA Institutional 837 Health
Care Claim ................................................... 1st Qtr 2003 52
Discontinue Usage of Edit 15 .......................... 3rd Qtr 2002 49
Drugs and Biologicals, Payments Limit for ......... 4th Qtr 2002 9
Durable Medical Equipment Ordered with
Surrogate Unique Physician Identification
Numbers ...................................................... 1st Qtr 2003 10


# E


Electrical Stimulation Claims with CPT Code 97014
and HCPCS Code G0283, Reporting .............. 3rd Qtr 2003 7
Electrical Stimulation for Treatment of Wounds .. 2nd Qtr 2003 13
Electronic Claim Submission guidelines for ANSI
Version 4010, Changes to Medicare Part A ...... 2nd Qtr 2003 41
EMC Transmissions, Avoiding Duplicate ............ 4th Qtr 2002 112
***End Stage Renal Disease***
Coverage of Noninvasive Vascular Studies ...... 1st Qtr 2002 11
Blood Pricing Update .................................... 1st Qtr 2002 23
Drug Pricing Update ..................................... 2nd Qtr 2003 29
.............................................................. 4th Qtr 2002 23
Enrollment Forms, Electronic Medicare Provision . 3rd Qtr 2002 6
Enrollment Applications, New Provider .............. 1st Qtr 2002 10
Epoetin Alfa (EPO), Instructions for Billing
Hospital Outpatient Claims ............................ 1st Qtr 2002 22
Excluding Hospitals Providing Part B only Services
from the OPPS .............................................. 4th Qtr 2002 21


# F


Fee Schedule Update, 2003 Medicare Physician . 3rd Qtr 2003 8
Financial Limitation for Outpatient Rehabilitation
Services, Implementation .............................. 3rd Qtr 2003 19
***Fraud and Abuse***
Four "Rights" Can't Be Wrong ......................... 3rd Qtr 2002 42
Inappropriate Billing of Free Samples ............... 3rd Qtr 2002 42
Medicare Advisory: No HIPAA Audits ............... 1st Qtr 2002 16
Medicare Fraud Alert ..................................... 4th Qtr 2002 10
OIG Warns Against Misuse of HHS Words,
Symbols, Emblems ...................................... 3rd Qtr 2003 55
Ordering Diagnostic Services ......................... 2nd Qtr 2002 14

*F (continued)*

TriCenturion Selected as Program Safeguard
Contractor for Florida and Connecticut ........... 1st Qtr 2003 50

## G

Get Paid the First Time - Reduce your RTPs ...... 4th Qtr 2002 6
................................................................ 3rd Qtr 2002 6
................................................................ 2nd Qtr 2002 8
Group Therapy Services, Billing for ................... 1st Qtr 2003 27

## H

HBO Treatment of Diabetic Wounds of Lower
Extremities .................................................. 2nd Qtr 2003 14
***HCPCS Annual Update***
Additions, Revisions, Reactivations and
Discontinuation Lists of Modifiers and
*CPT*/HCPCS Codes – Year 2003 ...................... Jan 2003 3
Grace Period Established for 2003 ...................... Jan 2003 4
***Health Insurance Portability and Accountability Act (HIPAA)***
Administration Simplification Compliance ACT
(ASCA) – Questions and Answers ................. 3rd Qtr 2002 53
Benefits Of Electronic Claim Filing under, ......... 3rd Qtr 2003 58
Clarification on HIPAA-AS Institutional 837 Health
Care Claim Implementation Updates ............. 3rd Qtr 2002 51
CMS Issues Model Plan to Extend Deadline for
Compliance with Electronic Transactions Rule . 3rd Qtr 2002 50
Administrative Simplification Provisions of the .. 2nd Qtr 2002 15
HIPAA-Administrative Simplification ................. 1st Qtr 2002 89
HIPAA Makes Electronic Claims Submission the
Best Choice ................................................ 3rd Qtr 2003 57
Privacy Regulations, Overview ........................ 1st Qtr 2002 91
HIPAA–AS .................................................. 2nd Qtr 2003 33
HIPAA–AS Update ......................................... 1st Qtr 2003 53
HIPAA Model Compliance Extension Plan and
Instructions now Available ............................. 4th Qtr 2002 109
Implementation of HIPAA-As Standard Health Care
Eligibility Transaction .................................... 3rd Qtr 2002 51
Medicare HIPAA-AS Related News ................. 3rd Qtr 2002 55
Readiness Checklist – Getting Started ............ 2nd Qtr 2003 35
Resources ................................................... 3rd Qtr 2003 59
101 for Health Care Providers; Office .............. 2nd Qtr 2003 37
Hepatitis B Vaccine ......................................... 2nd Qtr 2003 7
Holiday Schedule, 2003 ................................... 1st Qtr 2003 15
Home Health Agency Responsibility Regarding
Patient Notification ......................................... 1st Qtr 2003 12
**Home Health Consolidated Billing**
Annual Update of HCPCS Codes for ............... 1st Qtr 2003 13
HCPCS Quarterly Update .............................. 2nd Qtr 2003 6
Services Subject to ....................................... 4th Qtr 2002 7
Supplies and Therapy Codes Annual Update ... 1st Qtr 2002 10
Hospice Care Enhances Dignity and Peace as
a Life Nears Is End ......................................... 3rd Qtr 2003 9

## I

***ICD-9-CM***
2003 Annual Update of the International
Classification of Diseases, Ninth Revision,
Clinical Modification .................................... 4th Qtr 2002 5
Coding for Diagnostic Tests ............................. 1st Qtr 2002 5
Part A LMRP Changes, 2003 Changes to ......... 1st Qtr 2003 34
Local Medical Review Policies, 2002 Changes to 1st Qtr 2002 79
Inpatient Claims Containing HCPCS Codes
J7198, J7199, and Q2022, Handling of ........... 2nd Qtr 2002 6

*I (continued)*

Inpatient Rehabilitation Facility, Implementation
of Prospective Payment System ...................... 1st Qtr 2002 18
Inpatient Rehabilitation Facility, PRICER Annual
Update ........................................................ 4th Qtr 2002
of Prospective Payment System ...................... 1st Qtr 2002 18
Intestinal and Multi-Visceral Transplants ............ 3rd Qtr 2003 32
Intestinal Transplants Furnished to
Beneficiaries Enrolled in Medicare+Choice ...... 1st Qtr 2002 16
Intracoronary (Intravascular) Brachytherapy ....... 1st Qtr 2003 34
Intravenous Immuno Globulin for the Treatment of
Autoimmune Mucocutaneous Blistering
Diseases .................................................... 4th Qtr 2002 11
Investigational device Exemption vs. Routine
Cost of Deemed Qualifying Clinical Trial ........... 1st Qtr 2003 3

## L

Laboratory National Coverage Determination,
2003 April Update Software ............................ 3rd Qtr 2003 29
Levocarnitine – HCPCS Code J1955, Billing
Issues with .................................................. 4th Qtr 2002 26
Local Medical Review Policy Reconsideration
Process for the Florida Medicare Part A
Intermediary ............................................... 1st Qtr 2003 30
Long-Term Care Hospital Prospective Payment
System Implementation ................................. 1st Qtr 2003 5

## M

Mammography Claims, Holding Screening and
Diagnostic .................................................... 3rd Qtr 2003 8
Mammography Quality Standard Act File for
Certified Digital Centers, Update to the ............ 2nd Qtr 2003 16
Medical Nutrition Therapy Services for Beneficiaries
with Diabetes or Renal Disease ....................... 4th Qtr 2002 14
Policy Changes ........................................... 2nd Qtr 2003 19
Medical Record Documentation ....................... 2nd Qtr 2002 79
Medicare Beneficiaries in State or Local Custody
under a Penal Authority ................................. 1st Qtr 2003 11
Medicare+Choice Enrollees to Non-IPPS
Hospital, Payment ......................................... 3rd Qtr 2003 34
***Medicare Secondary Payer***
Debt Collection Improvement act of 1996 ......... 3rd Qtr 2003 22
CMS Relaxes Instructions for Hospital ............. 1st Qtr 2002 17
How to Submit Claims to Medicare When There
Are Multiple Primary Payers .......................... 3rd Qtr 2003 22
Information Collection Policies Changed for
Hospitals .................................................. 3rd Qtr 2002 22
Recoveries/Debt-Related Issues–Frequently
Asked Q&A ............................................... 3rd Qtr 2003 22
Mental Health Services, Medicare Payments for
Part B ......................................................... 3rd Qtr 2003 15
Multiple Electroconvulsive Therapy, Noncoverage .. 2nd Qtr 2003 13

## N

Neuromuscular Electrical Stimulation ............... 2nd Qtr 2003 15
New Patient Status Codes 62 and 63,
Clarification ................................................. 3rd Qtr 2002 21
New Patient Status Codes 64 .......................... 4th Qtr 2002 9
Newsletters Will Not Be Printed Between
July and September 2002 .............................. 4th Qtr 2002 8
Non-contact Normothermic Wound
Therapy (NNWT) .......................................... 3rd Qtr 2002 12
Noncovered Charges on Other than Part A
Inpatient Claims, Reporting of ........................ 2nd Qtr 2003 5
............................................................... 2nd Qtr 2002 6

# O

Observation Services for Outpatient Prospective
Payment System, Admitting Diagnosis ............ 1st Qtr 2003 27
Outpatient Physical Therapy Providers, Change in
Payment for Certain Services
***Outpatient Prospective Payment System***
Activity Therapy and Patient Education/
Training Services ........................................ 1st Qtr 2002 88
April 2003 Update to the Hospital OPPS .......... 3rd Qtr 2003 51
Further Guidance Regarding Billing Under, ...... 3rd Qtr 2003 53
"Inpatient Only" Services, Clarifications ............ 1st Qtr 2002 86
Hospital OPPS, October 2002 Update ............. 1st Qtr 2003 48
July 2002 Update to the Hospital OPPS ........... 4th Qtr 2002 101
Pass-Through Device, Removal of
Category C1723 ......................................... 1st Qtr 2002 85
Same Day Rule Billing Requirements .............. 1st Qtr 2002 85
Technical Corrections under the Hospital
Outpatient .................................................. 1st Qtr 2002 86
2002 Update of the Hospital OPPS .................. 3rd Qtr 2002 43
Outpatient Pulmonary Rehabilitation Services in
Chronic Respiratory Disease Policy, Delay in
Implementation of ......................................... 3rd Qtr 2002 40
***Outpatient Services Fee Schedule***
Clinical Laboratory, 2003 ................................... Jan 2003 14
Orthotic/Prosthetic Devices ................................ Feb 2002 11
Surgical Dressing Items, 2002 ........................... Feb 2002 11
Overpayment Interest Rate ............................. 3rd Qtr 2003 8

# P

***Patient Friendly Advisory***
Easy Resources to help your Patients with their
Medicare ...................................................... 1st Qtr 2003 56
Easy-to-Access Help Available at Medicare.gov 3rd Qtr 2002 56
Helping Medicare Patients Pay for Prescriptions . 4th Qtr 2002 113
Medicare Sets its "Sights" on Healthy Eyes ...... 2nd Qtr 2002 81
Patient Status Code for Discharge Services
to an Inpatient Rehabilitation Facility (IRF),
Clarification on ................................................ Feb 2002 2
Peripheral Neuropathy with Loss of Protective
Sensation in People with Diabetes
Percutaneous Image-Guided Breast Biopsy,
Coverage and Billing ..................................... 1st Qtr 2003 28
Percutaneous Transluminal Angioplasty,
Expansion of Coverage ................................. 4th Qtr 2001 12
***Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes***
Restating Guidelines .................................... 2nd Qtr 2003 16
Diagnosis and Treatment of ........................... 3rd Qtr 2002 8
Correction to Billing for Diagnosis and Treatment .. 4th Qtr 2002 13
Peripheral Neuropathy, Revision to HCPCS
Codes for Diagnosis and Treatment ............... 4th Qtr 2002 16
PHPPROG: Documentation Requirements
for Certification/Recertification of Psychiatric
Partial Hospitalization Services—Revision
to Policy ..................................................... 2nd Qtr 2002 79
Pleurx Pleural Catheters, Billing for .................... 4th Qtr 2002 6
Positron Emission Tomography Scans –
Requirements for Breast Cancer and Revised
Coverage Conditions for Myocardial Viability and
Related Claims Processing Changes ............ 4th Qtr 2002 16
Prosthetics and Orthotics Fee Schedule,
HCPCS Updates .......................................... 1st Qtr 2003 10
Provider Information Available on CMS Web Site . 4th Qtr 2002 8
PulmRehab: Outpatient Pulmonary

*P (continued)*

Rehabilitation Services in Chronic
Respiratory Disease .......................................... Feb 2002 3

# R

Rebilling of Inpatient Claims .............................. 4th Qtr 2002 9
Rehabilitation Services for Beneficiaries with
Vision Impairment ......................................... 4th Qtr 2002 18
Remittance Advice Remark Codes and Claim
Adjustment Reason Code, New ...................... 3rd Qtr 2003 62
................................................................ 1st Qtr 2003 51
................................................................ 4th Qtr 2002 111
***Rural Health Clinic Services***
Guidelines for Signature and Documentation of
Medical Records ......................................... 3rd Qtr 2003 49

# S

Sacral Nerve Stimulation, Clarification to the
Billing ........................................................... 3rd Qtr 2002 12
Sacral Nerve Stimulation, Coverage/Billing ........ 1st Qtr 2002 12
................................................................ 1st Qtr 2002 12
Screening Mammography Services, Billing for ... 4th Qtr 2002 10
Single Drug Pricer Initiative - 2003 Fees for Blood
Clotting Factors ........................................... 2nd Qtr 2003 20
***Skilled Nursing Facilities***
Audiologic Function Test, Correction to Edits .... 3rd Qtr 2003 47
Deactivation of Edits C7252 and C7256 ........... 4th Qtr 2002 100
Demand Bills ................................................ 1st Qtr 2003 41
Diagnostic Services Furnished to Beneficiaries
Receiving Treatment for ESRD .................... 2nd Qtr 2003 28
Fee Schedule for Additional Part B Services
Furnished by a SNF or Another Entity under
Arrangements with the SNF .......................... 1st Qtr 2002 81
Health Insurance Prospective Payment
Psychotropic Drug Use in SNF ....................... 1st Qtr 2003 42
Respiratory Services under PPS ..................... 1st Qtr 2002 81
Restating Three-Day Window Requirements .... 3rd Qtr 2003 47
SNF Prospective Payment System Update ...... 4th Qtr 2002 100
Sodium Hyaluronate, Coding Changes ............. 4th Qtr 2002 18
Sulzer Inter-Op Acetabular Shell Recall
Settlement .................................................... 4th Qtr 2002 5
***Swing-Bed Facility Services***
Conversion to Skilled Nursing Facility
Prospective Payment System ....................... 3rd Qtr 2002 13
Eligibility and Coverage ................................. 3rd Qtr 2002 19
Presumption of Coverage ............................... 3rd Qtr 2002 18
Responsibility for Billing Ancillary Services ........ 3rd Qtr 2002 20
Revision to Billing for Swing-Bed Services under
SNF PPS ................................................... 4th Qtr 2002 21

# T

Telehealth Update .......................................... 2nd Qtr 2003 17
Telehealth Services, Correction to the
Revision of Medicare Reimbursement ............. 1st Qtr 2002 9
Telephone Hours of Operation for Medicare
Customer Service Call Centers ....................... 1st Qtr 2003 12
Timely Filing Impacts to PIP Providers, Interim
Billing of Part A Claims ................................... 3rd Qtr 2003 34
Timely Filing Guidelines for All Medicare A
Providers .................................................... 2nd Qtr 2003 7
Three-Day Payment Window Under the Short-
Term Hospital IPPS ....................................... 3rd Qtr 2003 33
................................................................ 1st Qtr 2003 9
Transferring Patients to IRFs, Hospital ............... 4th Qtr 2002 22

*T (continued)*

Three-Day Payment Window Under the Short-Term Hospital IPPS ........ 3rd Qtr 2003 33
Three-Day Payment Window vs. One-Day Payment Window, Clarification ........ 3rd Qtr 2003 33

# V

VISCO: Viscosupplementation Therapy for Knee ........ 2nd Qtr 2002 76

# W

***Widespread Medical Review Probes:***
36245: Extracardiac Arteriography Associated and Billed with Primary Cardiac Catheterization .... 1st Qtr 2003 37
*70540* ........ 1st Qtr 2003 38
*76370* ........ 1st Qtr 2003 38
*90875* ........ 1st Qtr 2003 39
*70540* ........ 1st Qtr 2003 38
*92507* and *92508* ........ 1st Qtr 2003 39
*97112, 97530;* and *97140, 97535* ........ 1st Qtr 2003 39

# Procedure Codes

## CPT Codes

## Anesthesia/Surgery, 00100-69979

*10060*: Incision and Drainage of Abscess of Skin, Subcutaneous and Accessory Structures ........ 1st Qtr 2003 30
........ 1st Qtr 2002 27
*11600*: Excision of Malignant Skin Lesions ........ 1st Qtr 2002 28
*20974*: Osteogenic Stimulator for Fracture Healing ....... 1st Qtr 2003 31
*22520*: Percutaneous Vertebropasty ........ 4th Qtr 2002 28
........ 3rd Qtr 2002 24
*22899*: Kyphoplasty ........ 4th Qtr 2002 30
........ 2nd Qtr 2002 21
*29540*: Strapping ........ 1st Qtr 2003 31
........ 1st Qtr 2002 31
*33282*: Insertable Loop Recorder (ILR) ........ 1st Qtr 2002 33
*36521*: Protein A Column Apheresis (Prosorba®) 4th Qtr 2002 32
*43235*: Diagnostic and Therapeutic Esophagogastroduodenoscopy ........ 4th Qtr 2002 34
*44388*: Colonoscopy, Addition to Policy ........ 2nd Qtr 2002 78
*52282*: Urethal Stents ........ 4th Qtr 2002 97
*53850*: Prostate Treatments ........ 2nd Qtr 2002 23
*66821*: YAG Laser Capsulotomy ........ 3rd Qtr 2002 26
*67221*: Ocular Photodynamic Therapy (OPT) with Verteporfin ........ 1st Qtr 2003 31
*69220*: Mastoidectomy Cavity Debridement ....... 4th Qtr 2002 38

## Diagnostic Tests, 70010-89399

*70450*: Computerized Tomography Scans ......... 1st Qtr 2002 78
*70544*: Magnetic Resonance Angiography (MRA) ........ 1st Qtr 2003 31
*71010*: Chest X-ray, Addition to Policy ........ 4th Qtr 2002 97
*71250*: Computerized Axial Tomography of the Thorax ........ 4th Qtr 2002 40
Addition to Policy ........ 2nd Qtr 2002 78
*72192*: Computed Tomography of the Pelvis ...... 3rd Qtr 2002 39
*76075*: Bone Mineral Density Studies ........ 1st Qtr 2002 35
*77280*: Therapeutic Radiology Simulation-Aided Field Setting ........ 4th Qtr 2002 42

*Diagnostic Tests, 70100-89399 (continued)*

*77300*: Basic Radiation Dosimetry Calculation ...... 4th Qtr 2002 45
........ 2nd Qtr 2002 25
*77301*: Intensity Modulated Radiation Therapy ... 4th Qtr 2002 47
*77332*: Treatment Devices, Design, and Constructions ........ 4th Qtr 2002 50
*77336*: Radiation Physics Consultation ........ 4th Qtr 2002 53
*78460*: Myocardial Perfusion Imaging ........ 1st Qtr 2003 32
........ 1st Qtr 2002 39
*78267:* Breath Test for Helicobacter Pylori (H. PYLORI) ........ 2nd Qtr 2002 27
*80061*: Lipid Profile/Cholesterol Testing ........ 1st Qtr 2002 42
*80162*: Digoxin ........ 1st Qtr 2002 45
*82270*: Fecal Occult Blood Testing ........ 1st Qtr 2002 47
*82310*: Total Calcium ........ 1st Qtr 2002 78
*82378*: Carcinoembryonic Antigen (CEA) ......... 2nd Qtr 2002 78
*82607*: Vitamin-12 (Cyanocobalamin ) Assay ..... 4th Qtr 2002 55
*82728*: Serum Ferritin ........ 4th Qtr 2002 97
*82947*: Blood Glucose Testing ........ 3rd Qtr 2001 46
*83540*: Iron ........ 4th Qtr 2002 97
*84100*: Serum Phosphorus ........ 4th Qtr 2002 57
........ 3rd Qtr 2002 39
*84436*: Thyroid Function Test ........ 3rd Qtr 2002 39
........ 1st Qtr 2002 78
*85651*: Sedimentation Rate, Erythrocyte ........ 1st Qtr 2003 32
........ 3rd Qtr 2002 39
*86706*: Hepatitis B Surface Antigen ........ 4th Qtr 2002 60
*87086*: Urine Bacterial Culture ........ 4th Qtr 2002 97
........ 3rd Qtr 2002 39
........ 2nd Qtr 2002 78
*87536*: Myocardial Perfusion Imaging ........ 1st Qtr 2003 32

## Medicine, 90281-99199

*92597*: Tympanometry ........ 1st Qtr 2003 32
........ 4th Qtr 2002 65
*93000*: Electrocardiography ........ 4th Qtr 2002 67
*93015*: Cardiovascular Stress Test ........ 3rd Qtr 2002 28
*93025*: Microvolt T-wave ........ 1st Qtr 2003 32
........ 4th Qtr 2002 70
*93224*: Electrocardiographic Monitoring of Hours (Holter Monitoring) ........ 1st Qtr 2002 51
*93350*: Stress Echocardiography ........ 1st Qtr 2002 54
*93501*: Cardiac Catheterization, Revision to Policy ........ 1st Qtr 2002 78
*93724*: Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator ..... 1st Qtr 2003 32
........ 4th Qtr 2002 72
*93784*: Ambulatory Blood Pressure Monitoring ... 4th Qtr 2002 76
*93975-93979*: Duplex Scanning ........ 4th Qtr 2002 97
........ 2nd Qtr 2002 29
*93990*: Duplex Scan of Hemodialysis Access ........ 2nd Qtr 2002 33
*94010*: Spirometry ........ 4th Qtr 2002 97
........ 3rd Qtr 2002 39
........ 1st Qtr 2002 56
*94240*: Functional Residual Capacity or Residual Volume ........ 4th Qtr 2002 98
........ 3rd Qtr 2002 39
*94620*: Pulmonary Stress Test ........ 4th Qtr 2002 98
*94642*: Aerosolized Pentamidine Isethionate ...... 4th Qtr 2002 98
*94664*: Diagnostic Aerosol or Vapor Inhalation .... 4th Qtr 2002 98
*94760*: Noninvasive ear or Pulse Oximetry for Oxygen Saturation ........ 4th Qtr 2002 98
........ 1st Qtr 2002 60
*95115*: Allegen Immunotherapy ........ 1st Qtr 2002 63
*95900*: Nerve Conduction Studies ........ 4th Qtr 2002 98
........ 2nd Qtr 2002 35

*Medicine 90281-99199 (continued)*

*95250*: Continuous Glucose Monitoring System . 4th Qtr 2002 78
*97003*: Occupational Therapy Policy for
Rehabilitation Services ................................ 3rd Qtr 2002 40
................................................................ 2nd Qtr 2002 38
*97010*: Physical Medicine and Rehabilitation ..... 2nd Qtr 2002 47
*97110*: Complex Decongestive Physiotherapy .... 2nd Qtr 2002 60

## HCPCS Codes

A0425: Ground Ambulance Services ................. 4th Qtr 2002 81
A0430: Air Ambulance Services ........................ 4th Qtr 2001 54
C1300: Hyperbaric Oxygen (HBO) Therapy ....... 1st Qtr 2002 78
G0030: Positron Emission Tomography
(PET) Scan .................................................. 1st Qtr 2003 33
................................................................ 2nd Qtr 2002 63
................................................................ 1st Qtr 2002 78
G0108: Diabetes Outpatient Self- Management
Training ...................................................... 2nd Qtr 2001 92
G0117: Screening Glaucoma System .............. 2nd Qtr 2002 72
G0245: Peripheral Neuropathy with Loss of
Protective Sensation (LOPS) .......................... 4th Qtr 2002 86
G0248: Home Prothrombin Time International
Normalized Ratio Monitoring ........................... 4th Qtr 2002 88
J0150: Adenosine (Adenocard®, Adenoscan®) ..... 1st Qtr 2002 65
J0587: Botulinum Toxin Type B (Myobloc™) ...... 4th Qtr 2002 90
J0635: Vitamin D Analogs in Chronic Renal Disease 4th Qtr 2002 98
................................................................ 3rd Qtr 2002 30
J1561: Intravenous Immune Globulin ................ 1st Qtr 2003 33
................................................................ 4th Qtr 2002 99
................................................................ 3rd Qtr 2002 38
J1745: Infliximab (Remicade™) ....................... 1st Qtr 2003 33
J2820: Sargramostim (GM-CSF, Leukine®) ....... 4th Qtr 2002 92
J2915: Ferrlecit® ........................................... 2nd Qtr 2002 74
J3490: Zoledronic Acid (Zometa®) .................... 4th Qtr 2002 95
J7190: Hemophilia Clotting Factors ................... 1st Qtr 2002 68
J9212: Interferon ............................................ 1st Qtr 2003 33
J9999: Antineoplastic Drugs ............................ 1st Qtr 2003 33
................................................................ 4th Qtr 2002 99
................................................................ 3rd Qtr 2002 40
................................................................ 2nd Qtr 2002 78
................................................................ 1st Qtr 2002 70
VISCO: Viscosupplementation Therapy for Knee 1st Qtr 2003 33

## 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

FIRST COAST SERVICE OPTIONS, INC. ❖ P.O. BOX 2078 ❖ JACKSONVILLE, FL 32231-0048