Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

Features

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

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

Routing Suggestions:

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

CMS Centers for Medicare & Medicaid Services

FIRST COAST SERVICE OPTIONS, INC.℠

A CMS Contracted Carrier & Intermediary

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Special Issue
January
2003

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

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

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

2003 HCPCS Annual Update

Annual Procedure Code Update

Effective for Services Furnished on or After January 1, 2003

The Centers for Medicare & Medicaid Services (CMS) uses the Healthcare Common Procedure Coding System (HCPCS) to administer the Medicare program. The HCPCS is a collection of codes and descriptors for reporting medical procedures, supplies, products and services that may be provided to Medicare beneficiaries. The HCPCS annual update is designed to promote uniform reporting and statistical data collection of medical procedures, supplies and services.

The HCPCS is updated annually to reflect changes in the practice of medicine and provisions of the health care industry. The HCPCS annual update also contains modifiers, which are two-position codes and descriptors used to indicate a furnished or performed service that has been altered by some specific circumstance but not changed in its definition or code.

This special issue provides an overview of changes to the HCPCS coding structure for 2003. This publication only covers specific coding changes. Related billing and reimbursement changes if applicable will be provided on the provider education Web site at *www.floridamedicare.com* and in future issues of the *Medicare A Bulletin***.** This information is also shared with the Florida Medical Association, all county medical societies and all active specialty associations. Stay in contact with these organizations and read their bulletins for additional HCPCS information.

When filing claims to Medicare Part A of Florida for dates of service beginning January 1, 2003, refer to the coding changes in this publication.

Description of HCPCS Coding Levels

Code additions, deletions and revisions may be made annually to the three levels of the HCPCS coding structure and to Category III temporary codes established for reporting new emerging technologies. These coding levels structures are:

Level I – Numeric Codes (*CPT*)

Level I codes include five-digit numeric codes. These codes describe various physician and laboratory procedures and are contained in the American Medical Association (AMA) *Current Procedural Terminology* Fourth Edition *(CPT®)*. It also includes two-digit alpha and or numeric modifiers.

Level II – Alpha Numeric (HCFA-Assigned)

Level II codes and modifiers include alphanumeric codes assigned by CMS. These codes describe various non-physician and a relatively few number of physician services. These procedure codes begin with an alpha character in the A-V range and are used for durable medical equipment (DME), ambulance services, prosthetics, orthotics, ostomy supplies, etc.

Level III – Alpha Numeric (Locally-Assigned)

Level III codes and modifiers include alphanumeric codes assigned locally by Medicare of Florida. Level III codes describe procedures not included in Level I or Level II and begin with an alpha prefix of W-Z. Many level III, or locally assigned, codes are being discontinued as part of the standardization of the Medicare program.

Category III Codes – New Emerging Technology Codes

During 2001, the AMA CPT Editorial Panel established a new category of *CPT* codes called Category III codes. These codes are a set of temporary codes intended for tracking emerging technologies. Review of emerging technology codes is made by the CPT Editorial Panel as part of its procedures to annually update *CPT* codes. The CPT Editorial Panel will determine if a temporary emerging technology code should be converted to a permanent existing technology Category I *CPT* code or if a new emerging technology code should be established. The syntax of emerging technology codes is four digits followed by the letter "T". ❖

The 2003 HCPCS Update

The 2003 HCPCS update is divided into the following major sections:

Additions

The procedure/modifier codes listed under "Modifiers and Procedure Codes Added for 2003" section (pages 5-6) are newly identified *CPT*/HCPCS codes and modifiers that must be used only for services furnished **on or after January 1, 2003.**

Revisions

The procedure/modifier codes listed under "Modifiers and Procedure Codes Revised for 2003" section (pages 7-8) include *CPT*/HCPCS codes in which the descriptor or administrative instructions have changed from 2002. When using these codes, refer to the *2003 CPT* or HCPCS coding books to ensure the correct code is billed for the service furnished.

Discontinued Procedures

The procedure codes listed under "Modifiers and Procedure Codes Discontinued for 2002" section (pages 9-10) should not be used for service dates **after December 31, 2002.** However, Medicare contractors will continue to accept claims with discontinued *CPT*/HCPCS codes with 2003 service dates received prior to April 1, 2003. Services provided in 2003 that are billed with discontinued *CPT*/

The 2003 HCPCS Update (continued)

HCPCS codes, will be allowed at 2002 payment rates when received between January 1, 2003, and March 31, 2003.

Effective for claims received **on or after April 1, 2003,** services furnished in 2003 billed to Medicare Part A using discontinued codes will be denied payment. Providers will be notified that a discontinued *CPT*/HCPCS code was submitted and a valid *CPT*/HCPCS code must be used.

When billing for services listed in the discontinued code section, the code(s) indicated in the "Codes to Report" column must be used. If more than one replacement code or no replacement code exists, refer to the appropriate coding book for additional guidelines.

A Word About Coverage

CPT/HCPCS codes that are noncovered by Medicare due to statute are not represented on these lists. However, inclusion of a code on the lists does not necessarily constitute Medicare coverage. For example, a code may be noncovered on the basis of local medical review policy (LMRP). Diagnostic tests that are noncovered due to a LMRP are noncovered whether purchased or personally furnished.

Jurisdiction

The lists of added, revised, or discontinued *CPT*/HCPCS codes for 2003 are complete with no regard to contractor jurisdiction. The majority of procedure codes in the HCPCS are processed in Florida by the local Medicare Part A fiscal intermediary, First Coast Service Options, Inc. (FCSO). However, some *CPT*/HCPCS codes listed represent services processed by the durable medical equipment regional carrier (DMERC). The DMERC that serves Florida is Palmetto Government Benefits Administratrors (*www.palmettogba.com*). It is the responsibility of the billing provider to submit claims to the appropriate Medicare contractor.

Use of Unlisted *CPT*/HCPCS Codes

If a *CPT*/HCPCS code cannot be found that closely relates to the actual service furnished, an "unlisted or not otherwise classified" *CPT*/HCPCS code may be submitted with a complete narrative description of the service provided in the "Remarks" field of Form UB-92 CMS-1450 or its electronic equivalent.

Every effort should be made to locate a specific replacement code, since the use of unlisted procedure codes may result in delays in claim processing.

Reminder for EMC Billers

Unlisted or not otherwise classified *CPT*/HCPCS codes may be submitted with a brief descriptor, the required information may be indicated in the appropriate narrative record. Providers may need to contact their EMC (electronic media claims) vendors to determine if their system has this capability.

Questions or Concerns?

Providers are encouraged to refer to all available resource materials for specific *CPT*/HCPCS coding instructions and claims filing information. Medicare Part A reference materials include the *Medicare A Bulletin* and special bulletins.

However, if the information cannot be found in any of the reference materials, contact the Medicare Part A Customer Service department at (877) 602-8816.

Obtaining the 2003 Coding Books

Because of the many changes to the HCPCS coding structure, providers are strongly encouraged to purchase the 2003 *CPT* (Level I) book and/or the *2003 HCPCS Level II* coding book. Providers may purchase the 2003 edition of the *CPT* (Level I codes) from the American Medical Association (AMA) online at *www.ama-assn.org/catalog* by calling the toll-free number (800) 621-8335, or by writing:

American Medical Association
P.O. Box 109050
Chicago, IL 60610-0946

Obtaining the 2003 HCPCS Alphanumeric Hardcopy

The 2003 alphanumeric hardcopy, titled *Healthcare Common Procedure Coding System, HCPCS 2003* may be obtained from:

Superintendent of Documents
U.S. Government Printing Office
Washington D.C. 20402
Telephone: (202) 512-1800 ❖

***Third-party Web sites**. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.*

Grace Period Established for 2003 HCPCS Update

The 2003 Healthcare Common Procedure Coding System (HCPCS) update is effective for services provided **on or after January 1, 2003.** The Centers for Medicare & Medicaid Services extends a 90-day grace period when either 2002 or 2003 *CPT*/HCPCS codes and modifiers are accepted by Medicare contractors. This grace period applies to claims received prior to April 1, 2003, and includes the codes discontinued for dates of service January 1, 2003 or later.

Effective January 1, 2003 through March 31, 2003, providers may use 2002 and/or 2003 *CPT*/HCPCS codes and modifiers. **Effective April 1, 2003, Medicare will only accept the 2003 *CPT* and HCPCS codes and modifiers.** Since codes and modifiers discontinued for 2003 include an updated payment rate if billed during the grace period, inequities between the old and new *CPT*/HCPCS codes do not exist. Consequently, adjustments to change a discontinued or invalid code to a new code (or vice versa) for additional payment will not be honored. ❖

Source: CMS Transmittal AB-02-132, CR 2358

Modifiers and Procedure Codes Added for 2003

MODIFIERS

AU
AV
AW
AX
BA
BO
EY
H9
HA
HB
HC
HD
HE
HF
HG
HH
HI
HJ
HK
HL
HM
HN
HO
HP
HQ
HR
HS
HT
HU
HV
HW
HX
HY
HZ
JW
KB
QJ
ST
SU
SV
TS
TT
TU
TV
TW

CPT-4 Codes

00326
00539
00541
00640
00834
00836
00921
01829
01991
01992
20612
21046
21047
21048
21049
21742
21743
29827
29873
29899
33215
33224
33225
33226
33508
34833
34834
34900
35572
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36512
36513
36514
36515
36516
36536
36537
37182
37183
37500
37501
38204
38205
38206
38207
38208
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38210
38211
38212
38213
38214
38215
38242
43201
43236
44206
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44212
44238
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44701
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45340
45381
45386
46706
49419
49904
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64416
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66990
75901
75902
75954
76071
76496
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76801
76802
76811
76812
76817
83880
84302
85004
85032
85049
85380
87255
87267
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88174
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89055
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CMS ASSIGNED

A4266
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A4281
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A6440
A6501
A6502

Modifiers and Procedure Codes Added for 2003 (continued)

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A9603
A9699
B4100
C1015
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C1021
C1022
C2614
C2632
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C9121
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D4265
D4275
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D4342
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D5671
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D7485
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E0445
E0454
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E0483
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E1037
E1038
E1161
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E1234
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E1237
E1238
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H0048
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H1011
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L1652
L1836
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L3652
L3701
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L3909
L3911
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L6025
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L6647
L6648
L7367
L7368
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Q3022
Q3023
Q3025
Q3026
S0114
S0195
S2130
S9562
S9590
S9802
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T1022
T1023
T1024
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T1027
T1028
T1029
T1030
T1031
T1500
T1502
T1999
T2007
V5095
V5298

Modifiers and Procedure Codes Revised for 2003

MODIFIERS

GN
GO
GP
K0
Q3

CPT-4 Codes

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00942
01382
01400
01464
01622
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01732
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01961
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01996
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CMS ASSIGNED

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D4210
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D9241
D9242
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G0239
H0002
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H0018
H0019
H0023
H0024
H0025
H0030
J1056
J1825
J2790
J3070
J3240
J7626
L0500
L0510
L1843
L1844
L3260
L4350
L4360
L4370
L4380
L7510
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S0091
S0092
S0093
S9123
S9347
T1013

CPT/HCPCS Codes Discontinued for 2003

CPT-4 Codes

00869	
21041	To Report, See 21040, 21046-21047
36520	To Report, See 35611-36512
36521	To Report, Use 36516
38231	To Report, Use 38205-38206
44209	To Report, Use 44238
53670	To Report, See 51701, 51702
53675	To Report, Use 51703
58551	To Report, See 58545, 58546
80090	To Report, See Codes for Specific Tests
85021	
85022	
85023	To Report, Use 85007 and 85027
85024	To Report, Use 85025
85031	To Report, Use 85014, 85018 and 85032
85585	To Report, Use 85008
85590	To Report, Use 85032
85595	To Report, Use 85049
86915	To Report, See 38210-38213
87198	To Report, Use 87271
87199	To Report, Use 87267
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88145	
90709	
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92598	
92599	To Report, Use 92700
94650	
94651	
94652	
94665	
99297	To Report, Use 99296
99508	To Report, Use 95806-95811
99539	To Report, Use 99600

CMS ASSIGNED

A4360	
A4370	
A4374	
A4386	
A4454	
A4460	
A4464	
A4572	Xref L0210
A4801	Xref J1644
A5123	
A6263	
A6264	
A6265	
A6405	
A6406	
C9020	Discontinued 01/01/2002
C1012	Discontinued 12/31/2002
C1013	Discontinued 12/31/2002
C1014	Discontinued 12/31/2002
C1058	Discontinued 12/31/2002
C1064	Discontinued 12/31/2002
C1065	Discontinued 12/31/2002
C1066	Discontinued 12/31/2002
C1087	Discontinued 12/31/2002
C1094	Discontinued 12/31/2002
C1096	Discontinued 12/31/2002
C1097	Discontinued 12/31/2002
C1098	Discontinued 12/31/2002
C1099	Discontinued 12/31/2002
C1188	Discontinued 12/31/2002
C1202	Discontinued 12/31/2002
C1207	Discontinued 12/31/2002
C1348	Discontinued 12/31/2002
C1713	Discontinued 12/31/2002
C1714	Discontinued 12/31/2002
C1715	Discontinued 12/31/2002
C1716	Discontinued 12/31/2002
C1717	Discontinued 12/31/2002
C1718	Discontinued 12/31/2002
C1719	Discontinued 12/31/2002
C1720	Discontinued 12/31/2002
C1721	Discontinued 12/31/2002
C1722	Discontinued 12/31/2002
C1724	Discontinued 12/31/2002
C1725	Discontinued 12/31/2002
C1726	Discontinued 12/31/2002
C1727	Discontinued 12/31/2002
C1728	Discontinued 12/31/2002
C1729	Discontinued 12/31/2002
C1730	Discontinued 12/31/2002
C1731	Discontinued 12/31/2002
C1732	Discontinued 12/31/2002
C1733	Discontinued 12/31/2002
C1750	Discontinued 12/31/2002
C1751	Discontinued 12/31/2002
C1752	Discontinued 12/31/2002
C1753	Discontinued 12/31/2002
C1754	Discontinued 12/31/2002
C1755	Discontinued 12/31/2002
C1756	Discontinued 12/31/2002
C1757	Discontinued 12/31/2002
C1758	Discontinued 12/31/2002
C1759	Discontinued 12/31/2002
C1760	Discontinued 12/31/2002
C1762	Discontinued 12/31/2002
C1763	Discontinued 12/31/2002
C1764	Discontinued 12/31/2002
C1766	Discontinued 12/31/2002
C1767	Discontinued 12/31/2002
C1768	Discontinued 12/31/2002
C1769	Discontinued 12/31/2002
C1770	Discontinued 12/31/2002
C1771	Discontinued 12/31/2002
C1772	Discontinued 12/31/2002
C1773	Discontinued 12/31/2002
C1776	Discontinued 12/31/2002
C1777	Discontinued 12/31/2002
C1778	Discontinued 12/31/2002
C1779	Discontinued 12/31/2002
C1780	Discontinued 12/31/2002
C1781	Discontinued 12/31/2002
C1782	Discontinued 12/31/2002
C1784	Discontinued 12/31/2002
C1785	Discontinued 12/31/2002
C1786	Discontinued 12/31/2002
C1787	Discontinued 12/31/2002
C1788	Discontinued 12/31/2002
C1789	Discontinued 12/31/2002
C1813	Discontinued 12/31/2002
C1815	Discontinued 12/31/2002
C1816	Discontinued 12/31/2002
C1817	Discontinued 12/31/2002
C1874	Discontinued 12/31/2002
C1875	Discontinued 12/31/2002
C1876	Discontinued 12/31/2002
C1877	Discontinued 12/31/2002
C1878	Discontinued 12/31/2002
C1879	Discontinued 12/31/2002
C1880	Discontinued 12/31/2002
C1881	Discontinued 12/31/2002
C1882	Discontinued 12/31/2002
C1883	Discontinued 12/31/2002
C1885	Discontinued 12/31/2002
C1887	Discontinued 12/31/2002
C1891	Discontinued 12/31/2002
C1892	Discontinued 12/31/2002
C1893	Discontinued 12/31/2002
C1894	Discontinued 12/31/2002
C1895	Discontinued 12/31/2002
C1896	Discontinued 12/31/2002
C1897	Discontinued 12/31/2002
C1898	Discontinued 12/31/2002
C1899	Discontinued 12/31/2002
C2615	Discontinued 12/31/2002
C2616	Discontinued 12/31/2002
C2617	Discontinued 12/31/2002
C2619	Discontinued 12/31/2002
C2620	Discontinued 12/31/2002
C2621	Discontinued 12/31/2002
C2622	Discontinued 12/31/2002
C2625	Discontinued 12/31/2002
C2626	Discontinued 12/31/2002
C2627	Discontinued 12/31/2002
C2628	Discontinued 12/31/2002
C2629	Discontinued 12/31/2002
C2630	Discontinued 12/31/2002
C2631	Discontinued 12/31/2002
C9019	Discontinued 12/31/2002
C9100	Discontinued 12/31/2002
C9108	Discontinued 12/31/2002
C9110	Discontinued 12/31/2002
C9114	Discontinued 12/31/2002
C9115	Discontinued 12/31/2002
C9117	Discontinued 12/31/2002
C9118	Discontinued 12/31/2002
E0608	Xref E0618
E0690	
E1638	Xref E0210
G0002	Xref 51702, 51703
G0004	Xref 93268
G0005	Xref 93270
G0006	Xref 93271
G0007	Xref 93272
G0015	Xref 93012
G0026	
G0027	Xref 89310
G0050	Xref 51798
G0131	Xref 76070
G0132	Xref 76071
G0185	Xref 0016T
G0187	

Modifiers and Procedure Codes Discontinued for 2003 (continued)

G0192	
G0193	Xref 92612
G0194	Xref 92614
G0195	Xref 92610
G0196	Xref 92611
G0197	Xref 92607
G0198	Xref 92609
G0199	Xref 92607, 92608
G0200	Xref 92506
G0201	Xref 92507
G0240	
G0241	
J0286	
J0635	
J1050	
J1095	
J1561	
J1755	
J1820	Xref J1815
J2500	
J2915	
J7316	Xref J7317
K0021	Xref E0971
K0034	Xref E0951
K0101	Xref E0958
K0183	Xref A7034
K0184	Xref A7032, A7033
K0185	Xref A7035
K0186	Xref A7036
K0187	Xref A7037
K0188	Xref A7038
K0189	Xref A7039
K0551	Xref E1020
K0561	Xref A4405
K0562	Xref A4406
K0563	Xref A4407
K0564	Xref A4408
K0565	Xref A4409
K0566	Xref A4410
K0567	
K0568	
K0569	Xref A4413
K0570	Xref A4414
K0571	Xref A4415
K0572	Xref A4450
K0573	Xref A4452
K0574	
K0575	
K0576	
K0577	
K0578	
K0579	Xref A4422
K0580	
L0300	
L0310	
L0315	
L0317	
L0320	
L0321	
L0330	
L0331	
L0340	
L0350	
L0360	
L0370	
L0380	
L0390	
L0391	
L0400	
L0410	
L0420	
L0430	
L0440	
L0900	Xref L0500
L0910	Xref L0510
L0920	Xref L0500
L0930	Xref L0510
L0940	Xref L0500
L0950	Xref L0510
L0986	
L3218	
L3223	
L5660	
L5662	
L5663	
L5664	
Q0184	Xref J7342
Q3017	
Q3030	Xref J7317

2003 Oupatient Services Fee Schedule

2003 Medicare Physician Fee Schedule Services

The Centers for Medicare & Medicaid Services (CMS) has issued guidelines for processing claims for dates of service **on or after January 1, 2003,** subject to the Medicare physician fee schedule (MPFS) payment methodology. Because publication of the final MPFS regulation was delayed, implementation plans for the calendar year (CY) 2003 MPFS update will be effective March 1, 2003.

Processing Instructions

Since the new 2003 rates for services paid under the MPFS are not effective until March 1, 2003, the following processing guidelines are being implemented:

- The CY 2003 payment rates for services paid under the MPFS will be effective **March 1, 2003.**
- Claims for services furnished **on or after January 1, 2003, through February 28, 2003,** payable under the MPFS will be reimbursed based on the 2002 MPFS, with the exception of new (added) CY 2003 CPT/HCPCS codes. A list of new CY 2003 HCPCS codes affected by the MPFS is provided below.
- New 2003 HCPCS codes payable under the MPFS are not effective in the fiscal intermediary systems **until March 1, 2003.**

  Providers are encouraged not to submit claims for new CY 2003 HCPCS for services furnished on or after January 1, 2003 through February 28, 2003 payable under the MPFS methodology. Providers should continue to use the MPFS HCPCS code billed in 2002 for January and February 2003 services. Claims submitted with new CY 2003 HCPCS codes payable on the Medicare physician fee schedule for services furnished in January and February 2003 will be returned to the provider.
- Claims for services furnished **on or after March 1 2003 through December 31, 2003,** will be paid at the CY 2003 MPFS payment rate.
- CY 2003 payment amounts for all other services **not** paid under the MPFS methodology are effective **January 1, 2003.**

New 2003 *CPT*/HCPCS Codes Subject to Payment under the Medicare Physician Fee Schedule

D7111	D7140	D7261	G0262	G0268	G0269	G0270	G0271
G0272	G0273	G0274	G0275	G0278	G0279	G0280	G0281
G0283	G0288	G0289	0027T	0028T	0029T	0030T	0031T
0032T	0033T	0034T	0035T	0036T	0037T	0038T	0039T
0040T	0041T	0042T	0043T	0044T	20612	21046	21047
21048	21049	21742	21743	29827	29873	29899	33215
33224	33225	33226	33508	34833	34834	34900	35572
36511	36512	36513	36514	36515	36516	36536	36537
37182	37183	37500	37501	38204	38205	38206	38242
43201	43236	44206	44207	44208	44210	44211	44212
44238	44239	44701	45335	45340	45381	45386	46706
49419	49904	50542	50543	50562	51701	51702	51703
51798	55866	56820	56821	57420	57421	57455	57456
57461	58146	58290	58291	58292	58293	58294	58545
58546	58552	58553	58554	61316	61322	61323	61517
61623	62148	62160	62161	62162	62163	62164	62165
62264	64416	64446	64447	64448	66990	75901	75902
75954	76071	76496	76497	76498	76801	76802	76811
76812	76817	92601	92602	92603	92604	92605	92606
92607	92608	92609	92610	92611	92612	92613	92614
92615	92616	92617	92700	93580	93581	95990	96920
96921	96922	99293	99294	99299	❖		

Source: CMS Transmittal AB-02-181, CR 2486

2003 Clinical Laboratory Services Subject to Fee Schedule and Reasonable Charge Payment Methodologies

In accordance with section 1833(h)(2)(A)(i) of the Social Security Act (the Act), the annual update to the local clinical laboratory fees for 2003 is 1.1 percent. Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA). For a cervical or vaginal smear test (Pap smear), section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (Pap smear), payment may also not exceed the actual charge. The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National Minimum Payment Amounts

For a cervical or vaginal smear test (Pap smear), the 2003 national minimum payment amount is $14.76 ($14.60 plus 1.1 percent update for 2003). The affected codes for the national minimum payment amount are:

88142 88143 88144 88145 88147 88148 88150 88152 88153 88154 88164 88165 88166 88167 88174 88175 G0123 G0143 G0144 G0145 G0147 G0148 P3000.

National Limitation Amounts (Maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with section 1833(h)(4)(B)(viii) of the Act.

Pricing Information

The 2003 laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes G0001, P9612, and P9615). The fees have been established in accordance with section 1833(h)(4)(B) of the Act.

Instructions on separately payable fees for traveling to perform a specimen collection for either a nursing home or homebound patient were issued in June 1999. There are two codes: P9603 for a per mileage trip basis or code P9604 for a flat rate trip basis where the average round trip is generally less than 20 miles (or an average of 10 miles per leg of the trip). To bill either code requires documentation of the number of specimens performed per trip (for both Medicare and non-Medicare patients) to compute the Medicare prorated fee. Code P9604 requires the laboratory to determine the appropriateness of billing on an average round trip basis for all trips during a one-year time period. Thus, payment for travel under code P9604 is made to reasonably pay on average for a varying range of trip miles so that the laboratory should not also require payment with another basis. The payment for codes P9603 and P9604 reflects personnel and transportation costs. For dates of service January 1, 2003 through December 31, 2003, the personnel payment is $.45 per mile updated in accordance with section 1833(h)(4)(B) of the Act. For dates of service January 1, 2003 through December 31, 2003, the standard mileage rate for transportation costs is $0.36 (decreased from year 2002). More explanation of the development of the 2003 standard mileage rate will be available by late December at the Web site *www.gsa.gov*, search for privately owned vehicle reimbursement rates.

The 2003 laboratory fee schedule also includes codes that have a 'QW' modifier to both identify codes and determine payment for tests performed by a laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

For 2003, the *CPT* Editorial Panel revised specimen collection code 36415 to represent *Collection of venous blood by venipuncture* and added code 36416 *Collection of capillary blood specimen (e.g., finger, heel, ear stick)*. However, the Centers for Medicare & Medicaid Services (CMS) must undertake further efforts before implementing codes 36415 and 36416. For 2003, the clinical laboratory fee schedule will continue to include code G0001 *Routine venipuncture for collection of specimen(s*) and laboratories should continue to bill code G0001 for Medicare payment of venous blood collection by venipuncture.

For 2003, the *CPT* Editorial Panel developed 12 new codes 38204 through 38215 for bone marrow or stem cell services and procedures. These codes describe numerous steps in the harvesting and transplantation of cells. However, due to concerns about beneficiary liability and implications for the Medicare physician fee schedule, new codes 38207 through 38215 will be invalid for Medicare purposes. Instead, the 2003 laboratory fee schedule will retain codes 88240 and 88241 related to the harvesting and transplantation of cells for diagnostic purposes and will include two new codes G0265 and G0266 for therapeutic purposes. Code 86915 is discontinued and replaced by code G0267 for Medicare billing. G0267 is subject to laboratory reasonable charge payment methodology.

G0265	Cryopreservation, freezing and storage of cells for therapeutic use, each cell line
G0266	Thawing and expansion of frozen cells for therapeutic use, each cell line
G0267	Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (e.g., T-cells, metastatic, carcinoma)

For 2003, the CPT Editorial Panel made changes in the reporting of automated complete blood count (CBC) parameters. Laboratories must review the coding changes to ensure claims accurately reflect automated CBC testing that was ordered and performed. CMS will monitor claims to detect potential misuse of these codes and may reevaluate these services in the future.

Based on comments regarding codes 87800 and 87801, the mappings were revised. Code 87800 has been mapped to two times code 87797 and code 87801 has been mapped to two times code 87798.

Organ or Disease Oriented Panels

Similar to prior years, the 2003 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the fee schedule amount or the NLA for each individual test code included in the panel code. The national limitation amount field on the data file is zero-filled.

2003 Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge ... (continued)

Cervical or Vaginal Smear Tests (Pap smears)

For 2003, the *CPT* Editorial Panel created new codes 88174 and 88175 (and deleted codes 88144 and 88145) for cervical or vaginal smear tests performed for diagnostic purposes by automated testing systems with thin layer preparation. For the same tests performed for preventive or 'screening purposes,' alphanumeric HCPCS codes G0144 and G0145 are billed. For 2003, CMS revised the descriptor of codes G0144 and G0145 to match new codes 88174 and 88175.

Codes that Required Gap-Fill Amounts

Carriers are required to establish an initial gap-fills amount for new laboratory tests and provide this payment information to the fiscal intermediary. The established gap-fill amounts for 2003 new laboratory codes will be published upon availability in a future issue of the *Medicare A Bulletin.*

Laboratory Costs Subject to Reasonable Charge Payment in 2003

The following codes relate to services subject to laboratory reasonable charge payment method.

When these services are performed for a hospital outpatient, payment is made under the hospital outpatient bundled prospective payment system. Sections MIM 3628C and MCM 5114.1B provide reasonable charge payment instructions for other outpatient settings. When the reasonable charge payment method applies (for example, a service rendered for a nonpatient of a hospital), the inflation-indexed update is 1.1 percent for year 2003. The inflation-indexed update is calculated in accordance with section 1842(b)(3) of the Act and Section 42 CFR 405.509(b)(1).

Blood Products

P9010	P9011	P9012	P9016	P9017	P9019
P9020	P9021	P9022	P9023	P9031	P9032
P9033	P9034	P9035	P9036	P9037	P9038
P9039	P9040	P9041	P9043	P9044	P9045
P9046	P9047	P9048	P9050		

Transfusion Medicine and Other Procedures

86850	86860	86870	86880	86885	86886	86890
86891	86900	86901	86903	86904	86905	86906
86920	86921	86922	86927	86930	86931	86932
86945	86950	86965	86970	86971	86972	86975
86976	86977	86978	86985	89250	89251	89252
89253	89254	89255	89256	89257	89258	89259
89260	89261	89264	G0267 ❖			

Source: CMS Transmittal AB-02-163, CR 2420

2003 Fee Schedules for Medicare Outpatient Services

The Centers for Medicare & Medicaid Services (CMS), in conjunction with the Medicare Part B carrier, develops the Medicare Part A annual outpatient fee schedule. The fee schedule reimbursement amounts published in this bulletin are effective for services furnished **on or after January 1, 2003.**

Fee Schedule Lists

The following fee schedule reimbursement amounts are available at the time of this publication:

- Clinical Laboratory Services
- Ambulance Services (by locality)

Ambulance services are reimbursed based on the geographical locality in Florida.

Clinical laboratory services are reimbursed based on the standard fee schedule for Florida. All providers are reimbursed at the same fee scheduled allowance for these services, regardless of geographical location.

Additional 2002 outpatient services fee schedules will be published in future publications and will be posted on the provider education Web site *www.floridamedicare.com* as soon as they become available.

Locality Structure

CMS reduced the number of localities in 1997. This means that Florida is now divided into three geographic localities. *Localities 01 and 02 are merged and priced at the same fee schedule rate*. For this reason, locality 01 fee schedule reimbursement information is not repeated for locality 02.

Note: Although the attached fee schedule listings do not reflect reimbursement in locality 02, the Direct Data Entry (DDE) system will reflect all four localities. However, localities 01 and 02 are the same fee schedule rates.

Questions regarding these fees may be addressed to Medicare Part A customer service representatives by calling 1-877-602-8816. ❖

CLINICAL LABORATORY SERVICES FEE SCHEDULE

CODE/MD	60%	62%
ATP02	7.28	7.52
ATP03	9.29	9.60
ATP04	9.80	10.13
ATP05	10.93	11.29
ATP06	10.96	11.33
ATP07	11.42	11.80
ATP08	11.83	12.22
ATP09	12.13	12.53
ATP10	12.13	12.53
ATP11	12.34	12.75
ATP12	12.62	13.04
ATP16	14.77	15.26
ATP18	14.87	15.37
ATP19	15.45	15.97
ATP20	15.95	16.48
ATP21	16.45	17.00
ATP22	16.95	17.52
G0001	3.00	3.00
G0026	5.96	6.16
G0027	9.09	9.39
G0103	25.70	26.56
G0107	4.54	4.69
G0123	28.21	29.15
G0143	28.21	29.15
G0144	29.39	30.37
G0145	34.70	35.86
G0147	14.76	14.76
G0148	14.76	14.76
G0265	14.11	14.58
G0266	14.11	14.58
P2038	7.02	7.25
P3000	14.76	14.76
P9612	3.00	3.00
P9615	3.00	3.00
Q0111	5.96	6.16
Q0112	5.96	6.16
Q0113	7.56	7.81
Q0114	9.99	10.32
Q0115	13.83	14.29
78267	10.98	11.35
78268	94.11	97.25
80048	11.83	12.22
80051	9.80	10.13
80053	14.77	15.26
80061	18.72	19.34
80061QW	18.72	19.34
80069	12.13	12.53
80074	66.54	68.76
80076	11.42	11.80
80090	80.44	83.12
80100	20.32	21.00
80101	19.24	19.88
80101QW	19.24	19.88
80102	18.51	19.13
80150	21.06	21.76
80152	25.01	25.84
80154	25.84	26.70
80156	20.34	21.02
80157	13.89	14.35
80158	24.31	25.12
80160	24.05	24.85
80162	18.55	19.17
80164	18.93	19.56
80166	21.66	22.38
80168	22.83	23.59
80170	22.90	23.66
80172	22.76	23.52
80173	20.34	21.02
80174	24.05	24.85
80176	16.26	16.80
80178	9.24	9.55
80182	18.93	19.56
80184	16.01	16.54
80185	18.52	19.14
80186	19.23	19.87
80188	23.18	23.95
80190	23.41	24.19
80192	23.41	24.19
80194	20.39	21.07
80196	9.92	10.25
80197	19.17	19.81
80198	19.77	20.43
80200	22.52	23.27
80201	16.66	17.22
80202	18.93	19.56
80299	19.13	19.77
80400	45.56	47.08
80402	121.46	125.51
80406	109.34	112.98
80408	175.34	181.18
80410	112.23	115.97
80412	460.50	475.85
80414	72.16	74.57
80415	78.08	80.68
80416	184.38	190.53
80417	61.46	63.51
80418	809.76	836.75
80420	100.64	103.99
80422	64.38	66.53
80424	66.56	68.78
80426	207.40	214.31
80428	93.16	96.27
80430	109.60	113.25
80432	177.43	183.34
80434	141.30	146.01
80435	143.85	148.65
80436	127.36	131.61
80438	70.41	72.76
80439	93.88	97.01
80440	81.24	83.95
81000	4.43	4.58
81001	4.43	4.58
81002	3.57	3.69
81003	3.14	3.24
81003QW	3.14	3.24
81005	3.03	3.13
81007	3.59	3.71
81007QW	3.59	3.71
81015	4.02	4.15
81020	5.15	5.32
81025	8.84	9.13
81050	4.19	4.33
82000	17.31	17.89
82003	28.28	29.22
82009	6.31	6.52
82010	9.99	10.32
82010QW	9.99	10.32
82013	15.61	16.13
82016	19.37	20.02
82017	23.57	24.36
82024	53.97	55.77
82030	18.08	18.68
82040	5.73	5.92
82042	2.46	2.54
82043	2.46	2.54
82044	6.39	6.60
82044QW	6.39	6.60
82055	15.10	15.60
82055QW	15.10	15.60
82075	16.84	17.40
82085	13.56	14.01
82088	56.94	58.84
82101	41.94	43.34
82103	18.77	19.40
82104	20.20	20.87
82105	23.44	24.22
82106	23.44	24.22
82108	35.60	36.79
82120	4.02	4.15
82120QW	4.02	4.15
82127	19.37	20.02
82128	19.37	20.02
82131	23.57	24.36
82135	23.00	23.77
82136	23.57	24.36
82139	23.57	24.36
82140	20.36	21.04
82143	9.61	9.93
82145	21.72	22.44
82150	9.06	9.36
82154	40.29	41.63
82157	40.90	42.26
82160	34.94	36.10
82163	28.68	29.64
82164	20.39	21.07
82172	19.80	20.46
82175	26.51	27.39
82180	13.81	14.27
82190	17.08	17.65
82205	16.01	16.54
82232	22.61	23.36
82239	23.94	24.74
82240	24.31	25.12
82247	7.02	7.25
82248	7.02	7.25
82252	2.73	2.82
82261	23.57	24.36
82270	4.54	4.69
82273	4.54	4.69
82273QW	4.54	4.69
82274	0.00	0.00
82274QW	0.00	0.00
82286	9.62	9.94

Clinical Laboratory Services Fee Schedule (continued)

CODE/MD	60%	62%
82300	13.25	13.69
82306	41.36	42.74
82307	45.02	46.52
82308	37.41	38.66
82310	7.20	7.44
82330	19.09	19.73
82331	7.23	7.47
82340	8.43	8.71
82355	16.17	16.71
82360	12.22	12.63
82365	17.30	17.88
82370	17.51	18.09
82373	24.35	25.16
82374	6.83	7.06
82375	17.22	17.79
82376	7.94	8.20
82378	26.51	27.39
82379	23.57	24.36
82380	12.89	13.32
82382	24.02	24.82
82383	35.01	36.18
82384	33.28	34.39
82387	29.07	30.04
82390	15.01	15.51
82397	19.74	20.40
82415	17.70	18.29
82435	6.42	6.63
82436	4.55	4.70
82438	6.83	7.06
82441	8.38	8.66
82465	6.08	6.28
82465QW	6.08	6.28
82480	9.93	10.26
82482	8.31	8.59
82485	20.02	20.69
82486	24.35	25.16
82487	20.02	20.69
82488	20.02	20.69
82489	20.02	20.69
82491	24.35	25.16
82492	24.35	25.16
82495	28.34	29.28
82507	38.85	40.15
82520	21.17	21.88
82523	26.11	26.98
82523QW	26.11	26.98
82525	17.34	17.92
82528	31.45	32.50
82530	23.35	24.13
82533	22.78	23.54
82540	6.48	6.70
82541	24.35	25.16
82542	24.35	25.16
82543	24.35	25.16
82544	24.35	25.16
82550	9.10	9.40
82552	18.71	19.33
82553	13.00	13.43
82554	13.00	13.43
82565	7.16	7.40
82570	7.23	7.47
82570QW	7.23	7.47
82575	13.20	13.64
82585	11.98	12.38
82595	9.04	9.34
82600	27.11	28.01
82607	21.06	21.76
82608	20.01	20.68
82615	11.41	11.79
82626	35.31	36.49
82627	31.07	32.11
82633	43.28	44.72
82634	40.90	42.26
82638	17.11	17.68
82646	27.81	28.74
82649	35.91	37.11
82651	36.07	37.27
82652	53.78	55.57
82654	19.11	19.75
82657	24.35	25.16
82658	24.35	25.16
82664	48.00	49.60
82666	30.01	31.01
82668	26.26	27.14
82670	39.04	40.34
82671	45.13	46.63
82672	30.30	31.31
82677	33.79	34.92
82679	34.88	36.04
82679QW	34.88	36.04
82690	21.99	22.72
82693	13.75	14.21
82696	32.95	34.05
82705	7.11	7.35
82710	22.12	22.86
82715	24.05	24.85
82725	12.08	12.48
82726	24.35	25.16
82728	19.03	19.66
82731	89.99	92.99
82735	12.62	13.04
82742	27.66	28.58
82746	20.54	21.22
82747	4.30	4.44
82757	16.89	17.45
82759	30.01	31.01
82760	15.64	16.16
82775	29.43	30.41
82776	11.71	12.10
82784	12.99	13.42
82785	23.01	23.78
82787	4.36	4.51
82800	4.88	5.04
82803	27.04	27.94
82805	39.65	40.97
82810	12.20	12.61
82820	13.96	14.43
82926	7.61	7.86
82928	7.32	7.56
82938	24.72	25.54
82941	24.64	25.46
82943	19.97	20.64
82945	5.48	5.66
82946	21.06	21.76
82947	5.48	5.66
82947QW	5.48	5.66
82948	4.43	4.58
82950	6.64	6.86
82950QW	6.64	6.86
82951	17.99	18.59
82951QW	17.99	18.59
82952	5.48	5.66
82952QW	5.48	5.66
82953	6.63	6.85
82955	13.55	14.00
82960	8.12	8.39
82962	3.27	3.38
82963	30.01	31.01
82965	7.28	7.52
82975	22.13	22.87
82977	10.06	10.40
82978	19.91	20.57
82979	9.62	9.94
82980	24.31	25.12
82985	21.06	21.76
82985QW	21.06	21.76
83001	25.97	26.84
83001QW	25.97	26.84
83002	25.88	26.74
83002QW	25.88	26.74
83003	23.29	24.07
83008	23.45	24.23
83010	17.58	18.17
83012	24.02	24.82
83013	94.11	97.25
83014	10.98	11.35
83015	26.31	27.19
83018	30.68	31.70
83020	17.99	18.59
83021	24.35	25.16
83026	3.30	3.41
83030	11.56	11.95
83033	6.50	6.72
83036	13.56	14.01
83036QW	13.56	14.01
83045	4.88	5.04
83050	5.86	6.06
83051	10.21	10.55
83055	6.87	7.10
83060	8.12	8.39
83065	6.00	6.20
83068	11.83	12.22
83069	5.51	5.69
83070	6.64	6.86
83071	9.61	9.93
83080	23.57	24.36
83088	41.26	42.64
83090	23.57	24.36
83150	17.30	17.88
83491	24.47	25.29
83497	18.01	18.61
83498	37.95	39.22
83499	35.22	36.39
83500	31.65	32.71
83505	33.96	35.09
83516	16.12	16.66
83518	11.85	12.25
83518QW	11.85	12.25
83519	18.88	19.51
83520	18.09	18.69
83525	15.98	16.51
83527	18.09	18.69
83528	22.22	22.96
83540	9.05	9.35
83550	12.21	12.62
83570	12.36	12.77
83582	19.80	20.46
83586	17.89	18.49

Clinical Laboratory Services Fee Schedule (continued)

CODE/MD	60%	62%	CODE/MD	60%	62%	CODE/MD	60%	62%
83593	36.75	37.98	83945	17.99	18.59	84307	21.61	22.33
83605	14.92	15.42	83950	89.99	92.99	84311	9.77	10.10
83605QW	14.92	15.42	83970	57.67	59.59	84315	3.50	3.62
83615	8.44	8.72	83986	5.00	5.17	84375	12.22	12.63
83625	17.88	18.48	83986QW	5.00	5.17	84376	7.69	7.95
83632	28.24	29.18	83992	20.54	21.22	84377	7.69	7.95
83633	7.69	7.95	84022	21.76	22.49	84378	11.17	11.54
83634	11.17	11.54	84030	7.69	7.95	84379	11.17	11.54
83655	16.91	17.47	84035	5.11	5.28	84392	6.64	6.86
83661	27.56	28.48	84060	10.32	10.66	84402	35.57	36.76
83662	26.43	27.31	84061	11.06	11.43	84403	36.08	37.28
83663	13.22	13.66	84066	13.50	13.95	84425	12.22	12.63
83664	6.61	6.83	84075	7.23	7.47	84430	16.26	16.80
83670	12.80	13.23	84078	10.20	10.54	84432	22.44	23.19
83690	9.62	9.94	84080	20.66	21.35	84436	9.61	9.93
83715	15.73	16.25	84081	23.09	23.86	84437	7.94	8.20
83716	17.30	17.88	84085	9.42	9.73	84439	12.60	13.02
83718	11.44	11.82	84087	11.31	11.69	84442	20.66	21.35
83718QW	11.44	11.82	84100	6.63	6.85	84443	23.47	24.25
83719	16.26	16.80	84105	6.50	6.72	84445	24.31	25.12
83721	13.33	13.77	84106	5.99	6.19	84446	19.81	20.47
83727	24.02	24.82	84110	11.80	12.19	84449	21.05	21.75
83735	9.36	9.67	84119	12.03	12.43	84450	7.22	7.46
83775	10.30	10.64	84120	20.55	21.24	84460	7.40	7.65
83785	34.36	35.51	84126	35.59	36.78	84460QW	7.40	7.65
83788	24.35	25.16	84127	16.28	16.82	84466	17.84	18.43
83789	24.35	25.16	84132	6.42	6.63	84478	8.04	8.31
83805	24.63	25.45	84133	6.01	6.21	84478QW	8.04	8.31
83825	22.72	23.48	84134	20.38	21.06	84479	9.04	9.34
83835	23.67	24.46	84135	26.73	27.62	84480	19.81	20.47
83840	22.81	23.57	84138	26.46	27.34	84481	21.97	22.70
83857	15.01	15.51	84140	23.53	24.31	84482	21.97	22.70
83858	18.72	19.34	84143	31.89	32.95	84484	13.75	14.21
83864	27.82	28.75	84144	29.15	30.12	84485	10.01	10.34
83866	13.76	14.22	84146	27.08	27.98	84488	10.01	10.34
83872	8.19	8.46	84150	34.88	36.04	84490	10.01	10.34
83873	24.04	24.84	84152	25.70	26.56	84510	12.22	12.63
83874	18.04	18.64	84153	25.70	26.56	84512	7.58	7.83
83880	47.43	49.01	84154	25.70	26.56	84520	5.51	5.69
83883	19.00	19.63	84155	5.12	5.29	84525	4.02	4.15
83885	7.94	8.20	84160	7.23	7.47	84540	6.64	6.86
83887	33.09	34.19	84165	15.01	15.51	84545	9.23	9.54
83890	3.56	3.68	84181	23.80	24.59	84550	6.31	6.52
83891	3.56	3.68	84182	25.15	25.99	84560	6.64	6.86
83892	3.56	3.68	84202	10.67	11.03	84577	17.43	18.01
83893	3.56	3.68	84203	10.67	11.03	84578	4.54	4.69
83894	3.56	3.68	84206	18.72	19.34	84580	9.92	10.25
83896	3.56	3.68	84207	26.00	26.87	84583	7.02	7.25
83897	3.56	3.68	84210	15.17	15.68	84585	21.66	22.38
83898	23.42	24.20	84220	7.28	7.52	84586	26.81	27.70
83901	23.42	24.20	84228	7.94	8.20	84588	47.43	49.01
83902	15.17	15.68	84233	89.99	92.99	84590	16.20	16.74
83903	23.42	24.20	84234	90.64	93.66	84591	16.20	16.74
83904	23.42	24.20	84235	73.12	75.56	84597	9.77	10.10
83905	23.42	24.20	84238	51.09	52.79	84600	22.45	23.20
83906	23.42	24.20	84244	30.73	31.75	84620	16.55	17.10
83912	3.56	3.68	84252	17.81	18.40	84630	15.91	16.44
83915	15.58	16.10	84255	35.67	36.86	84681	26.81	27.70
83916	27.42	28.33	84260	21.19	21.90	84702	21.03	21.73
83918	21.19	21.90	84270	11.17	11.54	84703	10.49	10.84
83919	21.19	21.90	84275	10.28	10.62	84703QW	10.49	10.84
83921	21.19	21.90	84285	32.90	34.00	84830	14.02	14.49
83925	27.19	28.10	84295	6.72	6.94	85002	6.29	6.50
83930	9.24	9.55	84300	6.79	7.02	85004	9.04	9.34
83935	9.52	9.84	84302	6.79	7.02	85007	4.81	4.97
83937	28.73	29.69	84305	27.55	28.47	85008	4.81	4.97

Clinical Laboratory Services Fee Schedule (continued)

CODE/MD	60%	62%	CODE/MD	60%	62%	CODE/MD	60%	62%
85009	5.19	5.36	85441	5.88	6.08	86280	11.44	11.82
85013	3.31	3.42	85445	9.52	9.84	86294	27.41	28.32
85014	3.31	3.42	85460	10.81	11.17	86294QW	27.41	28.32
85014QW	3.31	3.42	85461	9.26	9.57	86300	28.50	29.45
85018	3.31	3.42	85475	12.40	12.81	86301	28.50	29.45
85018QW	3.31	3.42	85520	13.25	13.69	86304	28.50	29.45
85021	7.80	8.06	85525	13.25	13.69	86308	7.23	7.47
85022	7.67	7.93	85530	13.25	13.69	86308QW	7.23	7.47
85023	11.84	12.23	85536	9.04	9.34	86309	9.04	9.34
85024	11.83	12.22	85540	12.02	12.42	86310	10.30	10.64
85025	10.86	11.22	85547	12.02	12.42	86316	28.50	29.45
85027	9.04	9.34	85549	26.21	27.08	86317	20.95	21.65
85031	8.27	8.55	85555	9.34	9.65	86318	18.09	18.69
85032	6.01	6.21	85557	18.66	19.28	86318QW	18.09	18.69
85041	4.20	4.34	85576	30.01	31.01	86320	31.32	32.36
85044	6.01	6.21	85585	4.02	4.15	86325	31.24	32.28
85045	5.59	5.78	85590	6.01	6.21	86327	31.70	32.76
85046	7.80	8.06	85595	6.25	6.46	86329	19.62	20.27
85048	3.55	3.67	85597	25.12	25.96	86331	16.75	17.31
85049	6.25	6.46	85610	5.49	5.67	86332	34.05	35.19
85130	16.62	17.17	85610QW	5.49	5.67	86334	31.21	32.25
85170	5.05	5.22	85611	5.51	5.69	86336	21.77	22.50
85175	6.35	6.56	85612	13.37	13.82	86337	29.92	30.92
85210	8.12	8.39	85613	13.37	13.82	86340	21.06	21.76
85220	24.66	25.48	85635	13.76	14.22	86341	27.65	28.57
85230	25.02	25.85	85651	4.96	5.13	86343	17.41	17.99
85240	25.02	25.85	85652	3.77	3.90	86344	11.16	11.53
85244	28.53	29.48	85660	7.71	7.97	86353	68.49	70.77
85245	32.06	33.13	85670	8.07	8.34	86359	4.47	4.62
85246	32.06	33.13	85675	6.50	6.72	86360	9.77	10.10
85247	32.06	33.13	85705	11.17	11.54	86361	5.86	6.06
85250	26.60	27.49	85730	8.38	8.66	86376	20.33	21.01
85260	25.02	25.85	85732	9.04	9.34	86378	27.51	28.43
85270	25.02	25.85	85810	16.32	16.86	86382	23.62	24.41
85280	27.04	27.94	86000	9.75	10.08	86384	15.91	16.44
85290	22.83	23.59	86001	7.30	7.54	86403	14.24	14.71
85291	12.42	12.83	86003	7.30	7.54	86406	14.87	15.37
85292	7.28	7.52	86005	11.14	11.51	86430	7.93	8.19
85293	7.28	7.52	86021	21.03	21.73	86431	7.93	8.19
85300	8.12	8.39	86022	25.66	26.52	86590	12.22	12.63
85301	15.11	15.61	86023	17.40	17.98	86592	5.96	6.16
85302	16.80	17.36	86038	16.89	17.45	86593	6.16	6.37
85303	19.32	19.96	86039	15.60	16.12	86602	8.11	8.38
85305	16.20	16.74	86060	10.20	10.54	86603	17.98	18.58
85306	21.41	22.12	86063	8.07	8.34	86606	21.03	21.73
85307	21.41	22.12	86140	7.23	7.47	86609	18.00	18.60
85335	17.99	18.59	86141	18.09	18.69	86611	8.11	8.38
85337	14.56	15.05	86146	23.12	23.89	86612	18.03	18.63
85345	6.01	6.21	86147	23.12	23.89	86615	18.43	19.04
85347	5.95	6.15	86148	22.44	23.19	86617	21.64	22.36
85348	5.20	5.37	86155	22.33	23.07	86618	21.05	21.75
85360	11.17	11.54	86156	9.36	9.67	86618QW	21.05	21.75
85362	9.62	9.94	86157	11.27	11.65	86619	18.69	19.31
85366	12.03	12.43	86160	16.78	17.34	86622	12.48	12.90
85370	14.83	15.32	86161	16.78	17.34	86625	18.33	18.94
85378	9.97	10.30	86162	28.39	29.34	86628	11.31	11.69
85379	14.22	14.69	86171	14.00	14.47	86631	16.52	17.07
85380	14.22	14.69	86185	12.50	12.92	86632	17.74	18.33
85384	11.87	12.27	86215	18.51	19.13	86635	16.03	16.56
85385	11.87	12.27	86225	19.20	19.84	86638	16.94	17.50
85390	6.63	6.85	86226	16.92	17.48	86641	15.86	16.39
85400	12.36	12.77	86235	25.06	25.90	86644	20.11	20.78
85410	10.77	11.13	86243	28.68	29.64	86645	23.54	24.32
85415	13.25	13.69	86255	16.84	17.40	86648	21.25	21.96
85420	9.13	9.43	86256	16.84	17.40	86651	18.43	19.04
85421	14.23	14.70	86277	21.99	22.72	86652	18.43	19.04

Clinical Laboratory Services Fee Schedule (continued)

CODE/MD	60%	62%	CODE/MD	60%	62%	CODE/MD	60%	62%
86653	18.43	19.04	86808	41.47	42.85	87205	5.96	6.16
86654	18.43	19.04	86812	36.06	37.26	87206	7.50	7.75
86658	18.20	18.81	86813	81.02	83.72	87207	8.37	8.65
86663	18.33	18.94	86816	38.92	40.22	87210	5.96	6.16
86664	21.38	22.09	86817	89.95	92.95	87210QW	5.96	6.16
86665	25.35	26.20	86821	78.88	81.51	87220	5.96	6.16
86666	8.11	8.38	86822	51.07	52.77	87230	27.59	28.51
86668	14.53	15.01	86880	7.50	7.75	87250	27.32	28.23
86671	17.13	17.70	86885	7.99	8.26	87252	36.42	37.63
86674	19.64	20.29	86886	7.23	7.47	87253	28.22	29.16
86677	20.28	20.96	86900	4.17	4.31	87254	6.83	7.06
86682	18.17	18.78	86903	8.46	8.74	87255	47.31	48.89
86684	22.14	22.88	86904	13.28	13.72	87260	16.76	17.32
86687	11.72	12.11	86905	5.34	5.52	87265	16.76	17.32
86688	19.57	20.22	86906	10.83	11.19	87267	16.76	17.32
86689	27.05	27.95	86940	11.46	11.84	87270	16.76	17.32
86692	23.98	24.78	86941	13.27	13.71	87271	16.76	17.32
86694	20.11	20.78	87001	18.47	19.09	87272	16.76	17.32
86695	18.43	19.04	87003	23.52	24.30	87273	16.76	17.32
86696	27.05	27.95	87015	9.33	9.64	87274	16.76	17.32
86698	17.46	18.04	87040	14.42	14.90	87275	16.76	17.32
86701	12.41	12.82	87045	13.18	13.62	87276	16.76	17.32
86702	18.88	19.51	87046	3.30	3.41	87277	16.76	17.32
86703	19.17	19.81	87070	12.03	12.43	87278	16.76	17.32
86704	16.84	17.40	87071	6.59	6.81	87279	16.76	17.32
86705	16.44	16.99	87073	6.59	6.81	87280	16.76	17.32
86706	15.01	15.51	87075	13.22	13.66	87281	16.76	17.32
86707	16.16	16.70	87076	11.29	11.67	87283	16.76	17.32
86708	17.31	17.89	87077	11.29	11.67	87285	16.76	17.32
86709	15.73	16.25	87077QW	11.29	11.67	87290	16.76	17.32
86710	18.94	19.57	87081	9.26	9.57	87299	16.76	17.32
86713	21.39	22.10	87084	12.03	12.43	87300	8.38	8.66
86717	17.12	17.69	87086	11.28	11.66	87301	16.76	17.32
86720	18.43	19.04	87088	11.31	11.69	87320	16.76	17.32
86723	18.43	19.04	87101	10.77	11.13	87324	16.76	17.32
86727	17.98	18.58	87102	11.74	12.13	87327	16.76	17.32
86729	16.69	17.25	87103	12.60	13.02	87328	16.76	17.32
86732	18.43	19.04	87106	14.42	14.90	87332	16.76	17.32
86735	18.23	18.84	87107	14.42	14.90	87335	16.76	17.32
86738	18.51	19.13	87109	21.50	22.22	87336	16.76	17.32
86741	18.43	19.04	87110	23.73	24.52	87337	16.76	17.32
86744	18.43	19.04	87116	15.10	15.60	87338	17.19	17.76
86747	21.00	21.70	87118	15.29	15.80	87339	16.76	17.32
86750	13.00	13.43	87140	7.79	8.05	87340	14.43	14.91
86753	17.32	17.90	87143	17.51	18.09	87341	14.43	14.91
86756	18.01	18.61	87147	7.23	7.47	87350	16.10	16.64
86757	27.05	27.95	87149	17.79	18.38	87380	22.94	23.70
86759	18.43	19.04	87152	7.31	7.55	87385	16.76	17.32
86762	20.11	20.78	87158	7.31	7.55	87390	15.61	16.13
86765	18.00	18.60	87164	15.01	15.51	87391	15.61	16.13
86768	16.26	16.80	87166	15.78	16.31	87400	16.76	17.32
86771	18.33	18.94	87168	5.96	6.16	87420	16.76	17.32
86774	20.68	21.37	87169	5.96	6.16	87425	16.76	17.32
86777	20.11	20.78	87172	5.96	6.16	87427	16.76	17.32
86778	20.12	20.79	87176	8.22	8.49	87430	16.76	17.32
86781	18.50	19.12	87177	12.43	12.84	87449	16.76	17.32
86784	11.31	11.69	87181	1.17	1.21	87449QW	16.76	17.32
86787	18.00	18.60	87184	9.63	9.95	87450	13.39	13.84
86790	18.00	18.60	87185	1.17	1.21	87451	13.39	13.84
86793	18.33	18.94	87186	12.08	12.48	87470	17.79	18.38
86800	22.22	22.96	87187	14.48	14.96	87471	41.65	43.04
86803	19.94	20.60	87188	8.12	8.39	87472	59.85	61.85
86804	21.64	22.36	87190	7.90	8.16	87475	17.79	18.38
86805	73.05	75.49	87197	20.99	21.69	87476	41.65	43.04
86806	66.49	68.71	87198	16.76	17.32	87477	59.85	61.85
86807	55.29	57.13	87199	16.76	17.32	87480	17.79	18.38

Clinical Laboratory Services Fee Schedule (continued)

CODE/MD	60%	62%
87481	41.65	43.04
87482	58.33	60.27
87485	17.79	18.38
87486	41.65	43.04
87487	59.85	61.85
87490	17.79	18.38
87491	41.65	43.04
87492	48.84	50.47
87495	17.79	18.38
87496	41.65	43.04
87497	59.85	61.85
87510	17.79	18.38
87511	41.65	43.04
87512	58.33	60.27
87515	17.79	18.38
87516	41.65	43.04
87517	59.85	61.85
87520	17.79	18.38
87521	41.65	43.04
87522	59.85	61.85
87525	17.79	18.38
87526	41.65	43.04
87527	58.33	60.27
87528	17.79	18.38
87529	41.65	43.04
87530	59.85	61.85
87531	17.79	18.38
87532	41.65	43.04
87533	58.33	60.27
87534	17.79	18.38
87535	41.65	43.04
87536	98.47	101.75
87537	17.79	18.38
87538	41.65	43.04
87539	59.85	61.85
87540	17.79	18.38
87541	41.65	43.04
87542	58.33	60.27
87550	17.79	18.38
87551	41.65	43.04
87552	59.85	61.85
87555	17.79	18.38
87556	41.65	43.04
87557	59.85	61.85
87560	17.79	18.38
87561	41.65	43.04
87562	59.85	61.85
87580	17.79	18.38
87581	41.65	43.04
87582	58.33	60.27
87590	17.79	18.38
87591	41.65	43.04
87592	59.85	61.85
87620	17.79	18.38
87621	41.65	43.04
87622	58.33	60.27
87650	17.79	18.38
87651	41.65	43.04
87652	58.33	60.27
87797	17.79	18.38
87798	41.65	43.04
87799	59.85	61.85
87800	35.58	36.77
87801	83.30	86.08
87802	16.76	17.32
87803	16.76	17.32
87804	16.76	17.32
87810	16.76	17.32
87850	16.76	17.32
87880	16.76	17.32
87880QW	16.76	17.32
87899	16.76	17.32
87899QW	16.76	17.32
87901	359.69	371.68
87902	359.69	371.68
87903	682.72	705.48
87904	36.42	37.63
88130	21.02	21.72
88140	11.17	11.54
88142	28.21	29.15
88143	28.21	29.15
88144	28.21	29.15
88145	28.21	29.15
88147	14.76	14.76
88148	14.76	14.76
88150	14.76	14.76
88152	14.76	14.76
88153	14.76	14.76
88154	14.76	14.76
88155	8.37	8.65
88164	14.76	14.76
88165	14.76	14.76
88166	14.76	14.76
88167	14.76	14.76
88174	29.39	30.37
88175	34.70	35.86
88230	162.77	168.20
88233	196.63	203.18
88235	205.74	212.60
88237	176.47	182.35
88239	206.12	212.99
88240	14.11	14.58
88241	14.11	14.58
88245	190.23	196.57
88248	241.96	250.03
88249	241.96	250.03
88261	246.93	255.16
88262	174.14	179.94
88263	190.23	196.57
88264	174.14	179.94
88267	251.17	259.54
88269	190.23	196.57
88271	20.22	20.89
88272	35.39	36.57
88273	44.89	46.39
88274	48.63	50.25
88275	56.11	57.98
88280	35.07	36.24
88283	95.84	99.03
88285	26.54	27.42
88289	40.56	41.91
88371	31.05	32.09
88372	31.79	32.85
88400	3.51	3.63
89050	6.61	6.83
89051	7.70	7.96
89055	5.96	6.16
89060	9.99	10.32
89125	6.03	6.23
89160	5.15	5.32
89190	6.64	6.86
89300	12.45	12.87
89300QW	12.45	12.87
89310	12.03	12.43
89320	16.84	17.40
89321	16.84	17.40
89325	14.91	15.41
89329	29.30	30.28
89330	13.83	14.29
89355	4.67	4.83
89365	7.69	7.95

AMBULANCE SERVICE FEE SCHEDULE

Ambulance Fee Schedule Updates for 2003

Section 1834(l)(3)(A) of the Act provides the basis for updating payment limits for ambulance services. Specifically, this section provides for an update in payments for 2003 that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the ambulance inflation factor (AIF). The AIF for calendar year 2003 is **1.1 percent**.

During the transition period, the AIF is applied to both the fee schedule portion of the blended payment amount (incorporated in the ambulance fee schedule file) and to the reasonable cost portion of the blended payment amount separately for each ambulance provider/supplier. Then, these two amounts are added together to determine the total payment amount for each provider/supplier.

The blending percentages used to combine these two components of the payment amounts for ambulance services for the calendar year 2003 are **60 percent** of the reasonable cost and **40 percent** of the ambulance fee schedule (AFS).

The AFS rates for 2003 for Florida based on localities are provided below. Providers may calculate their payment by combining 40 percent of the appropriate fee schedule with 60 percent of their 2003 reasonable cost for the same service.

The point of pickup determines the basis for payment under the fee schedule, and the point of pickup is reported by its five-digit ZIP code. Thus, the ZIP code of the point of pickup determines both the applicable locality fee schedule amount, and whether a rural adjustment applies.

If the ambulance transport requires a second or subsequent leg, then the ZIP code of the point of pickup of the second or subsequent leg determines both the applicable fee for such leg and whether a rural adjustment applies.

Accordingly, the ZIP code of the point of pickup must be reported on every claim to determine both the correct fee schedule amount and, if applicable, any rural adjustment.

Part B coinsurance and deductible requirements apply to these services.

2003 Ambulance Fee Schedule Rates

HCPCS Codes	Locality 01/02	Locality 03	Locality 04	Type
A0425	5.53	5.53	5.53	
A0426	199.08	209.51	214.44	
A0427	315.21	331.73	339.52	
A0428	165.90	174.59	178.70	
A0429	265.44	279.35	285.91	
A0430	2,276.79	2,361.03	2,400.81	Urban
	3,415.19	3,541.54	3,601.21	Rural
A0431	2,647.10	2,745.05	2,791.29	Urban
	2,970.66	4,117.57	4,186.94	Rural
A0432	290.33	305.54	312.72	
A0433	456.33	480.13	491.41	
A0434	539.18	567.43	580.76	
A0435	6.64	6.64	6.64	Urban
	9.96	9.96	9.96	Rural
A0436	17.70	17.70	17.70	Urban
	26.55	26.55	26.55	Rural
Q3019	265.44	279.35	285.91	
Q3020	165.90	174.59	178.70	

Source: CMS Transmittal AB-02-173, CR 2489

GENERAL INFORMATION

Medicare Deductible Amounts for Calendar Year 2003

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

Year 2003 HI Deductible

Part A Hospital (Inpatient)	Calculation per Benefit Period	CY 2003 Benefit Period
Deductible – 1 through 60 days	Current year inpatient deductible	$840.00 per benefit period
Coinsurance – 61 through 90 days	Rate is ¼ of current year inpatient deductible amount	$210.00 per day
Lifetime Reserve – 91 through 150 days (non-renewable days)	Rate is ½ of current year inpatient deductible amount	$420.00 per day
Skilled Nursing Facility (SNF)	**Calculation Per Benefit Period**	**CY 2003 Benefit Period**
SNF – 1 through 20 days	No deductible or coinsurance (full days)	$0 per benefit period
SNF – 21 through 100 days	Rate is 1/8 of current year inpatient deductible amount	$105 per day
Blood Deductible	**Annual Requirement**	**CY 2003**
Part A/Part B	Satisfied via Part A and or Part B services	3 pints annually
Part B - Outpatient	**Annual Requirement**	**CY 2003**
Annual Deductible	Satisfied via Part B outpatient and or Physician/Supplier Services (Part B)	$100.00

Source: CMS Transmittal AB-02-159, CR #2451

Standardizing Prices for Medicare Covered Drugs

On January 1, 2003, the Centers for Medicare & Medicaid Services (CMS) is implementing a single drug pricer (SDP) for drugs and biologicals (hereinafter "drugs") with respect to drugs covered under Medicare Part B and priced by local carriers.

In the past, CMS has received much criticism concerning excessive expenditures related to the payment rates for the approximately 400 drugs that are currently paid based on 95 percent average wholesale price (AWP); i.e., physicians' offices, outpatient hospitals, dialysis centers, etc.

Currently, this payment rate is set at 95 percent of the drugs AWP; however, these payments have sometimes varied depending upon the individual local carrier's application of the payment methodology. Accordingly, CMS is establishing the SDP to correct identified differences amongst its local carriers and is establishing a uniform Medicare payment allowance as contemplated by the regulation (42 C.F.R. 405.517). Drug prices will be established centrally and will be more closely monitored. As a result, providers will receive the same payment for the same drug regardless of where their claim for the drug is submitted.

CMS will continue, in accordance with its longstanding practice, to set a price for each drug based on 95 percent of AWP, and will continue to rely on published compilations (e.g., *RedBook* and *First Data Bank*) to identify wholesale drug prices. Fiscal intermediaries will be furnished with drug pricing files from CMS and will begin processing claims they receive, for each drug identified on the file, on the basis of the prices shown on these files.

CMS believes that this initiative reflects an innovative approach to resolving some of the problems relating to the pricing of Medicare-covered drugs. ❖

Source: CMS Transmittal AB-02-174, CR 2381

OUTPATIENT HOSPITAL SERVICES

Billing for Immunosuppressive Drugs Furnished to Transplant Patients

Effective January 1, 2003, fiscal intermediaries will no longer make payments to hospital outpatient departments subject to the outpatient prospective payment system (OPPS) for immunosuppressive drugs furnished to beneficiaries for use after discharge (e.g., 30-day supplies).

Payment may be allowed under the hospital OPPS for **one** administration of an immunosuppressive drug when furnished to a beneficiary who is registered as an outpatient for the purpose of receiving outpatient services. However, claims for 30-day supplies of immunosuppressive drugs furnished to beneficiaries by a hospital are not payable under the OPPS. Immunosuppressive drugs and many other drugs are packaged into services the beneficiary receives on a given day. That is, the cost billed for the drug in the base year is part of the cost of the service, such as a clinic visit, with which it was billed. Thus, there is no mechanism for paying for 30-day supplies of drugs.

Billing Requirements

Hospitals that provide beneficiaries with immunosuppressive drugs must bill the durable medical equipment carrier (DMERC) in their area to receive payment for these supplies of immunosuppressive drugs.

Hospitals that already have a supplier number for billing the DMERC for durable medical equipment must use that number to bill the DMERC for immunosuppressive drug claims for dates of service on or after January 1, 2003.

If a hospital does **not** already have a supplier number for billing the DMERC, they must complete a Form CMS-855-S and obtain a supplier number from the National Supplier Clearinghouse (NSC). Supplier numbers are deleted if 12 months elapse without a claim submission.

Obtaining a Supplier Number

There are two ways to obtain a supplier number from the NSC:

1. Hospitals can call the NSC directly at 1-866-238-9652, request an application form, and the NSC will send them a CMS-855-S. Once the hospital has completed the 855-S, it must be submitted as soon as possible to the NSC at the address indicated on the form.
2. Hospitals may access the CMS Web site at: *cms.hhs.gov/providers/enrollment/default.asp*, and download the 855-S in Adobe Acrobat format. They can then complete the application hard copy and submit it to the NSC at the address indicated on the form.

Hospitals must attach the following information to their applications to expedite receiving their supplier number:

- Name of current intermediary
- Medicare provider number (OSCAR number).

Once a hospital has its supplier number, it can bill the appropriate DMERC using the claim Form CMS-1500 or electronic equivalent, listing the actual drug by HCPCS code and specifying the units given to the beneficiary. The DMERC will provide specific instructions to hospital pharmacies on billing requirements. Payment from the DMERC will be based on the instructions published in the Fourth Quarter 2002 *Medicare A Bulletin* (page 9). Part B deductible and coinsurance requirements apply to these services.

The DMERC with jurisdiction for Florida claims is:

Palmetto GBA Medicare
DMERC Operations
P.O. Box 10041
Columbia, SC 29202-3141
(803) 735-1034 ❖

Source: CMS Transmittal A-02-123, CR 2488

Billing for Low Osmolar Contrast Material

Under the hospital outpatient prospective payment system (OPPS), separate payment is not made for ionic and non-ionic contrast materials. Medicare payment for ionic and non-ionic contrast media, including low osmolar contrast material (LOCM), is packaged into the ambulatory payment classification for the diagnostic procedure. Under the OPPS, there is no longer a payment difference between LOCM and other contrast materials. Therefore, the Centers for Medicare & Medicaid Services is removing the requirements imposed under sections 443.C.3f and 443.C.3g of the Medicare Hospital Manual (MHM) and sections 631.C.3f and 3631.C.3g of the Part A Medicare Intermediary Manual (MIM) for LOCM furnished on or after January 1, 2003. For hospitals that are subject to the OPPS, this notification **supersedes** instructions that differentiate payment between high osmolar contrast material and LOCM and restrict payment for LOCM to only those patients having specific diagnoses as indicated in the above sections of the MHM and MIM.

Billing for LOCM

For LOCM furnished **on or after January 1, 2003,** hospitals subject to the OPPS must either include the charge for LOCM in the charge for the diagnostic procedure or, if billing for LOCM as a separate charge, bill using revenue code 255 – *Drugs Incident to Radiology,* or revenue code 254 – *Drugs Incident to Other Diagnostic Services,* as appropriate.

Until further notice, OPPS hospitals must not use LOCM codes A4644, A4645, or A4646 when billing for LOCM furnished **on or after January 1, 2003.** Claims submitted with LOCM codes A4644, A4645, or A4646 for services furnished on or after January 1, 2003, will be returned to the provider.

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

Source: CMS Transmittal A-02-120, CR 2185

ESRD SERVICES

End-Stage Renal Disease Drug Pricing Update

The following revised end-stage renal disease (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 and after January 1, 2003,** and represent the Medicare maximum reimbursement for separately billable ESRD drugs and/or pharmaceuticals.

All prices, as mandated by the Centers for Medicare & Medicaid Services (CMS), are 95 percent of either:

- the lesser of the median average wholesale price of all generic forms of the drug, or
- the lowest brand name average wholesale price.

ESRD providers may order the 2002 *Drug Topics® Red Book®*. Call **(800) 222-3045**, toll-free, or write to:

Drug Topics® Red Book®
5 Paragon Drive
Montvale, NJ 07645-1742

- 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).
- The drug prices in this revision include a five percent price reduction as mandated by CMS.

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 Part A reimbursement allowance for specific drug administered via ESRD environment.

CPT/HCPCS CODE	NAME	PRICE
J0170	Adrenalin, epinephrine, 1 mg/1 cc ampule	$ 2.26
J0210*	Aldomet, methyldopate HCL, up to 250 mg	$11.87
J2997	Alteplase, recombinant, activase, 1 mg	$35.62
00047	Amikin, Amikacin, 100 mg/2 cc	$30.88
J0280	Aminophylline, aminophyllin, 250 mg	$ 0.91
J0285	Amphotericin B, Fungizone, 50 mg	$17.66
J0290	Ampicillin sodium, 500 mg	$ 1.85
J0690	Ancef, cefazolin sodium, Kefzol, 500 mg	$ 4.94
J3430	Aquamephyton, phytonaidione (vitamin K), 1 mg	$ 2.39
J0380*	Aramine, metaraminol bitartrate, 10 mg	$ 1.26
J7504	Atgam, lymphocyte immune globine, 250 mg	$290.31
J2060	Ativan, lorazepam, 2 mg	$ 3.13
J0460	Atropine sulfate, 0.3 mg	$ 4.65
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	$ 8.80
J0540	Bicillin C-R, penicillin-G, 1,200,000 units	$17.97
J0550	Bicillin C-R, penicillin-G, 2,400,000 units	$35.95
J0560	Bicillin L-A,penicillin-G, 600,000 units	$ 7.41
J0570	Bicillin L-A, penicillin-G, 1,200,000 units	$19.61
J0580	Bicillin L-A, penicillin-G, 2,400,000 units	$29.65
J0592	Buprenex, Buprenorphine, .3 mg/1 cc	$ 2.82
J0635	Calcijex, calcitriol, 1 mcg/ml	$13.82
J0630	Calcitonin-salmon, up to 400 units	$ 3.73
X0014	Calcium chloride 10%, 10 cc	$2.05
J0610	Calcium gluconate, 10 ml	$ 1.34
J1955	Carnitine, levocarnitine, 1 gm	$32.06
J0710	Cefadyl, cephapirin sodium), 1 gm	$ 2.97
J0715	Ceftizoxime sodium, Cefizox, 500 mg	$10.82
00248	Cefobid, Cefoperazone sodium, 1 gm	$16.38
X0016	Cefotan, Cefotetan disodium gm	$10.60
J0698	Cefotaxime sodium, Claforan, 1 gm	$10.45

*This drug is included in the composite rate.

End-Stage Renal Disease Drug Pricing Update (continued)

CPT/HCPCS CODE	NAME	PRICE
J0697	Cefuroxime sodium, 750 mg	$ 6.42
J0702	Celestone Soluspan, 3 mg-3mg/ml	$ 3.88
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
J0745	Codeine phosphate, 30 mg	$ 1.20
J0800	Corticotropin Acthar Gel 40 Units	$92.93
J0835	Cortrosyn, cosyntropin, 0.25 mg	$16.75
J9070	Cyclophosphamide, Cytoxan, 100 mg	$ 5.97
J9080	Cyclophosphamide, Cytoxan, 200 mg	$11.34
J9090	Cyclophosphamide, Cytoxan, 500 mg	$24.12
J9091	Cyclophosphamide, Cytoxan, 1 gm	$47.64
J9092	Cyclophosphamide, Cytoxan, 2 gm	$95.26
J2597	DDAVP, desmopressin acetate), 1mcg	$4.67
J1100	Decadron, dexamethasone sodium phosphate, 1 mg	$ 0.17
J2175	Demerol, meperidine HCL, 100 mg	$ .79
J1070	Depo-Testosterone, up to 100 mg	$ 4.70
J1080	Depo-Testosterone, 1 cc, 200 mg	$19.29
J0895	Desferal, deferoxamine mesylate), 500 mg/5 cc	$14.15
J1100	Dexamethasone sodium phosphate, 1 mg/ml	$ 0.17
J7060	Dextrose 5%, 500 cc	$ 6.99
J1730*	Diazoxide, Hyperstat, 300 mg/20 ml	122.95
J1450	Diflucan, Fluconazole, 200 mg	$90.86
J1160*	Digoxin, Lanoxin, up to 0.5 mg	$ 2.64
J1165	Dilantin, phenytoin sodium, 50 mg	$ 1.23
J1170	Dilaudid, hydromophone, 4 mg	$ 1.54
J1200*	Diphenhydramine HCL (Benadryl), up to 50 mg	$ 0.80
X0023*	Dopamine HCL, Intropin, 40 mg/1 cc	$ 0.62
J1240	Dramamine, dimenhydrinate, 50 mg	$ 0.38
J1364	Erythromycin lactobionate, 500 mg	$ 3.50
J0970	Estradiol valerate, Delestrogen, up to 40 mg	$22.60
J2915	Ferrlecit, sodium ferric gluconate, 62.5 mg/5 ml	$40.85

CPT/HCPCS CODE	NAME	PRICE
00623	Flagyl, Metronidazole, 500 mg	$13.35
J9190	Fluorouracil, 500 mg	$ 2.88
X0100	Folic Acid, 5 mg/cc	$1.28
J0713	Fortaz, ceftazidime, 500 mg	$ 9.67
J1470	Gamma globulin, 2 cc	$42.75
J1550	Gamma globulin, 10 cc	$114.00
J1570	Ganciclovir sodium, Cytovene, 500 mg	$35.24
J1580	Garamycin, gentamicin, 80 mg	$ 3.58
J1630	Haldol, haloperidol, 5 mg	$ 7.91
J1644*	Heparin sodium 1000 units	$ 0.39
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	$203.78
90747	Hepatitis B vaccine, dialysis or immunosupressed patient dosage (4 dose schedule), for intramuscular use	$105.81
J0360*	Hydralazine HCL, Apresoline, 20 mg	$14.25
J1720	Hydrocortisone sodium succinate (Solu-Cortef), 100 mg	$ 1.80
J3410	Hydroxyzine HCL, 25 mg	$ 0.70
J1561	Immune globulin, Gammimune N, 5%, 500 mg)	$38.00
J1563	Immune globulin, intravenous, 1 gm	$76.00
J7501	Imuran, Azathioprine, 100 mg	$59.84
J1790	Inapsine, droperidol), 5 mg	$ 1.55
J1800*	Inderal, propranolol HCL, 1 mg/1 cc	$ 5.93
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
J1820*	Insulin, 100 units	$ 4.76
J1840	Kantrex, kanamycin sulfate, 500 mg	$3.29
J1890	Keflin, cephalothin sodium, 1 gm	$10.26
J3301	Kenalog, triamcinolone acetonide), 10 mg	$ 1.48

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

End-Stage Renal Disease Drug Pricing Update (continued)

CPT/HCPCS CODE	NAME	PRICE
J1940	Lasix, furosemide, 20 mg	$1.17
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	$ 3.45
00971	Mandol, Cefamandole, 1 gm	$8.61
J2150*	Mannitol 25%, in 50 cc	$3.94
J1050	Medroxyprogesterone acetate, Depo-Provera, 100 mg	$33.91
J0694	Mefoxin, cefoxitin sodium, 1 gm	$10.36
00987	Mezlin, Mezlocillin, 1 gm	$ 4.24
J2270	Morphine sulfate, 10 mg	$0.77
J7505	Muromonab-CD3, parenteral, 5 mg	$777.31
X0027	Nafcil, nafcillin sodium, 500 mg	$ 1.34
J2320	Nandrolone decanoate, Deca-Durabolin, 50 mg	$ 5.20
J2321	Nandrolone decanoate, Deca-Durabolin, 100 mg	$ 6.98
J2322	Nandrolone decanoate, Deca-Durabolin, 200 mg	$25.49
J2310	Narcan, naloxone HCL, 1 mg	$ 4.20
J3260	Nebcin, tobramycin sulfate, 80 mg	$10.80
J2300	Nubain, nalbuphine HCL, 10 mg/1 cc	$ 1.90
J2700	Oxacillin sodium, 250 mg	$ 0.66
J2500	Paracalcitol, 5 mcg	$25.09
J2510	Penicillin G procaine, aqueous, 600,000 units	$ 8.07
X0101	Pentam, 300 mg	$93.81
J2550	Phenergan, promethazine HCL, 50 mg	$ 0.57
J2560	Phenobarbital sodium, 120 mg	$ 6.04
01231	Pipracil, Piperacillin sodium, 1 gm	$ 7.01
90732	Pneumovax, Pneumococcal vaccine 0.5 cc	$13.09
J3480*	Potassium chloride, per 2 mEq/ml	$ 0.27
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	$ 3.20

CPT/HCPCS CODE	NAME	PRICE
X0076	Prolastin, 500 mg	$104.50
J2680	Prolixin Decanoate, fluphenazine, 25 mg	$15.20
J2690*	Pronestyl, procainamide HCL, 1 gm	$11.02
J2720*	Protamine sulfate, 10 mg	$1.00
J2765	Reglan, metoclorpramide HCL, 10 mg	$0.80
J0696	Rocephin, ceftriaxone sodium, 250 mg	$16.16
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	$1.94
X0040	Solu Cortef 500 mg	$6.64
J2920	Solu-Medrol, methylprednisolone sodium succinate, up to 40 mg	$ 1.94
J2930	Solu-Medrol, methylprednisolone sodium succinate, up to 125 mg	$ 3.23
01478	Stadol, 1 mg	$ 7.66
01479	Stadol, 2 mg	$ 7.81
J3010	Sublimaze, fentanyl citrate, 2 cc	$ 2.52
J3070	Talwin Lactate, pentazocine HCL, 30 mg	$ 3.95
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	$ 1.14
J3150	Testosterone propionate, up to 100 mg	$ 1.09
90703	Tetanus toxoid, 1.ml	$ 7.65
J3230	Thorazine, chlorpromazine HCL, up to 50 mg	$ 1.90
01671	Ticar, Ticarcillin, 1 gm	$ 4.25
J3250	Tigan trimethobenzamide HCL, up to 200 mg	$ 3.04

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

End-Stage Renal Disease Drug Pricing Update (continued)

CPT/HCPCS CODE	NAME	PRICE
X0042	Timentin, 100 mg-3 gm	$14.32
J3280	Torecan, thiethylprrazine maleate, up to 10 mg	$ 4.97
J3320	Trobicin, spectinomycin dihydrochloride, up to 2 g	$26.79
X0099	Unasyn, 3 gm	$21.01
J3360	Valium, diazepam, 5 mg	$ 3.36
J3370	Vancocin, vancomycin HCL, 500 mg	$10.42
W0233	Venofer, 100 5 mg	$65.36
X0057*	Verapamil, 5 mg	$ 2.14
J2250	Versed, midazolam HCL, 1 mg	$ 2.63

CPT/HCPCS CODE	NAME	PRICE
X0044	Vibramycin, Doxycycline, 100 mg	$14.01
J3420	Vitamin B-12 cyanocobalamin, up to 1,000 mcg	$0.23
00522	Water for injection, 30 cc	$ 1.90
00521	Water for injection, 500 cc	$ 7.13
J2500	Zemplar, 5 mcg	$25.09
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.

Coverage of Levocarnitine for End-Stage Renal Disease Patients

The Centers for Medicare & Medicaid Services (CMS) has implemented a national coverage determination for intravenous levocarnitine (J1955) for use in the treatment of carnitine deficiency in end-stage renal disease (ESRD) patients for services provided **on or after January 1, 2003.**

Carnitine is a naturally occurring substance that functions in the transport of long-chain fatty acids for energy production by the body. Deficiency can occur due to a congenital defect in synthesis or utilization, or from dialysis. The causes of carnitine deficiency in hemodialysis patients include dialytic loss, reduced renal synthesis and reduced dietary intake.

Intravenous levocarnitine will only be covered for those ESRD patients who have been on dialysis for a minimum of three months for one of the following indications.

Patients must have documented carnitine deficiency, defined as a plasma free carnitine level<40 micromol/L (determined by a professionally accepted method as recognized in current literature), along with signs and symptoms of:

1. Erythropoietin–resistant anemia (persistent hematocrit <30 percent with treatment) that has not responded to standard erythropoietin dosage (that which is considered clinically appropriate to treat the particular patient) with iron replacement, and for which other causes have been investigated and adequately treated, or
2. Hypotension on hemodialysis that interferes with delivery of the intended dialysis despite application of usual measures deemed appropriate (e.g., fluid management). Such episodes of hypotension must have occurred during at least 2 dialysis treatments in a 30-day period.

Continued use of levocarnitine will not be covered if improvement has not been demonstrated within six months of initiation of treatment. All other indications for levocarnitine are noncovered in the ESRD population.

For a patient currently receiving intravenous levocarnitine, Medicare will cover continued treatment if:

1. Levocarnitine has been administered to treat erythropoietin-resistent anemia (persistent hematocrit <30 percent with treatment) that has not responded to standard erythropoietin dosage (that which is considered clinically appropriate to treat the particular patient) with iron replacement, and for which other causes have been investigated and adequately treated, or hypotension on hemodialysis that interferes with delivery of the intended dialysis despite application of usual measures deemed appropriate (e.g., fluid management) and such episodes of hypotension occur during at least **two** dialysis treatments in a 30-day period; and
2. The patient's medical record documents a pre-dialysis plasma free carnitine level <40 micromol/L prior to the initiation of treatment; or
3. The treating physician certifies (documents in the medical record) that in his/her judgment, if treatment with levocarnitine is discontinued, the patient's pre-dialysis carnitine level would fall below 40 micromol/L and the patient would have recurrent erythropoietin-resistant-anemia or intradialytic hypotension.

Billing Requirements

The applicable types of bill are:

- 13x – Reimbursed at cost
- 72x – Reimbursed at 95 percent of AWP
- 85x – Reimbursed at cost

This drug must be billed on Form UB-92 CMS-1450 or its electronic equivalent under the revenue code 636 along with HCPCS J1955.

Deductible and coinsurance apply to this service.

A local medical review policy is being developed and will be published in a future issue of the *Medicare A Bulletin.* ❖

Source: CMS Transmittal AB-02-165, CR 2438

SKILLED NURSING FACILITY SERVICES

2003 Update of HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement

The Centers for Medicare & Medicaid Services (CMS) has issued a comprehensive list of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing (CB) provision of the skilled nursing facility prospective payment system (SNF PPS). Services appearing on this list submitted on claims to both Medicare fiscal intermediaries (FIs) and carriers, including durable medical equipment regional carriers (DMERCs), will not be paid by Medicare to providers, other than a SNF, when **included** in SNF CB on dates when a beneficiary for whom such a service is being billed resides in a SNF. Services **excluded** from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries in a SNF stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

SNF Consolidated Billing HCPCS Coding List

The following HCPCS codes subject to SNF CB have been classified into five major categories. **New codes listed subsequent to prior publications appear in bold in HCPCS code charts.** Codes from previous lists not appearing in this article **have been deleted**. Since there is a three-month grace period in which deleted HCPCS codes are still allowed to process, codes remain listed here if the three-month grace period overlaps with this update.

Major Category I

Exclusion of Services Beyond the Scope of a SNF

The services must be provided on an outpatient basis at a hospital, including a critical access hospital (CAH), **not by a SNF**, and are excluded from SNF PPS and CB for beneficiaries in a Part A stay. Services directly related to these services, defined as services billed for the same place of service and with the same line item date of service (LIDOS) as the services listed below, are also excluded fro SNF CB, with exceptions as listed below.

- Anesthesia, drugs incident to radiology and supplies (**revenues codes 037x, 0255, 027x and 062x**) will be bypassed by enforcement edits when billed with computerized tomography (CT) scans, cardiac catheterizations, magnetic resonance imaging (MRIs), radiation therapies, or angiographies or surgeries.
- In general, bypasses also allow CT scans, cardiac catheterization, MRI, radiation therapy, angiography, and outpatient surgery **HCPCS codes 0001T – 0021T, 0024T – 0026T, or 10021 – 69990** (except HCPCS codes listed in the table below) to process and pay. This includes all other revenue code lines on the incoming claim that have the same LIDOS.

Computerized Axial Tomography Scans

70450	70460	70470	70480	70481	70482
70486	70487	70488	70490	70491	70492
70496	70498	71250	71260	71270	71275
72125	72126	72127	72128	72129	72130
72131	72132	72133	72191	72192	72193
72194	73200	73201	73202	73206	73700
73701	73702	73706	74150	74160	74170
74175	75635	76355	76360	76362	76370
76375	76380	**76497**	G0131	G0132	

Cardiac Catheterization

33967	**33968**	93501	93503	93505	93508
93510	93511	93514	93524	93526	93527
93528	93529	93530	93531	93532	93533
93539	93540	93541	93542	93543	93544
93545	93555	93556	93561	93562	93571
93572					

Magnetic Resonance Imaging

70336	70540	70542	70543	70544	70545
70546	70547	70548	70549	70551	70552
70553	71550	71551	71552	71555	72141
72142	72146	72147	72148	72149	72156
72157	72158	72195	72196	72197	73218
73219	73220	73221	73222	73223	73718
73719	73720	73721	73722	73723	73725
74181	74182	74183	74185	75552	75553
75554	75555	**75556***	76093	76094	76390
76394	76400	**76498**	**C8900**	**C8901**	**C8902**
C8903	**C8904**	**C8905**	**C8906**	**C8907**	**C8908**
C8909	**C8910**	**C8911**	**C8912**	**C8913**	**C8914**

***** This service is not covered by Medicare.

Radiation Therapy

77261	77262	77263	77280	77285	77290
77295	77299	77300	77301	77305	77310
77315	77321	77326	77327	77328	77331
77332	77333	77334	77336	77370	77399
77401	77402	77403	77404	77406	77407
77408	77409	77411	77412	77413	77414
77416	77417	77418	77427	77431	77432
77470	77499	77520	77522	77523	77525
77600	77605	77610	77615	77620	77750
77761	77762	77763	77776	77777	77778
77781	77782	77783	77784	77789	77790
77799	G0173	G0242	G0243		

Angiography, Lymphatic, Venous and Related Procedures

75600	75605	75625	75630	75635	75650
75658	75660	75662	75665	75671	75676
75680	75685	75705	75710	75716	75722
75724	75726	75731	75733	75736	75741
75743	75746	75756	75774	75790	75801*
75803*	75805*	75807*	75809*	75810*	75820*
75822*	75825*	75827*	75831*	75833*	75840*
75842*	75860*	75870*	75872*	75880*	75885*
75887*	75889*	75891*	75893*	75894	75896

2003 Update of HCPCS Codes Used for SNF Consolidated Billing Enforcement (continued)

75898	75900	75940	75960	75961	75962
75964	75966	75968	75970	75978	75980
75982	75992	75993	75994	75995	75996

***** Lymphatic procedures are *CPT* codes 75801 through 75807, and venous procedures are *CPT* codes 75809 through 75893 **.**

Outpatient Surgery and Related Services–INCLUSION

Inclusions, rather than exclusions, are given in this one case, because of the great number of surgery procedures that are excluded and can only be safely performed in a hospital operating room setting. *Procedures associated with splints and casts* are included with minor surgical procedures and appear *with an asterisk (*).*

Note: Anesthesia, drugs, supplies and laboratory services (revenues codes 037x, 0250, 027x, 062x and 030x) will be bypassed by enforcement edits when billed with outpatient surgeries excluded from SNF CB.

These CPT**/HCPCS Codes May Not Be Paid Separately from SNF PPS**

10040	10060	10080	10120	11040	11041
11042	11043	11044	11055	11056	11057
11200	11300	11305	11400	11719	11720
11721	11740	11900	11901	11920	11921
11922	11950	11951	11952	11954	11975
11976	11977	15780	15781	15782	15783
15786	15787	15788	15789	15792	15793
15810	15811	16000	16020	17000	17003
17004	17110	17111	17250	17340	17360
17380	17999	20000	**20526**	20551	20552
20553	20974	21084	21085	21497	26010
29058	29065	29075	29085	29086	29105
29125	29126	29130	29131	29200	29220*****
29240*****	29260*****	29280*****	29345	29355	29358
29365	29405	29425	29435	29440	29445
29450	29505	29515	29540*****	29550*****	29580*****
29590*****	29700	29705	29710	29715	29720
29730	29740	29750	29799	30300	30901
31720	31725	31730	36000	36002	36140
36400	36405	36406	36430	36468	36469
36470	36471	36489******	36491******	36600	36620
36680	38220	38221	44500	51772	51784
51785	51792	51795	51797	53601	53660
53661	53670	53675	54150	54235	54240
54250	55870	57160	57170	58301	58321
58323	59020	59025	59425	59426	59430
62367	62368	64550*****	65205	69000	69200
69210	95970	95971	95972	95973	95974
95975	99183	G0167	G0168		

*****For Part B, these codes are defined as therapy when rendered by a therapist. When rendered by physicians (including nurse practitioners, clinical nurse specialists, or physician assistants), these codes are defined as surgery and may be billed by the rendering provider.

******These HCPCS codes are included in Part A payment when performed alone or with other surgery, but are excluded if they occur with the same LIDOS as an excluded chemotherapy agent.

Emergency Services

These services are identified on claims submitted to FIs by a hospital or CAH using revenue code **045x –** emergency room services.

Ambulance Trips – With Application to Major Category II

Ambulance trips associated with services in major category II provided in renal dialysis facilities (RDFs) are also excluded from SNF consolidated billing.

A0425	A0426	A0427	A0428	A0429	A0430
A0431	A0432	**A0433**	A043	**A0435**	A0436
Q3019	**Q3020**				

Major Category II

Additional Services Excluded when Rendered to Specific Beneficiaries

These services must be provided to specific beneficiaries, either: (A) end-stage renal disease (ESRD) beneficiaries, or (B) beneficiaries who have elected hospice, by specific licensed Medicare providers, and are excluded from SNF PPS and consolidated billing.

SNFs will not be paid for Category II services (dialysis, EPO, etc.) when the SNF is the place of service, as to receive Medicare payment, these services must be provided in a renal dialysis facility. Hospices must also be the only type of provider billing hospice services.

Dialysis, EPO and Other Dialysis Related Services for ESRD Beneficiaries

Specific coding is used to differentiate dialysis and related services that are excluded from SNF consolidated billing for ESRD beneficiaries in three cases:

1. When the services are provided in a RDF (including ambulance services listed under major category I.
2. Home dialysis when the SNF constitutes the home of the beneficiary.
3. When the drug EPO is used for ESRD beneficiaries.

Note: SNFs may not be paid for home dialysis supplies.

Coding Applicable to Services Provided in a RDF

Institutional dialysis services billed only by a RDF are identified by **type of bill 72x**. Services for method 2 ESRD beneficiaries billed by a RDF must be accompanied by the dialysis related **diagnosis code 585.**

Coding Applicable to Services Provided in a RDF or SNF as Home

RDFs, or suppliers use only the following **revenue codes** when billing for home dialysis services for beneficiaries who reside in the SNF:

__825 – Hemodialysis OPD/home support services
__835 – Peritoneal OPD/home support services
__845 – Continuous ambulatory peritoneal dialysis OPD/ home support services
__855 – Continuous cycling peritoneal dialysis OPD/home support services

HCPCS codes recognized for use with these revenue codes are:

Dialysis Supplies

A4651	A4652	A4653	A4656	A4657	A4660
A4663	A4670*	A4680	A4690	A4706	A4707
A4708	A4709	A4712	A4714	A4719	A4720

2003 Update of HCPCS Codes Used for SNF Consolidated Billing Enforcement (continued)

A4721 A4722 A4723 A4724 A4725 A4726
A4730 A4736 A4737 A4740 A4750 A4755
A4760 A4765 A4766 A4770 A4771 A4772
A4773 A4774 A4802 A4860 A4870 A4890
A4911 A4913** A4918 A4927 A4928 A4929
A4930 A4931

***** Not covered by Medicare
****** A4913 is a carrier priced code not billed by SNFs.

Dialysis Equipment

E1500 E1510 E1520 E1530 E1540 E1550
E1560 E1570 **E1575** E1580 E1590 E1592
E1594 E1600 E1610 E1615 E1620 E1625
E1630 E1632 E1635 E1636 **E1637**
E1638 E1639 E1699***

***** E1699 is a carrier priced code not billed by SNFs.
****** E1638 is being deleted starting 2003, so a 3-month grace period for billing will last into March 2003.

Coding Applicable to EPO Services

EPO is a Medicare-approved drug for use by ESRD beneficiaries. Intermediary EPO claims for ESRD beneficiaries are identified with the following **revenue codes when services are provided in RDF:**

_ **634** – EPO with less than 10,000 units
_ **635** – EPO with 10,000 or greater units

Hospice Care for a Beneficiary's Terminal Illness

Hospice services for terminal conditions are identified with the following **bill types: 81x or 82x.**

Major Category III

Additional Excluded Services Rendered by Certified Providers

These services may be provided by any Medicare provider licensed to provide them, **except a SNF**, and are excluded from SNF PPS and consolidated billing.

HCPCS code ranges for chemotherapy, chemotherapy administration, radioisotopes and customized prosthetic devices are set in statute. This statute also gives the Secretary authority to make modifications in the particular codes that are designated for exclusion within each of these service categories; accordingly, the minor and conforming changes in coding that appear in the instruction are made under that authority.

Chemotherapy

J9000 J9001 **J9010** J9015 J9017 J9020
J9040 J9045 J9050 J9060 J9062 J9065
J9070 J9080 J9090 J9091 J9093 J9094
J9095 J9096 J9097 J9100 J9110 J9120
J9130 J9140 J9150 J9151 J9160 J9170
J9180 J9181 J9182 J9185 J9200 J9201
J9206 J9208 J9211 J9230 J9245 J9265
J9266 J9268 J9270 J9280 J9290 J9291
J9293 J9300 J9310 J9320 J9340 J9350
J9355 J9357 J9360 J9370 J9375 J9380
J9390 J9600

Chemotherapy Administration

These codes are included in SNF PPS payment for beneficiaries in a Part A stay when performed alone or with other surgery, but are excluded if they occur with the same line item date of service as an excluded chemotherapy agent. A chemotherapy agent must also be billed when billing these services, and physician orders must exist to support the provision of chemotherapy.

36260 36261 36262 36489 36491 36530
36531 36532 36533 36534 36535 36640
36823 96405 96406 96408 96410 96412
96414 96420 96422 96423 96425 96440
96445 96450 96520 96530 96542 Q0083
Q0084 Q0085

Radioisotopes

79030 79035 79100 79200 79300 79400 79420
79440

Customized Prosthetic Devices

K0556 K0557 K0558 K0559 L5050 L5060
L5100 L5105 L5150 L5160 L5200 L5210
L5220 L5230 L5250 L5270 L5280 L5301
L5311 L5321 L5331 L5341 L5500 L5505
L5510 L5520 L5530 L5535 L5540 L5560
L5570 L5580 L5585 L5590 L5595 L5600
L5610 L5611 L5613 L5614 L5616 L5617
L5618 L5620 L5622 L5624 L5626 L5628
L5629 L5630 L5631 L5632 L5634 L5636
L5637 L5638 L5639 L5640 L5642 L5643
L5644 L5645 L5646 L5647 L5648 L5649
L5650 L5651 L5652 L5653 L5654 L5655
L5656 L5658 L5660 L5661 L5662 L5663
L5664 L5665 L5666 L5668 L5670 L5671
L5672 L5674 L5675 L5676 L5677 L5678
L5680 L568 L5684 L5686 L5688 L5690
L5692 L5694 L5695 L5696 L5697 L5698
L5699 L5700 L5701 L5702 L5704 L5705
L5706 L5707 L5710 L5711 L5712 L5714
L5716 L5718 L5722 L5724 L5726 L5728
L5780 **L5782** L5785 L5790 L5795 L5810
L5811 L5812 L5814 L5816 L5818 L5822
L5824 L5826 L5828 L5830 L5840 L5845
L5846 **L5847 L5848** L5850 L5855 L5910
L5920 L5925 L5930 L5940 L5950 L5960
L5962 L5964 L5966 L5968 L5970 L5972
L5974 L5975 L5976 L5978 L5979 L5980
L5981 L5982 L5984 L5985 L5986 L5988
L5989 L5990 **L5995** L6050 L6055 L6100
L6110 L6120 L6130 L6200 L6205 L6250
L6300 L6310 L6320 L6350 L6360 L6370
L6400 L6450 L6500 L6550 L6570 L6580
L6582 L6584 L6586 L6588 L6590 L6600
L6605 L6610 L6615 L6616 L6620 L6623
L6625 L6628 L6629 L6630 L6632 L6635
L6637 **L6638** L6640 L6641 L6642 L6645
L6646 L6647 L6648 L6650 L6655 L6660
L6665 L6670 L6672 L6675 L6676 L6680
L6682 L6684 L6686 L6687 L6688 L6689
L6690 L6691 L6692 L6693 L6700 L6705
L6710 L6715 L6720 L6725 L6730 L6735
L6740 L6745 L6750 L6755 L6765 L6770
L6775 L6780 L6790 L6795 L6800 L6805
L6806 L6807 L6808 L6809 L6810 L6825
L6830 L6835 L6840 L6845 L6850 L6855
L6860 L6865 L6867 L6868 L6870 L6872
L6873 L6875 L6880 L6881 L6882 L6920

2003 Update of HCPCS Codes Used for SNF Consolidated Billing Enforcement (continued)

L6925 L6930 L6935 L6940 L6945 L6950
L6955 L6960 L6965 L6970 L6975 L7010
L7015 L7020 L7025 L7030 L7035 L7040
L7045 L7170 L7180 L7185 L7186 L7190
L7191 L7260 L7261 L7266 L7272 L7274
L7362 L7364 L7366

Major Category IV

Additional Excluded Preventive and Screening Services

These services are covered as Part B benefits and are not included in SNF PPS. **Such** services must be billed by the SNF for beneficiaries in a Part A stay with Part B eligibility **on type of bill (TOB) 22x**. Swing bed providers must use TOB **12x** for eligible beneficiaries in a Part A SNF level.

Formerly, b*one mass measurement* (screening) was listed as a preventive service excluded from SNF consolidated billing. This was incorrect. Such services are diagnostic, not screening, procedures, and therefore are bundled into SNF PPS payment and subject to consolidated billing.

Mammography

Mammography screening codes are billed with **revenue code 0403** and no other services on the bill.

G0202 G0203 **76090** **76091** 76092

Vaccines (Pneumococcal, Flu or Hepatitis B)

Pneumococcal, flu or hepatitis B vaccines are billed with **revenue code 0636.**

90657 90658 90659 90723 90732 90740*
90743* 90744* 90746* 90747* 90748** **Q3021**
Q3022 **Q3023**

***** Not covered by Medicare
****** Medicare pays only when this procedure is medically necessary

Vaccine Administration

Vaccine administration codes are billed with **revenue code 0771.**

G0008 G0009 G0010

Screening Pap Smear and Pelvic Exams

Screening Pap smear and pelvic examination codes are billed with diagnosis codes V76.2 or V15.89.

G0101 G0123 G0143 G0144 G0145 G0147
G0148 P3000 Q0091

Colorectal Screening Services

Colorectal screening services are billed with any of the following diagnosis codes:

V10.05 V10.06 555.0 555.1 555.2 555.9
556.0 556.1 556.2 556.3 556.8 556.9
558.2 558.9

G0104 G0106 G0107 G0120 **G0122***

*****This service is not covered by Medicare.

Prostate Cancer Screening

G0102, prostate cancer screening digital rectal examination, is billed with **revenue code 0770**. **G0103,** prostate cancer screening specific antigen testing, is billed with **revenue code 030x.**

G0102 G0103

Glaucoma Screening

G0117 G0118

Major Category V

Part B Services Included in SNF Consolidated Billing

Therapy services are included in SNF PPS and consolidated billing for residents in a Part A stay, and must be billed by the SNF alone for its Part B residents and non-residents.

The following debridement HCPCS codes were incorrectly shown as being billable by a therapist. Effective July 1, 2002, CWF removed the HCPCS codes 11040, 11041, 11042, 11043, and 11044 from the therapy code files used in CWF editing. These HCPCS codes are still listed as included in SNF PPS and CB as ambulatory surgery. There is no distinct technical portion for these HCPCS codes that should have been billed to the FI. Physicians or physician equivalents may continue to bill Medicare carriers for their professional services for these codes:

11040 11041 11042 11043 11044.

Therapies billed with revenues codes 42x (physical therapy), 43x (occupational therapy), 44x (speech-language pathology)

0029T 29105* 29125* 29126* 29130* 29131*
29220* 29240* 29260* 29280* 29520 29530
29540* 29550* 29580* 29590* 64550* 90901
90911 92506 92507 92508 92510 92525†
92526 **92601** **92602** **92603** **92604** **92605**
92606 **92607** **92608** **92609** **92610** **92611**
92612 **92613** **92614** **92615** **92616** 95831
95832 95833 95834 95851 95852 96000
96001 96002 96003 96105 96110 96111
96115 97001 97002 97003 **97004** **†97005**
97006† 97010** 97012 97014 97016 97018
97020 97022 97024 97026 97028 97034
97035 97036 97039 97110 97112 97113
97116 97124 97032 97033 97139 97140
97150 97504 97520 97530 97532 97533
97535 97537 97542 97545 97546 97601
97602= 97703 97750 97799 G0192† G0193
G0194 G0195 G0196 G0197 G0198 G0199
G0200 G0201 **G0279** **G0280** **G0281** **G0282**.
G0283 **G0295**. V5362 V5363 V5364

***** For Part B, these codes are defined as therapy when rendered by a therapist (revenue codes 042x, 043 and 044x). When they are rendered by physicians (including nurse practitioners, clinical nurse specialists, or physician assistants) (any other revenue codes), they are defined as surgery and may be billed by the rendering provider. See Outpatient Surgery and Related Procedures (major category I) for other such codes.
****** Payment for code 97010 is bundled with other rehabilitation services. It may be bundled with any therapy code.
= 97602 is bundled with other rehabilitation services. It may be bundled with any therapy code.
† Procedures not covered by Medicare.
.G0282 and G0295 are being deleted in 2003, a three-month grace period for billing will last into March 2003. ❖

Source: CMS Transmittal A-02-118; CR 2459

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

2003 Update to the Hospital Outpatient Prospective Payment System

The Centers for Medicare & Medicaid Services (CMS) has issued changes to the hospital outpatient prospective payment system (OPPS) for 2003. Unless otherwise noted, all changes discussed in this notification are effective for services furnished **on or after January 1, 2003.**

Limitations on Beneficiary Copayment

For calendar year 2003, the national unadjusted copayment amount for an ambulatory payment classification (APC) will be limited to 55 percent of the APC payment rate, as it was in 2002. In addition, the wage-adjusted copayment amount for a service cannot exceed the inpatient hospital deductible amount for 2003 of $840.

Outlier Payments

For calendar year 2003, the outlier threshold is reduced from 3.5 to 2.75 times the OPPS payments for the service, and the outlier payment percentage is reduced from 50 percent to 45 percent of the cost in excess of the outlier threshold. In 2003, outlier payments will be made if the cost of providing a service exceeds 2.75 times the OPPS payments for the service, and the amount of the outlier payment will be 45 percent of the amount by which the provider's costs exceed 2.75 times the OPPS payments.

Outpatient Billing For Dialysis

Generally, Medicare does not allow payment under the OPPS for routine dialysis treatments furnished to end-stage renal disease (ESRD) patients in the outpatient department of a hospital that does not have a certified dialysis facility. However, in certain medical situations in which the ESRD patient cannot obtain her or his regularly scheduled dialysis treatment at a certified ESRD facility, the OPPS rule for 2003 allows payment for nonroutine dialysis treatments furnished to ESRD patients in the outpatient department of a hospital that does not have a certified dialysis facility. Payment is limited to unscheduled dialysis for ESRD patients in the following circumstances:

- Dialysis performed following or in connection with a vascular access procedure.
- Dialysis performed following treatment for an unrelated medical emergency; e.g., if a patient goes to the emergency room for chest pains and misses a regularly scheduled dialysis treatment that cannot be rescheduled, Medicare allows the hospital to provide and bill Medicare for the dialysis treatment.
- Emergency dialysis for ESRD patients who would otherwise have to be admitted as inpatients in order for the hospital to receive payment.

In these situations, non-ESRD certified hospital outpatient facilities are to bill Medicare using a new Healthcare Common Procedure Coding System (HCPCS) code, G0257 – Unscheduled or emergency treatment for dialysis for ESRD patient in the outpatient department of a hospital that does not have a certified ESRD facility**.** This new code is assigned to APC 0170, with status indicator "S."

Hospitals cannot use HCPCS code G0257 to bill for the provision of dialysis treatment to patients with acute renal failure.

Because of current edits that are in effect related to skilled nursing facility (SNF) consolidated billing, dialysis following or in connection with a vascular access procedure will not be separately payable when furnished by a hospital to beneficiaries who are in a covered Part A stay in a SNF.

Partial Hospitalization Program (PHP)

Coding Partial Hospitalization Services

CMS will be updating the provider and intermediary manuals in the near future to identify clearly all the HCPCS codes that are covered and may be billed for PHP patients. In the meantime, in order to avoid billing errors, the following list of the current revenue codes and *CPT*/HCPCS codes for PHPs is being provided:

Revenue Codes	CPT/HCPCS Codes
250 * – Pharmacy	HCPCS code not required
43x – Occupational Therapy	G0129
904 – Activity Therapy	G0176
910 – Psychiatric General Services	*90801*, *90802*, *90875*, *90876*, *90899*
914 – Individual Psychotherapy	*90816*, *90817*, *90818*, *90819*, *90821*, *90822*, *90823*, *90824*, *90826*, *90827*, *90828*, *90829*
915 – Group Therapy	*90849*, *90853*, *90857*
916 – Family Psychotherapy	*90846*, *90847*, *90849*
918 – Psychiatric Testing	*96100*, *96115*, *96117*
942 – Education/Training	G0177

*Limited to Medicare covered, i.e., not usually self-administered drugs.

Billing of Services Furnished by Clinical Social Workers (CSWs)

For calendar year 2003, hospitals and community mental health centers (CMHCs) will continue to bill the fiscal intermediary for costs associated with the services of clinical social workers (CSWs) furnished to PHP patients. The fiscal intermediary will continue to pay through the PHP per diem amount.

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

Billing and Payment Rules for Using Modifier CA

Effective January 1, 2003, a new modifier has been added to the list of reportable modifiers under OPPS.

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

CA Procedure payable only in the inpatient setting when performed emergently on an outpatient who dies prior to admission

To receive payment for a service billed with **modifier CA**, all of the following conditions must be met:

- The status of the patient is outpatient.
- The patient has an emergent, life-threatening condition.
- A procedure on the inpatient list (designated by payment status indicator C) is performed on an emergency basis to resuscitate or stabilize the patient.
- The patient dies without being admitted as an inpatient.

If all of the conditions for payment are met, hospitals can submit a claim using a type of bill 13x for all services that were furnished, including the inpatient procedure (e.g., a procedure designated by OPPS payment status indicator C). Hospitals should include modifier **CA** on the line with the HCPCS code for the inpatient procedure.

Payment for all services on a claim that have the same date of service as the HCPCS code billed with modifier **CA** is made under APC 977. Separate payment is not allowed for other services furnished on the same date.

Billing and Payment Rules When a Patient Dies

If a patient dies in the emergency department, and the patient's status is outpatient, the hospital should bill for payment under the OPPS for the services that were furnished.

If the emergency department or other physician orders the patient to the operating room for a surgical procedure, and the patient dies in surgery, payment will be made based on the status of the patient.

- If the patient was admitted as an inpatient, the hospital should submit a claim for payment under the hospital inpatient PPS (a DRG-based payment).
- If the patient dies and is not admitted as an inpatient, the hospital should bill for payment under the OPPS for the services that were furnished.
- If the patient dies and is not admitted as an inpatient, and a procedure designated as an inpatient procedure (by OPPS status indicator C) is performed, the hospital should bill for payment under the OPPS for the services that were furnished on that date and should include modifier **CA** on the line with the HCPCS code for the inpatient procedure. Payment for all services, other than the inpatient procedure designated under OPPS by a status indicator C, furnished on the same date is bundled into a single payment under APC 977.

Billing and Payment Rules When a Procedure Designated as an Inpatient Procedure (by OPPS status indicator C) Is Performed On a Patient Whose Status Is Outpatient

If a procedure designated as an inpatient procedure must be performed on a patient whose status is that of an outpatient, the hospital may:

- Admit the patient and submit an inpatient claim for payment under the inpatient PPS, or
- Admit and transfer the patient to another provider and submit a claim for a per diem DRG rate.

Under the OPPS, a procedure assigned status indicator C (indicating a procedure on the inpatient list) is never payable as an APC. Therefore, if a procedure designated as an inpatient procedure is billed without modifier **CA** for a patient whose status is that of an outpatient, the line on the claim for the procedure with status indicator C will receive a line item denial, and no services furnished on the same date will be paid.

Observation services are outpatient services and do not constitute an inpatient admission. Under the OPPS, a procedure assigned status indicator C (indicating a procedure on the inpatient list) is never payable as an APC. Therefore, if a procedure designated as an inpatient procedure is billed without modifier **CA** for a patient admitted for observation, the line on the claim for the procedure with status indicator C will receive a line item denial, and no services furnished on the same date will be paid.

Modifier **CA** is not to be used to bill for a procedure with status indicator "C" that is performed on an elective basis or scheduled to be performed on a patient whose status is that of an outpatient.

Documentation Requirements

For a hospital to receive payment when a procedure with OPPS status indicator C is performed and 1) the patient dies without being admitted as an inpatient, or 2) the patient survives the procedure and is admitted as an inpatient and transferred following the procedure, the patient's medical record must contain all of the following information:

- If the patient is transferred, written orders to admit the patient to the hospital performing the procedure and transfer the patient to another hospital following the procedure.
- Documentation that the reported HCPCS code for the surgical procedure with OPPS payment status indicator C was actually performed.
- Documentation that the reported surgical procedure with status indicator C was medically necessary.
- If the patient is admitted as an inpatient and subsequently transferred to another facility, documentation that the transfer was medically necessary, such as the patient requiring postoperative treatment unavailable at the transferring facility.

New G HCPCS Codes Under OPPS

The table below provides a summary of the new G HCPCS codes that have been issued since the October 2002 OPPS update. These HCPCS codes are effective for services furnished on or after January 1, 2003.

G0256 Prostate brachytherapy using permanently implanted palladium seeds, including transperitoneal placement of needles or catheters into the prostate, cystoscopy and application of permanent interstitial radiation source
Assigned APC: 0649.

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

G0257 Unscheduled or emergency treatment for dialysis for ESRD patient in the outpatient department of a hospital that does not have a certified ESRD
Assigned APC:0170.

G0259 Injection procedure for sacroiliac joint; arthrography

G0260 Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent and arthrography
Assigned APC: 0204.

G0261 Prostate brachytherapy using permanently implanted iodine seeds, including transperitoneal placement of needles or catheters into the prostate, cystoscopy and application of permanent interstitial radiation source
Assigned APC:0684.

G0262 Small intestinal imaging; intraluminal, from ligament of Treitz to the ileo cecal valve, includes physician interpretation and report
Assigned APC: 0711.
Note: Code created to describe a new diagnostic test for which there is no existing 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

G0264 Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma or patient directly admitted to observation with diagnosis of congestive heart failure, chest pain or asthma when the observation stay does not meet all criteria for G0244
Assigned APC: 0600.

G0265 Cryopreservation, freezing and storage of cells for therapeutic use, each cell line

G0266 Thawing and expansion of frozen cells for therapeutic use, each aliquot

G0267 Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (e.g. T-cells, metastatic carcinoma)

G0268 Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing
Assigned APC: 0340.

G0269 Placement of occlusive device into either a venous or arterial access site, post surgical or interventional procedure (e.g., angioseal plug, vascular plug)

G0270 Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes
Note: Must be billed to the Medicare carrier (not intermediary) prior to April 1, 2003.

G0271 Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease) group (2 or more individuals), each 30 minutes
Note: Must be billed to the Medicare carrier (not intermediary) prior to April 1, 2003.

G0272 Naso/oro gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)
Assigned APC: 0272.
Note: Code created because there is no existing code for this service.

G0273 Radiopharmaceutical biodistribution, single or multiple scans on one or more days, pre-treatment planning for radiopharmaceutical therapy of non-Hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies)
Assigned APC: 0718.

G0274 Radiopharmaceutical therapy, non-Hodgkin's lymphoma, includes administration of radiopharmaceutical (.e.g. radiolabeled antibodies)
Assigned APC: 0725.
Note: Code created because there is no existing code for this service.

G0275 Renal angiography (unilateral or bilateral) performed at the time of cardiac catheterization, includes catheter placement in the renal artery, injection of dye, flush aortogram and radiologic supervision and interpretation and production of images (List separately in addition to primary procedure)

G0278 Iliac artery angiography performed at the same time of cardiac catheterization, includes catheter placement in the iliac artery, injection of dye, radiologic supervision and interpretation and production of images (List separately in addition to primary procedure)

G0279 Extracorporeal shock wave therapy; involving elbow epicondylitis
Note: New code paid under the therapy fee schedule.

G0280 Extracorporeal shock wave therapy; involving other than elbow epicondylitis or plantar fascitis
Note: New code paid under the therapy fee schedule.

G0288 Reconstruction, computed tomographic angiography of aorta for surgical planning for vascular surgery
Assigned APC:0975.
Note: Code replaces C9708.

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

G0289 Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chrondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee

G0290 Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel

G0291 Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel

G0292 Administration of experimental drug(s) only in a Medicare qualifying clinical trial (includes administration for chemotherapy and other types of therapy via infusion and/or other than infusion), per day
Assigned APC:0708.

G0293 Noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a Medicare qualifying clinical trial, per day
Assigned APC:0710.

G0294 Noncovered surgical procedure(s) using either no anesthesia or local anesthesia only, in a Medicare qualifying clinical trial, per day
Assigned APC:0707.

G0295 Electromagnetic stimulation, to one or more areas
Note: Service not covered under Medicare.

Billing Instructions for the G code for Earwax Removal

Hospitals performing earwax removal on a beneficiary on the same day as audiologic function testing (*CPT* codes *92553* through *92598*, except for noncovered codes *92559* and *92560*) must use G0268 to report earwax removal. Reporting of G0268 indicates that a physician removed the earwax at a separate encounter from the audiologic function testing. If *69210* is reported, payment for the earwax removal will be denied.

Billing for Prostate Brachytherapy

The two new G codes for prostate brachytherapy, G0256 and G0261, include payment for transperineal placement of needles and/or catheters into the prostate, cystourethroscopy, radioelement application, and implanted brachytherapy sources. Therefore, hospitals must not report *CPT* codes *55859* and *77776-77778* in addition to either of the G code. Additionally, hospitals must not separately report any HCPCS for brachytherapy sources in addition to one of the G codes. Lastly, hospitals should report only one G code for this service. As with other procedure codes, post operative recovery and/or observation, is packaged into payment for the procedure. Other services provided during the performance of prostate brachytherapy (e.g. intraoperative ultrasound, laboratory testing, diagnostic services) are separately payable and should be separately reported. The G codes should be reported with only one unit of service.

Hospitals must not use these G codes to report prostate brachytherapy that does not utilize implantable sources (e. g. remote afterloading high intensity brachytherapy, *CPT* codes *77781-77784*). Remote afterloading high intensity brachytherapy is reported with the use of appropriate CPT codes.

Billing for Stereotactic Breast Biopsy

Stereotactic breast biopsy must be reported using the appropriate *CPT* code (e.g., *19103*). Radiological or ultrasound guidance for the biopsy should be reported separately using the appropriate *CPT* code.

Billing for Radiologic or Ultrasound Guidance

Hospitals must separately report radiological or ultrasound guidance, using the appropriate *CPT* code in addition to the HCPCS code for the procedure with which it is used.

Billing for Active Wound Care Procedures

CPT code *97601* is a physical therapy service and is paid under the Medicare physician fee schedule. Payment for *CPT* code *97602* is recognized under the OPPS as a packaged service, i.e., the service is not separately paid under OPPS; however, the cost of the service is packaged into whatever other service is provided on that date. It is common for *97602* to be performed at the time of another physical therapy service in which case payment for *97602* is packaged into payment for the other physical therapy service. If a service coded under *97602* is performed at the time of a clinic or emergency visit, the evaluation/management service must be documented in accordance with the hospital's documentation guidelines for clinic and emergency visits. If the only service provided to a beneficiary is *97602*, the hospital may bill outpatient visit code *99211*. Payment for *97602* will be packaged into the payment for *99211*. If a hospital provides and bills for *97601* or *97602* and a clinic or emergency department visit, the clinic or emergency visit must be separately identifiable and documented in accordance with the hospital's guidelines for documenting clinic and emergency visits.

Sacroiliac Joint Injections

CPT code *27096, Injection procedure for sacroiliac joint, arthrography and/or anesthetic steroid*, describes two distinct procedures, one used with diagnostic procedures and the other therapeutic. The code is properly packaged when used for diagnostic injections, but should be separately payable when used to report a therapeutic injection. Therefore, in order to facilitate appropriate reporting and payment for the procedures described by CPT code *27096*, two new codes have been created: G0259 – Injection procedure for sacroiliac joint, arthrography, and G0260 – Injection procedure for sacroiliac joint, provision of anesthetic and/or steroid. G0259 is a packaged service and G0260 is assigned to APC 0204.

Drug Eluting Stents

Effective for services furnished on or after April 1, 2003, contingent upon their prior approval by the Food and Drug Administration (FDA), Medicare is implementing payment under APC 656, Transcatheter Placement of Drug-Eluting Coronary Stents, for two temporary HCPCS codes that describe drug-eluting stents:

G0290 and G0291.

Payment for HCPCS codes G0290 and G0291 under APC 0656 will not be implemented **before April 1, 2003.**

- If the FDA approves the drug-eluting stents **before January 1, 2003,** hospitals should hold claims containing these HCPCS codes for services furnished on or after January 1, 2003 through March 31, 2003 until after April 1, 2003. If a hospital furnishes additional services that would be reported on the same claim as the codes for the insertion of drug-eluting stents (G0290 and G0291), they may wish to remove those codes from the claim in order to receive payment for the remaining services. In this instance, the hospital would have to submit an adjustment bill after April 1 2003 that includes the new HCPCS code(s) for insertion of the drug-eluting stents.
- If the FDA approves the drug-eluting stents **after December 31, 2002 but before April 1, 2003,** and a hospital, subsequent to their approval by the FDA, uses drug-eluting stents for services furnished in an outpatient setting prior to April 1, 2003, payment for placement of the stents will be made under APC 0104.
- If the FDA does not grant approval of drug-eluting stents **by April 1, 2003,** Medicare will announce a new effective date for APC 0656 and for HCPCS codes G0290 and G0291.

Outpatient Services Under Clinical Trials

There are three new G codes for use in reporting services furnished in hospital outpatient departments under national clinical trials:

G0292, G0293 and G0294.

On September 19, 2000, Medicare issued a national coverage decision stating that Medicare will pay for the routine costs of clinical trials. This policy is published as section 30-1 of Medicare's Coverage Issues Manual (CMS-Pub.6). Because the experimental intervention is not covered, but items and services required solely because of the intervention are covered, Medicare needed to identify ways to properly code for and pay for the routine costs when delivered in a hospital outpatient department.

To pay accurately for the covered services associated with the administration of drugs as part of a clinical trial, Medicare created a new code to allow for correct billing and payment for routine costs, as defined by the national coverage determination. Therefore, HCPCS code G0292 must be billed when only experimental drugs are administered as part of a Medicare qualifying clinical trial. When an experimental drug is being administered in conjunction with payable drugs or on the same day as payable drugs, G0292 must not be used. Instead, the appropriate drug administration code must be billed.

There are also procedures that may be performed in the hospital outpatient department as part of a qualifying clinical trial. Because the intervention is not covered under Medicare's clinical trial policy, Medicare needed a mechanism to pay the hospital for its covered fixed costs associated with providing the service under the clinical trial. Medicare has created two codes to allow for correct billing of procedures performed as the focus of qualifying clinical trials, HCPCS G0293 and G0294.

ICD-9 diagnosis code V70.7 must be reported on the claim as a diagnosis other than the primary diagnosis in order for hospitals to bill for G0292, G0293 and G0294. All three of these codes are for OPPS use only. Other provider types may not bill these codes.

Placement of Occlusive Device

HCPCS code G0269 device was developed to ensure proper reporting of this service. This service was being inappropriately reported with codes for such procedures as "blood vessel repair" and "repair of arterial pseudoaneurysm." This service is a packaged service under OPPS.

Radiopharmaceutical Biodistribution of Zevalin

A new code, HCPCS G0273 has been created to describe radionuclide scanning to determine the biodistribution of Zevalin. The procedure encompasses administration of Indium labeled Zevalin and whole body radionuclide scanning 2 - 24 hours and 48 - 72 hours after administration of Zevalin. Rarely, a third scan is necessary. The purpose of the scanning is to ensure that the biodistribution of Zevalin is normal, thus decreasing the risk of toxic effects from administration of a therapeutic dose of Zevalin. The published criteria for determining appropriate biodistribution involve making a qualitative comparison of isotope uptake in several organ systems between the two scans. Therefore, these scans cannot be read in isolation and this code should be reported only once no matter how many scans are performed.

This code includes the administration of the radiopharmaceutical and performance of all scans. Also note that the infusion of rituxumab prior to the administration of Zevalin is separately payable.

When billing G0273 and G0274 for Zevalin, the payment amount includes payment for both the procedure and the radiopharmaceutical. For diagnostic administration of Zevalin, G0273, *CPT* codes for diagnostic administration of radiopharmaceuticals (*78990* and *78999*) and diagnostic scanning must not be reported (*78800 -78803*). For therapeutic administration of Zevalin G0274, *CPT* codes for therapeutic administration of radiopharmaceuticals (*79900*), radiopharmaceutical therapy (*79100, 79400*), and infusion or instillation of radioelement solution (*77750*) must not be reported.

Renal and Iliac Angiography Performed with Cardiac Angiography

The add-on HCPCS codes G0275 and G0278 have been created to assure proper reporting of and payment for renal and iliac angiography performed at the time of cardiac angiography. These codes must be listed separately in addition to primary procedure.

These procedures are performed frequently on Medicare patients and are currently reported using codes that describe placement of a catheter in the renal and/or iliac artery(s) (*CPT* codes *36245* and *36246*) and radiological supervision and interpretation of renal and/or iliac

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

angiography (*CPT* codes *75710, 75716, 75722,* and *75724*). *CPT* codes *36245, 36246 75710, 75716, 75722,* and *75724* must not be used to report these procedures. The new codes, G0275 and G0278, are packaged services under OPPS.

Arthroscopic Procedures of the Knee

HCPCS code G0289 has been created to permit appropriate reporting of arthroscopic procedures performed in different compartments of the same knee during the same operative session.

This is an add-on code and must be added to the knee arthroscopy code for the major procedure being performed. This code is only to be reported once per extra compartment, even if chondroplasty, loose body removal, and foreign body removal are all performed. The code may be reported twice (or with a unit of two) if the physician performs these procedures in two compartments in addition to the compartment where the main procedure was performed.

HCPCS code G0289 must be reported only when the physician spends at least 15 minutes in the additional compartment performing the procedure. It must not be reported if the reason for performing the procedure is due to a problem caused by the arthroscopic procedure itself. This code is to be used when a procedure is performed in the lateral, medial, or patellar compartments in addition to the main procedure. Medicare Medicare does not allow billing of *CPT* codes *29874, Arthroscopy, knee, surgical; for removal of loose body or foreign body (e.g., osteochrondritis dissecans fragmentation, chondral fragmentation)* and *29877, Arthroscopy, knee,surgical; debridement/shaving of articular cartilage (chrondroplasty)* with other arthroscopic procedures on the same knee. The new code is a packaged service under OPPS. *CPT* code *29874* must not be used to report the services described by the new code G0289.

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

CPT codes *77401* through *77416* are to be reported only once per date of service. Furthermore, only one of these codes may be reported per date of service per patient. *CPT* codes *77402* through *77406* describe treatment delivery for a single treatment area. *CPT* codes *77407* through *77411* describe treatment delivery to two treatment areas. *CPT* codes *77412* through *77416* describe treatment delivery to three or more treatment areas. In the cases of *CPT* codes *77407* through *77416* the radiation delivered to each treatment area is added and the sum determines which code to report. For example, if three treatment areas are each treated with 11 MeV, then the proper code to bill is *77416* for "20 MeV or greater." It is incorrect to report *77414* (for "11-19 MeV") three times.

Hospital OPPS Modifiers

CMS requires the reporting of *CPT* Level I and HCPCS Level II modifiers for accuracy in reimbursement, coding consistency, editing, and capturing payment data for constructing Medicare outpatient groups for the OPPS.

Effective January 1, 2003, a new Level II modifier has been added to the list of reportable modifiers under the OPPS.

CA Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission

Below is a listing of all the modifiers that are reported under the OPPS as of January 1, 2003:

***Level I (CPT)*)**

25 27 50 52 58 59 73 74
76 77 78 79 91

Level II (HCPCS)

CA E1 E2 E3 E4 FA F1 F2 F3 F4
F5 F6 F7 F8 F9 GA GG GH GY GZ
LC LD LT QM QN RC RT TA T1 T2
T3 T4 T5 T6 T7 T8 T9 ❖

Source: CMS Transmittal A-02-129, CR 2503

Billing and Payment Requirements for Observation Services

Under the outpatient prospective payment system (OPPS), hospitals are required to bill for observation services in one of two ways:

1) As packaged services, or
2) As a separately payable ambulatory payment classification (APC) when certain conditions are met for patients having diagnoses of chest pain, asthma, or congestive heart failure, for whom observation services are furnished.

Changes in Billing and Payment Requirements for Observation Services

Hospitals may bill for patients who are "direct admissions" to observation. A "direct admission" occurs when a physician in the community refers a patient to the hospital for observation, bypassing the clinic or emergency department (ED). Effective for services furnished **on or after January 1, 2003,** hospitals may bill for patients directly admitted for observation services using one of the following HCPCS codes:

G0263 Direct admission of patient with diagnosis of congestive heart failure, chest pain or asthma for observation services that meet all criteria for G0244.

G0264 Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma or patient directly admitted to observation with diagnosis of congestive heart failure, chest pain or asthma when the observation stay does not meet all criteria for G0244.

The determination of whether use of G0263 is appropriate will be made after reviewing all diagnoses submitted on the claim (e.g., admission, principal, and secondary diagnoses).

Code G0263 must be billed with G0244. Although code G0263 is treated as a packaged service and will not generate a payment under OPPS, the code will be recognized as taking the place of a visit or critical care code in meeting the observation criteria for patients directly admitted to observation.

Code G0264 should not be billed with code G0244. HCPCS code G0264 is assigned to APC 0600 and is paid the same amount as a low-level clinic visit. This code provides a way to recognize and pay for the initial nursing assessment and any packaged observation services attributable to patients that are directly admitted to observation but whose observation services do not meet the criteria necessary to qualify for a separate observation payment.

Effective January 1, 2003, HCPCS code G0258 – *Intravenous infusion(s) during separately payable observation stay, per observation stay (must be reported with G0244),* is deleted from the OPPS. Hospitals must bill for infusion therapy provided during a separately payable observation stay (HCPCS code G0244) using HCPCS code Q0081 – *Infusion therapy, using other than chemotherapeutic drug.* As with code G0258, HCPCS code Q0081 may be reported for infusions started in the emergency department, clinic or observation area, so long as the infusion continues during the observation stay. An edit has been installed in the outpatient code editor (OCE) software to allow payment, effective for services furnished on or after April 1, 2002, for HCPCS code G0244 when billed with Q0081, subject to all other conditions for payment having been met.

Billing Requirements for Packaged Observation Services (for patients other than those with diagnoses of asthma, chest pain, or congestive heart failure)

Hospitals are required to report observation charges under revenue code 762 – Observation Room. HCPCS coding is not required but if reported, the appropriate CPT codes are *99217* through *99220* and *99234* through *99236.*

In the "units" field, hospitals must enter the number of hours the outpatient is in observation status.

Hospitals must report laboratory, radiology, or other diagnostic services under revenue codes 30x, 31x, 32x, etc., as appropriate.

When a physician in the community orders that an outpatient be directly admitted to observation, without going through the hospital's emergency department or clinic, the hospital must bill for the direct admission using HCPCS code G0264. Hospitals should report G0264 under revenue code 762.

Hospitals must use HCPCS code G0264 to bill for an outpatient directly admitted to observation with a diagnosis of asthma, congestive heart failure or chest pain that does not qualify for G0244 because the required criteria are not fully met, e.g., the observation stay was less than eight hours, the qualifying diagnostic tests were not performed, etc.

Billing Requirements to Receive Separate Payment Under APC 339

Hospitals must report HCPCS code G0244 – *Observation care provided by a facility to a patient with CHF, chest pain, or asthma, minimum eight hours, maximum forty-eight hours,* to bill for separate payment under APC 339 for observation services furnished to patients with diagnosis of asthma, chest pain, or congestive heart failure.

Admission requirements to bill for separate observation payment effective January 1, 2003

Hospitals must bill **either** an emergency department visit (APC 0610, 0611, or 0612), **or** a clinic visit (APC 0600, 0601,or 0602), **or** critical care (APC 620), **or** HCPCS code with each bill for separate observation payment using HCPCS G0244.

To receive separate payment for G0244, hospitals must bill an evaluation/management (E/M) code for an emergency room, clinic visit or critical care on the day before or the day that the patient is admitted to observation.

If hospitals bill for more than one period of observation on a single claim, each observation period must be paired with a separate E/M visit.

Hospitals must bill the E/M code associated with observation on the same claim as the observation service.

Hospitals must use **modifier 25** with the E/M code in order to receive payment for G0244.

Billing and Payment Requirements for Observation Services (continued)

Effective for services furnished **on or after January 1, 2003,** when a patient with congestive heart failure, chest pain, or asthma is a "direct admission" to observation, hospitals must bill HCPCS code G0263 or G0264 as approppiate.

A "direct admission" occurs when a physician in the community refers a patient to the hospital for observation, bypassing the clinic or emergency department (ED).

Hospitals must use modifier 25 with G0263 in order to receive payment for G0244.

Hospitals should bill G0263 and G0264 with revenue code 762.

Diagnoses Required for Separate Observation Payment

When billing for separate payment for observation services using HCPCS code G0244, hospitals must include at least one of the ICD-9-CM diagnoses listed below on the bill as the admitting, primary, or secondary diagnosis.

Required Diagnoses For Chest Pain:

411.0	Postmyocardial infarction syndrome
411.1	Intermediate coronary syndrome
411.81	Coronary occlusion without myocardial infarction
411.89	Other acute ischemic heart disease
413.0	Angina decubitus
413.1	Prinzmetal angina
413.9	Other and unspecified angina pectoris
786.05	Shortness of breath
786.50	Chest pain, unspecified
786.51	Precordial pain
786.52	Painful respiration
59.59	Other chest pain

Required Diagnoses For Asthma:

493.01	Extrinsic asthma with status asthmaticus
493.02	Extrinsic asthma with acute exacerbation
493.11	Intrinsic asthma with status asthmaticus
493.12	Intrinsic asthma with acute exacerbation
493.21	Chronic obstructive asthma with status asthmaticus
493.22	Chronic obstructive asthma with acute exacerbation
493.91	Asthma, unspecified with status asthmaticus
92.92	Asthma, unspecified with acute exacerbation

Required Diagnoses For Congestive Heart Failure:

391.8	Other acute rheumatic heart disease
398.91	Rheumatic heart failure (congestive)
402.01	Malignant hypertensive heart disease with congestive heart failure
402.11	Benign hypertensive heart disease with congestive heart failure
402.91	Unspecified hypertensive heart disease with congestive heart failure
404.01	Malignant hypertensive heart and renal disease with congestive heart failure
404.03	Malignant hypertensive heart and renal disease with congestive heart and renal failure
404.11	Benign hypertensive heart and renal disease with congestive heart failure
404.13	Benign hypertensive heart and renal disease with congestive heart and renal failure
404.91	Unspecified hypertensive heart and renal disease with congestive heart failure
404.93	Unspecified hypertensive heart and renal disease with congestive heart and renal failure
428.0	Congestive heart failure
428.1	Left heart failure
428.20*	Unspecified systolic heart failure
428.21*	Acute systolic heart failure
428.22*	Chronic systolic heart failure
428.23*	Acute on chronic systolic heart failure
428.30*	Unspecified diastolic heart failure
428.31*	Acute diastolic heart failure
428.32*	Chronic diastolic heart failure
428.33*	Acute on chronic diastolic heart failure
428.40*	Unspecified combined systolic and diastolic heart failure
428.41*	Acute combined systolic and diastolic heart failure
428.42*	Chronic combined systolic and diastolic heart failure
428.43*	Acute on chronic combined systolic and diastolic heart failure
428.9	Heart failure, unspecified

*Denotes new ICD-9-CM codes effective October 1, 2002.

Diagnostic Tests Required for Separate Observation Payment

In order to receive separate payment for observation services billed using HCPCS G0244, hospitals must furnish and bill for specific diagnostic services typically performed on patients requiring observation care for the three specified conditions. Hospitals must perform the specified diagnostic services within the dates of the E/M visit plus the first 24 hours of observation and must bill for the diagnostic services on the same claim as the observation services to which they are related. The required diagnostic tests are as follows:

- For chest pain, at least two sets of cardiac enzymes (**either** two CPK (*82550, 82552,* or *82553*), **or** two troponin (*84484 or 84512*), and two sequential electrocardiograms (*93005*).
- For asthma, a breathing capacity test (*94010*) **or** pulse oximetry (*94760* or *94761* or *94762*).
- For congestive heart failure, a chest X-ray (*71010, 71020,* or *71030*) **and** an electrocardiogram (*93005*) and pulse oximetry (*94760, 94761,* or *94762*).

Note: Pulse oximetry codes *94760*, *94761*, and *94762* are treated as packaged services under the OPPS. Although no separate payment is made for packaged codes, hospitals must separately report the HCPCS code and a charge for pulse oximetry in order to establish that observation services for congestive heart failure and asthma diagnoses meet the criteria for separate payment.

Billing and Payment Requirements for Observation Services (continued)

Additional billing requirements

In order to receive payment for G0244, hospitals must bill observation services for a minimum of 8 hours up to a maximum of 48 hours. In billing for observation services, hospitals should enter as units of service for G0244 the number of hours the patient spends in observation.

Hospitals must not use G0244 to bill for observation services of less than eight hours. Observation services of less than eight hours must be billed as packaged services using revenue code 762.

If a period of observation spans more than one calendar day, hospitals must include all of the hours for the entire period of observation on a single line and enter as the date of service for that line the date the patient is admitted to observation.

Observation time begins at the clock time appearing on the nurse's observation admission note, which should coincide with the initiation of observation care or with the time of the patient's arrival in the observation unit.

Observation time ends at the clock time documented in the physician's discharge orders, or, in the absence of such a documented time, the clock time when the nurse or other appropriate person signs off on the physician's discharge order. This time should coincide with the end of the patient's period of monitoring or treatment in observation.

The medical record must document that the beneficiary was under the care of a physician during the period of observation, as indicated by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

Effective for services furnished on or after January 1, 2003, hospitals must discontinue using HCPCS code G0258 to bill for intravenous infusion(s) furnished during a separately payable observation stay that is billed using G0244. Rather, hospitals must use HCPCS code Q0081, when billing for an infusion furnished during the observation stay. Hospitals may resubmit claims that were denied for services furnished on or after April 1, 2002 through December 31, 2002 because G0244 is billed with Q0081.

Requirements Affecting Separate Payment Under APC 339 for Observation Services Furnished to Patients With Diagnosis of Asthma, Chest Pain, or Congestive Heart Failure

If more than one nonoverlapping observation is billed on a single claim, each of which meets the required conditions for payment, each observation is paid separately.

Separate payment for observation services meeting the required conditions is allowed only when billed on a 13x bill type.

Separate payment is allowed for any service that is separately payable under the OPPS, that is, procedures with status indicators S, X, K, G, V, or H, when billed with G0244.

Payment for G0244 is **not** allowed if a surgical procedure or any service that has a status indicator of "T" (with the exception of Q0081) occurs on the day before or the day that the patient is admitted to observation.

Data in the admitting diagnosis field (form locator number 76 or its electronic equivalent) will be captured for use in outpatient claims processing as of January 1, 2003. The admitting diagnosis will be taken into account in determining separate observation payment for services furnished on or after April 1, 2002, when the bill is submitted or resubmitted, or when an adjustment bill is submitted after January 1, 2003.

Separate payment is allowed for multiple observation periods on a claim if the required criteria are met for each observation.

If there are multiple observation periods for the same diagnoses, each of the required diagnostic tests must be performed multiple times, i.e., the tests must be rerun for each period of observation. Therefore, if a claim contains two separate periods of observation related to chest pain, four EKGs and four cardiac enzyme tests must be performed.

If multiple observations are for different diagnoses, the re-use of tests is allowed. For example, if there are two periods of observation on a claim, one for chest pain and one for congestive heart failure, two EKGs, not three, are needed. The EKGs that are performed to meet the diagnostic test requirements for observation related to chest pain may also be used for the observation related to congestive heart failure.

No separate payment is allowed for any hours a beneficiary spends in observation over 24 hours; all costs beyond 24 hours will be included in the APC payment for observation services.

If all criteria for G0244 are not met, the claim will be returned to the provider. The hospital may resubmit the claim reporting the observation services under revenue code 762 alone or with CPT codes *99217* through *99220* or *99234* through *99236*.

Payment for G0264 is made under APC 600. Although no separate payment is made for G0263, charges billed with G0263 are packaged in determining costs associated with APC 339. ❖

Source: CMS Transmittal A-02-129, CR 2503

Pass-Through Devices

Below is a complete listing of the device categories that are reportable under the hospital outpatient prospective payment system (OPPS) as of January 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.

C-codes C1884, C2614, and C2632 are new pass-through categories reportable under the OPPS effective January 1, 2003.

	HCPCS Codes	Category Descriptor	Effective Date	APC
1	C1765*	Adhesion barrier	7/1/01	
2	C1783	Ocular implant, aqueous drainage assist device	7/1/02	
3	C1884	Embolization Protective System	1/1/03	1884
4	C1888	Catheter, ablation, non-cardiac, endovascular (implantable)	7/1/02	
5	C1900	Lead, left ventricular coronary venous system	7/1/02	
6	C2614	Probe, percutaneous lumbar discectomy	1/1/03	2614
7	C2618	Probe, cryoablation	4/1/01	
8	C2632	Brachytherapy solution, iodine –125, per mCi	1/1/03	2632

Explanation of Terms/Definitions for Specific Category Codes

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

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

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

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

Billing for Devices for Which C-codes Have Expired

Effective January 1, 2003, 95 pass-through device categories have expired and are no longer reportable. The list of device categories with expiration dates of December 31, 2002, was published in the Fourth Quarter 2002 *Medicare A Bulletin* (pages 102-105).

With the exception of C1716, C1718, C1719, C1720 and C2616, the respective "C" HCPCS codes for the device categories cannot be reported after December 31, 2002. The expiring "C" codes do not have a 90-day grace period. Any claims that contain these codes will be returned to the hospitals. The Outpatient Code Editor will return the claim to the hospital so that the hospital may remove the expired pass-through device HCPCS code.

Hospitals can resubmit the charge for the device with either no HCPCS code or, at the hospital's option, with a current HCPCS code, if one exists for the device. Hospitals are not required to bill using a HCPCS code, but they may do so. Hospitals must use one of the following revenue codes when billing for devices that are not pass-through devices: 272, 275, 276, 278, 279, 280, 289, or 624. Revenue codes 274 and 290, which are acceptable codes for reporting pass-through devices, always require HCPCS codes. If the non-pass-through device is an implantable orthotic or prosthetic device or implantable durable medical equipment, the device must be reported under a revenue code other than 274 or 290, for example 278 – other implants.

The code for cochlear implant system, L8614, is a permanent HCPCS code that will not expire. Although the cochlear implant system device category will expire for pass-through payment purposes, the code may continue to be reported after December 31, 2002. Beginning January 1, 2003 charges reported with L8614 will be considered as charges attributable to a packaged device under OPPS.

Only one unit may be reported under code C2616, *Brachytherapy seed, Yttrium-90*. Claims containing more than one unit for this code will be returned to the hospital.

Although a device may no longer be eligible for pass-through payment and may no longer have a reportable HCPCS code, it is essential that hospitals continue to include a charge on the claim for any device they furnish, either as part of the charge for the procedure or as a separate charge billed under a device revenue code. This is equally important for devices that have never been eligible for pass-through payments. Hospitals are required to bill for packaged devices to ensure that the cost of the device is taken into account in determining the hospital's transitional corridor and outlier payments and that all device costs are included in the data Medicare uses in updating APC payments for the procedure in the future. Hospitals have the option of whether or not to bill using HCPCS codes for packaged devices. However, hospitals must be aware that for purposes of future APC rate-setting for procedures that use devices, Medicare will include in calculating the median cost of a procedure the cost of all devices that appear on claims whether billed using a HCPCS code or billed with only a revenue code.

General Coding, Billing Instructions and Explanations For Pass-Through Devices

C1900 – Left ventricular coronary venous system lead – This code should be reported with *CPT* codes *33224* and *33225*. The APC assignments for these two *CPT* codes do not include payment for the pass-through device.

Devices Implanted, Removed, and Implanted Again, Not Associated With Failure (Applies to Transitional Pass-through Devices Only) – In instances where the physician is required to implant another device because the first device fractured, the hospitals

Pass-Through Devices (continued)

may bill for both devices – the device that resulted in fracture and the one that was implanted into the patient. Medicare realizes that there may be instances where an implant is tried but later removed due to the device's inability to achieve the necessary surgical result or due to inappropriate size selection of the device by the physician (e.g., physician implants an anchor to bone and the anchor breaks because the bone is too hard or must be replaced with a larger anchor to achieve desirable result). In such instances, Medicare will provide separate reimbursement for both devices. This situation does not extend to devices that result in failure or are found to be defective. For failed or defective devices, hospitals are advised to contact the vendor/manufacturer.

Note: This applies to transitional pass-through devices only and not to devices packaged into an APC.

Kits – Manufacturers frequently package a number of individual items used in a particular procedure in a kit. Generally, to avoid complicating the category list unnecessarily and to avoid the possibility of double coding, Medicare has not established codes for such kits. However, hospitals are free to purchase and use such kits. If the kits contain individual items that separately qualify for transitional pass-through payments, these items may be separately billed using applicable codes. Hospitals may not bill for transitional pass-through payments for supplies that may be contained in kits.

Multiple units – Hospitals must bill for multiple units of items that qualify for transitional pass-through payments when such items are used with a single procedure by entering the number of units used on the bill.

Reprocessed devices – Hospitals may bill for transitional pass-through payments only for those devices that are "single use." Reprocessed devices may be considered "single use" if they are reprocessed in compliance with enforcement guidance of the Food and Drug Administration (FDA) relating to the reprocessing of devices applicable at the time the service is delivered. The FDA is phasing in new enforcement guidance relating to reprocessing during 2001 and 2002. For further information, see FDA's guidance document entitled "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals," published August 14, 2000, and subsequent FDA guidance or regulatory documents.

Changes to Pass-Through Drugs, Biologicals and Radiopharmaceuticals

HCPCS Replacements Codes for Retiring Pass-Through Drugs

The HCPCS codes listed in the left column are being retired effective December 31, 2002; however, because of the grace period hospitals have for reporting the new 2003 HCPCS codes, these codes are in effect for hospital outpatient billing for drugs furnished through March 31, 2003. Beginning April 1, 2003, these codes are no longer reportable under the hospital OPPS. These codes have been replaced with new HCPCS codes indicated in the column titled "New HCPCS" effective April 1, 2003, and will be reportable under the hospital OPPS.

Old HCPCS	APC	New HCPCS	APC
C1012	1012	P9033	0954
C1013	1013	P9031	1013
C1014	1014	P9035	9501
C1058	1058	Q3009	*
C1064	1064	A9517	*
C1065	1065	A9518	1348
C1066	1066	A4642	*
C1087	1087	A9516	*
C1094	1094	A9519	*
C1096	1096	A9521	1096
C1097	1097	A9513	*
C1098	1098	A9515	*
C1099	1099	A9514	*
C1188	1188	A9517	*
C1202	1202	A9519	*
C1207	1207	J2352	7031
C1348	1348	A9518	1348
C9019	9019	J0637	9019
C9020	9020	J7520	9020
C9100	9100	A9524	*
C9108	9108	J3240	9108
C9110	9110	J9010	9110
C9114	9114	J2324	9114
C9115	9115	J3487	9115

* Denotes a drug code that is packaged under OPPS; therefore, no separate payment is made for the drug.
** Note that C9114 and C9115 are replaced by J2324 and J3487 but the descriptions are different. Refer to the complete list of pass-through drugs for payment information for those codes.

New Pass-Through Drugs

The following drugs have been designated as pass-through drugs under the hospital OPPS effective January 1, 2003:

C9120 Injection, fulvestrant, per 50 mg
Assigned APC: 9120.

C9121 Injection, argatroban, per 5 mg
Assigned APC: 9121.

J3315 Injection, triptorelin pamoate, 3.75 mg
Assigned APC: 9122.

Comprehensive List of Pass-through Drugs

The following is a list of the drugs paid as pass-through drugs as of January 1, 2003:

A9700 Injection, Octafluropropane, per 3 ml
Assigned APC: 9016.

C9111 Injection, Bivalirudin, 250 mg per vial
Assigned APC: 9111.

C9112 Injection, Perflutren lipid microsphere, per 2ml
Assigned APC: 9112.

C9113 Injection, Pantoprazole sodium, per vial
Assigned APC: 9113.

Pass-Through Devices (continued)

C9116 Injection, Ertapenem sodium, per 1 gm vial
Assigned APC: 9116.

C9119 Injection, Pegfilgrastim, per 6 mg single dose vial
Assigned APC: 9119.

C9120 Injection, Fulvestrant, per 50 mg
Assigned APC: 9120.

C9121 Injection, Argatroban, per 5 mg
Assigned APC: 9121.

C9200 Orcel, per 36 square centimeters
Assigned APC: 9200.

C9201 Dermagraft, per 37.5 square centimeters
Assigned APC: 9201.

J0587 Injection, Botulinum toxin, type B, per 100 units
Assigned APC: 9018.

J0637 Injection, Caspofungin acetate, 5 mg
Assigned APC: 9019.

J2324 Injection, Nesiritide, pre 0.5 mg
Assigned APC: 9114.

J3315 Injection, Triptorelin pamoate, per 3.75 mg
Assigned APC: 9122.

J3487 Injection, Zoledronic acid, per 1 mg
Assigned APC: 9115.

J7517 Mychophenolate mofetil, oral per 250 mg
Assigned APC: 9015.

J9010 Injection, Alemtuzumab, per 10 mg
Assigned APC: 9110.

J9017 Injection, Arsenic trioxide, per 1 mg $31.35
Assigned APC: 9012.

J9219 Implant, Leuprolide acetate, per 65 mg implan
Assigned APC: 7051.

Non-Pass-through Drugs Under OPPS

Changes in Payment For Orphan Drugs

Effective January 1, 2003, the following four codes will be excluded from payment under OPPS and be paid on a reasonable cost basis.

J1785 J0205 J0256 J9300

APC for Rubidium-RB-82

The following new code and APC will be effective January 1, 2003. This code was not previously paid as a pass-through drug or an otherwise separately payable drug.

Q3000 Supply of radiopharmaceutical diagnostic imaging agent, rubidium RB-82, per dose
Assigned APC: 9025.

Changes in Payment of Influenza Virus and Pneumococcal Pneumonia Vaccine (PPV)

Effective for claims with dates of service on or after January 1, 2003, payment for influenza virus and PPV vaccines and their administration provided in a hospital outpatient department, home health agency (HHA), and comprehensive outpatient rehabilitation facility (CORF) will change. Payment will no longer be made based on the outpatient prospective payment system (OPPS).

Payment will be based on the provider type. Hospitals (bill type 13x), and HHAs (bill type 34x) will be paid based on reasonable cost for the vaccines and their administration. CORFs (bill type 75x) will be paid based on the lower of the charges or 95 percent of the average wholesale price (AWP) for the vaccine and under the Medicare physician fee schedule for the administration.

Influenza and PPV vaccines and their administration are not subject to deductible or coinsurance. The applicable *CPT*/HCPCS codes are *90657, 90658, 90659, 90732,* G0008 and G0009.

Important Notification to Providers

Although the effective date of the change to the payment methodology for influenza and PPV vaccines and their administration is January 1, 2003, the system changes will not be implemented in January 2003. **As a result, claims submitted by hospitals, CORFs, and HHAs with dates of service January 1, 2003, through June 30, 2003, containing any of the *CPT*/HCPCS for the influenza and PPV vaccines and their administration, will be held and not processed until the system changes are implemented with the July 2003 release.**

Hospitals, CORFs or HHAs furnishing additional services that would be reported on the same claim as the vaccines furnished during January 1, 2003, through June 30, 2003 may wish to remove the vaccine and administration charges from the claim in order to receive payment for the remaining services. In this instance, an adjustment bill would need to be submitted to include the vaccine and administration charges after the July system release is implemented.

Note: Payment to all other providers for these vaccines will remain the same. In addition, payment for hepatitis B vaccine will also remain the same.

Policy Affecting Payment for Drugs Under the OPPS

In accordance with section 1861(s)(2)(B) of the Act and related Medicare regulations and program issuances, drugs and biologicals that are not usually self-administered by the patient are payable under the OPPS when furnished incident to a physician service. Under OPPS, Medicare makes separate payment for certain drugs and biologicals and packages payment for others into the procedure with which they are billed.

The fact that a drug has a HCPCS code and a payment rate under the OPPS does not imply that the drug is covered by the Medicare program, but indicates only how the drug may be paid if it is covered by the program.

Neither the OPPS nor other Medicare payment rules regulate the provision or billing by hospitals of non-covered drugs to Medicare beneficiaries. However, a hospital's decision not to bill the beneficiary for non-covered drugs potentially implicates other statutory and regulatory provisions, including the prohibition on inducements to beneficiaries, section 1128A(a)(5) of the Act, or the anti-kickback statute, section 1128B(b) of the Act.

Drugs Treated as Supplies

Certain drugs are so integral to a treatment or procedure that the treatment or procedure could not be performed without them. Because such drugs are so clearly an integral component part of the procedure or treatment, they are packaged as supplies under the OPPS into the APC for

Pass-Through Devices (continued)

the procedure or treatment. Consequently, payment for them is included in the APC payment for the procedure or treatment of which they are an integral part. Examples include:

- Sedatives administered to patients while they are in the preoperative area being prepared for a procedure are supplies that are integral to being able to perform the procedure.
- Mydriatic drops instilled into the eye to dilate the pupils, anti-inflammatory drops, antibiotic ointments, and ocular hypotensives that are administered to the patient immediately before, during, or immediately following an ophthalmic procedure are considered an integral part of the procedure without which the procedure could not be performed.
- Barium or low osmolar contrast media are supplies that are integral to a diagnostic imaging procedure.
- Topical solution used with photodynamic therapy furnished at the hospital to treat non-hyperkeratotic actinic keratosis lesions of the face or scalp.
- Local anesthetics such as marcaine, lidocaine (with or without epinephrine).
- Antibiotic ointments such as bacitracin, placed on a wound or surgical incision at the completion of a procedure.

Examples of cases where a drug is **not** directly related and integral to a procedure or treatment and would not be considered a packaged supply include:

- Cases where drugs are given to a patient for their continued use at home after leaving the hospital.
- In the situation where a patient who is receiving an outpatient chemotherapy treatment develops a headache, any medication given the patient for the headache would not meet the conditions necessary to be treated as a packaged supply.
- In the situation where a patient who is undergoing surgery needs his or her daily insulin or hypertension medication, the medication would not be treated as a packaged supply.
- Hospitals may not separately bill beneficiaries for items whose costs are packaged into the APC payment for the procedure with which they are used (except for the copayment that applies to the APC). Note that drugs treated as supplies should be reported under the revenue code associated with the cost center under which the hospital accumulates the costs for the drugs.

OPPS Policy on Payment for the Unused Portion of a Drug

Once a drug is reconstituted in the hospital's pharmacy, it may have a limited shelf life. Since an individual patient may receive less than the fully reconstituted amount, hospitals are encouraged to schedule patients in such a way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a Medicare patient, the provider may bill for the amount of drug discarded along with the amount administered. In the event that a drug is ordered and reconstituted by the hospital's pharmacy, but not administered to the patient, payment may not be made under OPPS.

Example 1: Drug X is available only in a 100-unit size. A hospital schedules three Medicare patients to receive drug X on the same day within the designated shelf life of the product. An appropriate hospital staff member administers 30 units to each patient. The remaining 10 units are billed to OPPS on the account of the last patient. Therefore, 30 units are billed on behalf of the first patient seen and 30 units are billed on behalf of the second patient seen. Forty units are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

Example 2: An appropriate hospital staff must administer 30 units of drug X to a Medicare patient, and it is not practical to schedule another patient who requires the same drug. For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and does not know the patient's condition. The hospital bills for 100 units on behalf of the patient, and OPPS pays for 100 units.

Hospital Billing Instructions for Drugs with Status Indicator "K" or "N"

In order to receive separate payment for any drug having a status indicator of "K," hospitals must bill for the drug using revenue code 636 "Drugs requiring detail coding" and report the appropriate HCPCS code for the drug.

Hospitals should bill for drugs with status indicator "N" using any of the drug revenue codes that are packaged revenue codes under OPPS: 250, 251, 252, 254, 255, 257, 258, 259, 631, 632, 633, or under revenue code 636. Hospitals may but are not required to use HCPCS codes when billing for packaged drugs. (Revenue code 636 does require HCPCS coding.) Although hospitals are not required to report the HCPCS codes for these drugs, it is essential that hospitals bill charges for packaged drugs by including the charge for packaged drugs in the charge for the procedure or service for which the drug is used or as a separate drug charge. This is critical because the costs of the packaged drugs are used for calculating the hospital's outlier and transitional corridor payments and used in the annual update of APC payments rates for the procedures and services with which the drugs are furnished. ❖

Source: CMS Transmittal A-02-129, CR 2503

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
(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
(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
877-602-8816

BENEFICIARY

800-333-7586

ELECTRONIC MEDIA CLAIMS

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

Electronic Eligibility
904-791-8131

Electronic Remittance Advice
904-791-6865

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

PC-ACE Support
904-355-0313

Testing
904-791-6865

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

Medicare Web Sites

PROVIDERS

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

BENEFICIARIES

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