Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

Features

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

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

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

Routing Suggestions:

- ☐ Medicare Manager
- ☐ Reimbursement Director
- ☐ Chief Financial Officer
- ☐ Compliance Officer
- ☐ DRG Coordinator
- ☐ _____
- ☐ _____
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The *Medicare A Bulletin* is published quarterly by Medicare Communication and Education, to provide timely and useful information to Medicare Part A providers in Florida.

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

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

A Physician's Focus

An Ongoing Focus of Medicare—Improving Quality of Health Care

A principal focus of the Medicare program is to ensure that Medicare beneficiaries have access to high quality health care. Unfortunately, health care quality varies for Medicare beneficiaries, and there are many reasons for this. Care is improving in some areas, but there remain significant gaps between what is known to be good care and the care that is delivered. These gaps signal a need for improvement in the quality of health care being delivered. Fortunately, quality can be measured, and more and more CMS is using these quality measures to improve the quality of health in doctors' offices, nursing homes, hospitals, and other areas of the health care delivery system.

During the past year, the Centers for Medicare & Medicaid Services (CMS) has issued a number of press releases on quality of care initiatives that is in keeping with their commitment to assure quality health care for all Medicare beneficiaries. These initiatives include:

- Home Health Quality Initiative
- Hospital Quality Initiative
- Nursing Home Quality Initiative
- Physician Focused Quality Initiative.

CMS made some more recent announcements including efforts to make it easier for consumers to assess hospital quality, making payment increases and policy changes to improve quality and access for acute care hospitals, improving safety and quality in long-term care facilities, improving care and quality of life for hemodialysis patients via the "fistula first" initiative, and boosting quality through new plans for quality improvement organizations. There are over fifty quality improvement organizations throughout the country that work with consumers, physicians, hospitals and other providers of care to refine our health care delivery systems to make sure patients get the right care at the right time. These quality efforts are paving the way for a transformation in health care where quality matters, where it can and will be measured and improved, and most important where quality will be rewarded.

It is becoming increasingly clear that a focus will be to improve quality in the Medicare program through a system that links payment to quality. The Medicare Modernization Act of 2003 (MMA) provides a financial incentive for hospitals to report quality of care data by linking quality to the payments hospitals receive for treating Medicare beneficiaries. Under the MMA, hospitals that submit quality information to CMS will be eligible to receive the full Medicare payment for services in 2005, those who do not report will receive a 0.4 percentage point reduction in their annual Medicare update rate. These payment incentives aid in quality reporting and in facilitating gathering quality information to provide improvements in care. The time has come where Medicare has taken the step towards quality improvement, and has put financial incentives for quality directly into its payment system. Linking payment to quality holds all providers of health care accountable for the care they deliver, and will help improve the quality of care that so many Americans, especially Medicare beneficiaries, want and deserve.

CMS, through its numerous quality initiatives, is serving as a catalyst for improving the quality of care delivered in our health care systems. The time has come for all to join in and play a role in improving health care quality. Quality matters.

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About *The Medicare A Bulletin*

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

Publication Name	Publication Date	Effective Date of Changes
First Quarter 2005	**Mid-November 2004**	**January 1, 2005**
Second Quarter 2005	Mid-February 2005	April 1, 2005
Third Quarter 2005	Mid-May 2005	July 1, 2005
Fourth Quarter 2005	Mid August 2005	October 1, 2005

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

Who Receives the *Bulletin*?

Anyone may view, print or dowload the *Bulletin* from our provider education Web site. Providers who cannot obtain the *Bulletin* from the Internet are required to register with us to receive a complimentary hardcopy (please see the hardcopy registration form on page 90).

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

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

We use the same mailing address for *all* correspondence, and cannot designate that the *Bulletin* be sent to a specific person/department within a medical facility. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare Provider Registration department. Please remember that address changes must be done using the appropriate Form CMS-855.

What Is in the *Bulletin*?

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

- The publication starts with a column by the Intermediary Medical Director.
- Following an administrative section are usually general information and coverage sections with informational and billing issues, processing guidelines, and medical coverage applicable to all Medicare Part A providers and facilities.
- Coverage guidelines and billing issues targeting specific facilities or Part A providers are usually included in individual sections named under the applicable facility type. These facility-specific sections are in the *Bulletin* only when an article in that category is published (for example, if no CORF/ORF information is in the issue, that section is omitted.)
- As needed, the *Bulletin* contains Electronic Data Interchange and Fraud and Abuse sections.
- The Local Medical Review Policy (LMRP) section contains notification of revisions to finalized medical policies and additions, revisions, and corrections to previously published LMRPs. In addition, this section may contain information on widespread probe reviews conducted by the fiscal intermediary. Whenever possible, the LMRP section will be placed in the center of the *Bulletin* to allow readers to remove it separately, without disturbing the rest of the publication.
- The Educational Resources section includes educational material, such as seminar schedules, Medicare provider education Web site information, and reproducible forms.
- An index and important addresses and phone numbers are in the back of every issue.

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

Do You Have Comments?

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

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

Sign up to our *eNews* electronic mailing list

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

GENERAL INFORMATION

Implementation of New Medicare Redetermination Notice

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Note: *CMS has revised this article on September 30, 2004, to show that providers and patients will receive the Medicare Redetermination Notice for any partially favorable or unfavorable decision made on a redetermination request* ***on or after October 1, 2004.*** *The original article on this issue was published in the Third Quarter 2004 Medicare A Bulletin (page 5).*

Providers Affected

All Medicare physicians, providers, and suppliers.

Provider Action Needed

STOP – Impact to You

Redeterminations are the new first level of appeal for fee-for-service appeals. You and your patients will receive a formal notification letter, the Medicare redetermination notice (MRN), for any partially favorable or unfavorable decision made on a request for redetermination made on or after October 1, 2004.

CAUTION – What You Need to Know

Contractors who judge these redetermination appeals must make their decisions within 60 days as a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and must then notify the providers and beneficiaries involved via the MRN. This document describes the redetermination process, explains the results of the Medicare appeal, and provides information about how to file an appeal regarding Medicare's decision.

GO – What You Need to Do

The newly initiated redetermination appeals process provides for timely notification of beneficiaries and providers via the MRN. Ensure that you understand how these new procedures affect your appeal rights.

Background

The Medicare claims appeal process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, section 521). Section 1869 (a)(3)(C)(ii) required contractors to mail a written notification of the redetermination decision to the parties of an appeal. This section was then amended by MMA [Sections 1869 (a)(5) and 1869 (a)(4)(B)] to include specific requirements for the notices themselves. The requirements ensure that claim appellants receive complete, accurate, and understandable information about their redetermination decisions, as well as information explaining the process of further appeals.

CMS has provided a model cover letter and an MRN to serve as guidelines for Medicare carriers and intermediaries who make the redeterminations. The MMA also ensures that redetermination decisions are made in a timely manner by requiring that 100 percent of redeterminations be completed and mailed within 60 days of the receipt of the request [Section 940(a)(1)].

Additional Information

The MRN must be written in language that is clear and understandable to the beneficiary and must be printed legibly on white paper using black ink. The MRN must include specific required elements such as the sections outlined below:

- An *Introductory* section.
- A *Summary Statement* about the appeal decision.
- A Summary of the Facts section with information specific to the appeal and background information.
- A *Decision* section stating whether the claim is covered by Medicare and whether the beneficiary is responsible for payment.
- An *Explanation of the Decision* section outlining the logic and specific reasons that led to the redetermination. This must include relevant clinical or scientific evidence used in making the redetermination.
- A *Who is Responsible for the Bill* section with information on limitation of liability, waiver of recovery, and physician/supplier refund requirements.
- A *What to Include in Your Request for Independent Appeal* section explaining what policy was used to make the decision and to identify documentation required to appeal at the Independent Appeal Level.
- An *Additional Relevant Information* section to present any additional relevant information, not including any sensitive medical information.
- A section on *Important Information About Your Appeal Rights*, including contact information and an explanation of the next level of the appeal process.

The official instruction issued to your intermediary regarding this change, including a copy of a model MRN, can be found at:
http://www.cms.hhs.gov/manuals/pm_trans/R97CP.pdf.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 2620
Related CR Release Date: February 6, 2004 Revised
Related CR Transmittal Number: R97CP
Effective Date: October 1, 2004
Implementation Date: July 6, 2004
Source: CMS Pub 100-4 Transmittal 97, CR 2620

Condition Code 59 for Dialysis Services at Non-Primary ESRD Facility

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

This special instruction describes the use of condition code 59 when billing for ESRD beneficiaries receiving non-scheduled or emergency dialysis services at a non-primary ESRD dialysis facilities

Background

Condition code 59 was created to help track treatments given at non-primary ESRD facilities.

The responsibility for the care plan and treatments remains with the patients' "home" facility even though arrangements are made to perform dialysis treatments at the other certified facility.

Condition Code for Dialysis Services Provided at a Facility That Is Not the Home Facility

ESRD facilities should note that:

- When a beneficiary receives dialysis services at a non-primary ESRD dialysis facility, condition code 59 should be used in completing Form CMS-1450 (form locators (FLs) 24-30) for billing, and
- When a patient (who is traveling or transient) receives scheduled services at a non-primary ESRD dialysis facility**, c**ondition code 59 should be used.

Related Instructions

You are also referred to Change Request (CR) 3183, Transmittal# 149, titled New Condition Code for ESRD Facilities and Patient Status Code Changes, dated April 23, 2004, which can be found at the following CMS website: *http://www.cms.hhs.gov/manuals/pm_trans?R149CP.pdf***.**

The associated Medlearn Matters article can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3183.pdf*.

Additional Information

An excellent booklet is also available titled Preparing for Medical Emergencies: A Guide for People on Dialysis that can be found at the following CMS website: *http://www.medicare.gov/publications/pubs/pdf/10150.pdf***.**

If you have any questions, please call your fiscal intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp***.**

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: N/A
Related CR Release Date: N/A

Source: CMS Medlearn Matters Special Edition SE0452

Medicare Deductible, Coinsurance, and Premium Rates for 2005

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

This instruction updates Medicare deductibles, coinsurance, and premium rates for calendar year CY 2005.

Background

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for health insurance (HI) or Part A benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but they are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30- 39 quarters of covered employment. **When voluntary enrollment takes place more than 12 months after a person's initial enrollment period for HI benefits, the monthly premium is increased by 10 percent.**

Under the Supplementary Medical Insurance (SMI) plan or Part B, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay) that are set by statute. **When SMI enrollment by a beneficiary takes place more than 12 months after the initial enrollment period, the monthly premium increases by 10 percent for each full 12-month period during which the individual could have been enrolled, but was not.**

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements.

Inpatient Hospital Services

A beneficiary is responsible for an inpatient hospital deductible amount for inpatient hospital services furnished in a spell of illness (which is deducted from the amount payable by the Medicare program to the hospital).

- **More than 60 Days.** When a beneficiary receives such services for more than 60 days during a spell of illness, he/she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per day for the 61st-90th day spent in the hospital.
- **After the 90th Day.** An individual has 60 lifetime reserve days of coverage, which he or she may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one half of the inpatient hospital deductible.
- **Skilled Nursing Facility (SNF) (21st through 100th day).** A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of SNF services furnished during a spell of illness.

Condition Code 59 for Dialysis Services at Non-Primary ESRD Facility (continued)

For CY 2005, the premium, deductible, and coinsurance amounts are as follows:

Year 2005 Medicare Part A Deductible, Coinsurance, and Premium Amounts:

- Deductible: $912.00 per benefit period
- Coinsurance:
  - $228.00 a day for days 61-90 in each period
  - $456.00 a day for days 91-150 for each lifetime reserve day used
  - $114.00 a day in a SNF for days 21-100 in each benefit period
- Premium per month:
  - $$375.00 for those who must pay a premium $$412.50 for those who must pay both a premium and a 10 percent increase
  - $$206.00 for those who have 30-39 quarters of coverage
  - $$226.60 for those with 30-39 quarters of coverage who must pay a 10 percent increase

Year 2005 Medicare Part B Deductible, Coinsurance, and Premium Amounts:

- Deductible: $110.00 per year
- Coinsurance: 20 percent
- Premium per month: $78.20

The following table compares Medicare Part A deductible, coinsurance, and premium amounts for years 2001 through 2005:

Year	Inpatient Hospital Deductible, 1st 60 Days ($)	Inpatient Hospital Coinsurance, 61st – 90th Days ($)	60 Lifetime Reserve Days Coinsurance ($)	SNF Coinsurance ($)
2005	912	228	456	114.00
2004	876	219	438	109.50
2003	840	210	420	105.00
2002	812	203	406	101.50
2001	792	198	396	99.00

Implementation

The implementation date for this instruction is January 3, 2005.

Related Instructions

CR 3121 (Transmittal 3), "New Part B Annual Deductible," was issued on March 12, 2004. CR 3121 updated the 2005 Part B deductible based on section 629 of the Medicare Prescription Drug, Improvement and Modernization Act. The same information held in CR 3121 is being communicated in CR 3463.

Therefore, CR 3463 is replacing CR 3121 to prevent unintended consequences that may result from implementing both CR 3463 and CR 3121 together.

Additional Information

The Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-01), Chapter 3 (Deductibles, Coinsurance Amounts, and Payment Limitations) has been revised and the updated manual instructions are attached to the official instruction released to your carrier/intermediary. You may view that instruction by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that web page, look for CR 3463 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3463 Medlearn Matters Number: MM3463
Related CR Release Date: September 10, 2004
Related CR Transmittal Number : 10
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-1 Transmittal 10, CR 3463

Instructions for Completion of CMS-1450 Billing Form

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All providers who bill Medicare fiscal intermediaries (FIs) including the regional home health intermediaries (RHHIs)

Provider Action Needed

This is primarily for informational purposes, but providers should note that the National Uniform Billing Committee (NUBC) has approved the use of new value codes with an effective date of January 1, 2005.

Background

According to section 42CFR 424.5(a)(5), providers of services need to submit a claim for payment prior to any Medicare reimbursement. The CMS-1450 Part A claim form is used to collect claims information for payments.

The Medicare Claims Processing Manual is being revised and the key revisions clarify the following forms locators (FLs):

- **FL 8** deals with noncovered days and it is a required entry for inpatient claims. The current revision includes as noncovered days those days after the date of covered services ended, such as noncovered level of care, or emergency services after emergency has ended in a non-participating institution.
- **FL 22** – The patient status code is required for all Part A inpatient, skilled nursing facility (SNF), hospice, home health agency, and outpatient hospital services. This code indicates the patient's status as of the "Through" date of the billing period (FL 6). The patient status code revisions made by CR 3417 are as follows:
  - Code 02 is modified to show that the patient was discharged/transferred to a short-term general hospital ***for inpatient care.***
  - Code 05 now indicates that the patient was discharged/transferred to a ***non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care.***

Note that with regard to use of patient status code 05, a Medicare distinct part unit/facility must meet certain Medicare requirements and is exempt from the inpatient prospective payment system; children's hospitals and cancer hospitals are two examples. Other distinct part units/facility types have specific patient status codes, including:

- SNFs (various codes)
- Inpatient rehabilitation facilities (IRFs) including rehabilitation distinct part units of a hospital (code 62)
- Medicare certified long term care hospitals (LTCH) (code 63)
- Psychiatric hospitals or psychiatric distinct part units of a hospital (code 65).

Also, the use of patient status code 43 relates to a discharge/transfer to a government operated health care facility such as a Department of Defense hospital, a Veterans Administration hospital or a Veterans Administration nursing facility and is used whenever the destination of a discharge is a federal health care facility, whether or not the patient resides there.

FL 24-30 would contain condition codes that apply to the relevant billing period. Condition code 59, nonprimary ESRD facility, may now be used and this code indicates that an ESRD beneficiary received nonscheduled or emergency dialysis services at a facility other than his/her primary ESRD facility. Condition code 59 was actually effective on October 1, 2004.

B4 is now a condition code for an admission unrelated to a discharge on the same day and this code is for discharges on or after January 1, 2004, though is not effective until January 1, 2005. Also, condition code D4 has been expanded for use in LTCHs, IRFs, and inpatient SNFs in addition to inpatient acute care hospitals.

FL 39-41 refers to value codes and has included two new codes that will become effective on January 1, 2005:

- A8 – Weight of patient in kilograms
- A9 – Height of patient in centimeters

Additional Information

The actual revisions to the Medicare Claims Processing Manual are included in the official instructions issued to your FI or RHHI. That instruction may be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***.**

Once at that site, scroll down the CR NUM column on the right to find CR 3417, then click on the file for that CR.

If you have any questions regarding these requirements, contact your FI or RHHI at their toll-free provider number, which may be found on the Medicare web site at: *http://www.cms.hhs.gov/medlearn/tollnums.asp***.**

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3417
Related CR Release Date: September 24, 2004
Related CR Transmittal Number: 311
Effective Date: January 3, 2005
Implementation Date: January 5, 2005

Source: CMS Pub 100-4 Transmittal 303, CR 3417

Update to the Frequency of Billing

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Skilled nursing facilities (SNFs), hospitals considered to be Tax Equity and Fiscal Responsibility Act (TEFRA) hospitals, and hospitals paid under the outpatient prospective payment system (OPPS)

Provider Action Needed

Effective January 1, 2005, Medicare fiscal intermediaries (FIs) will accept inpatient bills monthly from SNFs and TEFRA hospitals. Medicare encourages these facilities to bill monthly. In addition, this article clarifies billing of outpatient services under the OPPS on the same day that a repetitive OPPS service is billed on a separate claim.

Background

On October 1, 2003, The Centers for Medicare & Medicaid Services (CMS) implemented new edits. These edits forced monthly bill submissions for long term care hospitals (LTCHs), SNFs, and inpatient hospitals not subject to the inpatient prospective payment system (IPPS). However, these edits allowed monthly bill submission for periodic interim payment (PIP) providers and inpatient rehabilitation facilities (IRFs).

Inpatient services in TEFRA hospitals (i.e., psychiatric hospital or units, cancer and children's hospitals) and SNFs are to be billed:

- Upon discharge of the beneficiary;
- When the beneficiarys benefits are exhausted;
- When the beneficiarys need for care changes; or
- Monthly.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to monthly billing cycles.

Also, providers subject to the OPPS are reminded that repetitive services to a single individual **will be billed monthly.** Where there is an inpatient stay, or outpatient surgery, or outpatient hospital service subject to OPPS, one bill **will** be submitted for the entire month if the provider uses an occurrence span code 74 to encompass the inpatient stay, day of outpatient surgery, or outpatient service subject to OPPS.

Bills for outpatient services subject to OPPS **will** contain on a single bill all services provided on the same day except claims containing condition codes 20, 21, or G0 (zero) or kidney dialysis services, which are billed on a 72x bill type. If an individual OPPS service is provided on the same day as an OPPS repetitive service, the individual OPPS service ***is to be billed on a separate OPPS claim containing the individual service and all packaged and/or related services. For example, if a chemotherapy drug is administered on a day that a repetitive service is also rendered, then the chemotherapy drug, its administration, its related supplies, etc., are on a separate claim from the monthly repetitive services claim. However, if some of the services are for partial hospitalization, the provider shall place condition code 41 on the claim. For claims containing conditions code 41, all services billed on the same day are to be included on the monthly bill for repetitive services. Non-repetitive OPPS services, exclusive of partial hospitalization services, are to be put on a single claim along with any packaged services. Repetitive services are billed monthly on a separate claim.***

Additional Information

To view the official instruction and revised manual pages issued to your intermediary on this issue, see CR 3382, which may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R239CP.pdf***.**

If you have any questions, you may also contact your intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp***.**

The toll-free number for First Coast Service Options, Inc. Medicare Part A customer service representatives is 1-877-602-8816.

Related Change Request (CR) Number: 3382
Related CR Release Date: August 3, 2004
Related CR Transmittal Number: 239
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 270, CR 3382

Provider TeleTYpewriter Service Now Available

In accordance with Section 508 of the Rehabilitation Act of 1973 and the Workforce Investment Act of 1998, First Coast Service Options, Inc. (FCSO) provider call center has implemented a TeleTypewriter (TTY) line to service the provider community. A TTY equipment is a special device permitting hard of hearing, or speech impaired individuals to use the telephone by typing messages back and forth to one another instead of talking and listening. To communicate via TTY line, both parties involved in the conversation need to have TTY equipment.

The TTY number for Florida Medicare Part A and Part B providers is **1-877-660-1759.**

This service is available Monday-Friday, from 8:00 a.m. to 4:30 p.m. Eastern and Central time zones.

Source: CMS JSM 05016, October 18, 2004

Third Update to the 2004 Medicare Physician Fee Schedule

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Note: This instruction has been replaced by MM3505 (Transmittal 306, titled Full "Replacement of CR 3415, 3rd Update to the 2004 Medicare Physician Fee Schedule Database." CR 3415 is rescinded, dated October 1, 2004. To see MM3505, go to: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3505.pdf.

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

Physicians, providers, and suppliers should note the changes to the Medicare physician fee schedule database and identify those changes that impact their practice.

Background

Payment files were issued to carriers based upon the November 7, 2003 and January 7, 2004 final rules. This instruction amends those payment files and requires that carriers give providers 30 days notice before implementing the revised payment amounts reflected in this instruction. Carriers will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, carriers will adjust claims brought to their attention.

Unless otherwise stated in this instruction, changes will be retroactive to January 1, 2004.

Implementation

The implementation date for this instruction is October 4, 2004.

Additional Information

The actual changes to the fee schedule involve numerous CPT/HCPCS codes and the actual effective dates vary. You may view the official instruction issued to the carrier by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3415 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center 1-877-602-8816.

Related Change Request (CR) Number: 3415
Related CR Release Date:
Related CR Transmittal Number:
Effective Date: January 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 278, CR 3415
CMS Pub 100-4 Transmittal 306, CR 3505

Payment for Influenza Virus Vaccine and Pneumoccocal Vaccine Based on 95 Percent of the Average Wholesale Price

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, non-physician practitioners, providers, and suppliers

Provider Action Needed

STOP – Impact to You

Effective September 1, 2004, the Medicare Part B payment allowance for the influenza virus vaccine (*CPT 90658*) is $10.10 and for the pneumoccocal vaccine (*CPT 90732*) is $23.28 when payment is based on 95 percent of the average wholesale price (AWP).

CAUTION – What You Need to Know

Annual Part B deductible and coinsurance amounts do not apply

GO – What You Need to Do

Please take note of this pricing information to ensure accurate claims processing. Your fiscal intermediary or carrier will not search their files to adjust claims that were processed prior to the October 1, 2004 implementation date unless you bring such claims to their attention.

Additional Information

The official instruction issued regarding this change can be found online, referenced via CR 3490, at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

On the above online page, scroll down while referring to the CR column on the right to find the link for CR 3490. Click on the link to open and view the file for the CR.

If you have questions regarding this issue, you may also contact your carrier or fiscal intermediary on their toll free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3490
Related CR Release Date: September 17, 2004
Related CR Transmittal Number: 114
Effective Date: September 1, 2004
Implementation Date: October 1, 2004

Source: CMS Pub 100-20 Transmittal 114, CR 3490

Important News about Flu Shots for Medicare Beneficiaries

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

This instruction provides important information to physicians and other providers regarding flu vaccinations for Medicare beneficiaries for the 2004 – 2005 influenza season. Despite the flu vaccine shortage, Medicare beneficiaries are being encouraged to obtain the flu vaccine from their regular physician.

Background

One of the principal pharmaceutical companies manufacturing flu vaccine was unable to provide the quantity of vaccine needed for this flu season, and this caused the flu vaccine supply to be reduced by almost one half of the expected amount. **This shortage does not, however, include pneumococcal vaccine.**

Because of the limited availability of flu vaccines this season, the Centers for Disease Control and Prevention (CDC) is recommending that individuals be given priority for getting the flu vaccine who are 1) at high risk for serious flu complications; or 2) in contact with people at high risk for serious flu complications.

Individuals in the following groups are included in the high-risk category, and they should receive a flu vaccination this season:

- Individuals age 65 or older
- Individuals with a chronic condition such as heart or lung disease
- Nursing home residents
- Pregnant women
- Health care workers who provide direct patient care
- Infants and toddlers ages 6-23 months
- Children on aspirin therapy
- Individuals who care for or live with infants younger than six months of age.

Please note that CDC also recommends that the majority of individuals with Medicare should not take FluMist because it is approved only for people ages 5 – 49. The only Medicare beneficiaries who should take FluMist are healthy disabled persons ages 5 – 49.

These recommendations and other information for health care professionals, including Qs & As developed by CDC, can be found at: *http://cdc.gov/flu/* on the Web.

Medicare Billing for Flu Vaccines

Because Medicare beneficiaries generally fall into this high-risk category, they are being encouraged to obtain the flu vaccine from their regular physician. Beneficiaries can receive a flu vaccine from any licensed physician or provider. However, the billing procedure will vary depending on whether the physician or provider is enrolled in the Medicare program.

If you are a Medicare-enrolled physician or provider and have the flu vaccine available, you must bill Medicare for the cost of the vaccine and the beneficiary will pay nothing; i.e., there is no deductible or coinsurance payment. Medicare rules require you to bill the Medicare Program on an assignment basis.

Please remember that Medicare allows for roster billing when you administer flu vaccine to a number of beneficiaries at one location (e.g., a physician's office).

The specific rules to follow for roster billing can be found in Chapter 18, Section 10.3 of the Claims Processing Manual, at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*

If you do not have the vaccine available, you should refer your patients to 1-800-MEDICARE (1-800-633- 4227; TTY users should call 1-877-486-2048) or to *http://www.medicare.gov* where they can get the phone number for their state health department. Health departments throughout the United States are attempting to ensure that as many high-risk individuals as possible will get a flu vaccine.

If you are not a Medicare-enrolled physician or provider who gives a flu vaccine to a Medicare beneficiary, you can ask the beneficiary for payment at the time of service. The beneficiary can then request Medicare reimbursement. Medicare reimbursement will be approximately $18 for each flu vaccine.

To request reimbursement, the beneficiary will need to obtain and complete form CMS 1490S by calling 1-800-MEDICARE, or they may access and download the form at *http://www.cms.hhs.gov/forms* on the Web.

In order to receive reimbursement, you will need to provide the beneficiary with a receipt for the flu vaccine that has the following information written or printed on it:

- The doctor's or provider's name and address
- Service provided ("flu vaccine")
- Date flu vaccine received
- Amount paid.

If you are currently not enrolled in Medicare but want to enroll to bill Medicare directly for the flu vaccine, your enrollment application will be expedited. CMS 855 enrollment applications and carrier contact information can be found on the following CMS website: *http://www.cms.hhs.gov/providers/enrollment*.

Additional Information

Please note that beneficiaries have been advised to contact the Inspector General's hotline at 1-800-HHSTIPS (1-800-447-8477) to file a complaint if they believe their physician or provider charged an unfair amount for a flu vaccine.

If your patients have questions regarding flu vaccine, please refer them to *http://www.medicare.gov* on the Web or 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877- 486-2048.

Related Change Request (CR) Number: N/A
Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Matters SE0464

2005 Healthcare Common Procedure Coding System Annual Update Reminder

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

This instruction is a reminder that the complete HCPCS file is updated and released annually by the Centers for Medicare & Medicaid Services (CMS) to Medicare contractors. The 2005 version of the HCPCS file contains existing, new, revised, and discontinued HCPCS codes for 2005. Medicare contractors will use the file for processing claims for services provided on or after January 1, 2005.

All Medicare physicians, providers, and suppliers: there is no longer a 90-day grace period for billing discontinued HCPCS codes as of January 1, 2005.

Background

Medicare providers submitting claims to Medicare contractors for Part B services use a HCPCS code to indicate the service that was provided. HCPCS consist of Level I codes, which are the American Medical Association's (AMA's) Current Physician Terminology Codes (CPT-4) and Level II codes, which are alphanumeric and maintained by CMS.

The alpha-numeric index and the table of drugs will be posted to the CMS web site by the end of October.

CMS website address for that posting is: *http://www.cms.hhs.gov/providers/pufdownload/default.asp#alphanu*.

There is no longer a 90-day grace period for discontinued codes in order to be compliant with HIPAA standards.

To view further information regarding the elimination of this 90-day grace period, see the *Medlearn Matters* article MM 3093, which may be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3093.pdf*.

Implementation

The implementation date for this instruction is January 3, 2005.

Additional Information

For complete details, please see the official instruction issued to your carrier and fiscal intermediary regarding this change. That instruction may be viewed by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3422 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3422
Related CR Release Date: August 27, 2004
Related CR Transmittal Number: 283
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 283, CR 3422

October 2004 Quarterly Update to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

This instruction provides information for updating and implementing the October quarterly 2004 fee schedule amounts for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). It implements fee schedule amounts for new codes and revises any fee schedule amounts for existing codes that were calculated in error.

Background

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings (Socials Security Act, Sections 1834(a), (h), and (i)). In addition, payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in 42 CFR 414.102.

This instruction implements fee schedule amounts for new codes, deletes certain codes, and revises any fee schedule amounts for existing codes that were calculated in error in prior updates. Specifically, the changes for this update are as follows:

- Codes A4363, E1400 thru E1404, K0137 thru K0139, K0168 thru K0181, K0190 thru K0192, K0277 thru K0279, K0284, K0400, K0417, K0419 thru K0439, and K0530 were deleted from the Healthcare Common Procedure Coding System (HCPCS) effective December 31, 1999. These codes were inadvertently included in the 2004 fee schedule file, and they are being removed with this update.
- Codes E1019 and E1021 are also being removed, as they are not valid 2004 HCPCS codes.
- The 2004 Puerto Rico schedule amounts for codes A4351 and A4352 were based on incorrect pricing information. The durable medical equipment regional carriers (DMERCs) must revise the base fee schedule amounts for these codes as part of the October quarterly update.
- Codes K0630 thru K0649, representing lumbar sacral orthosis products were added to the HCPCS effective

October 2004 Quarterly Update to DMEPOS Fee Schedule (continued)

April 1, 2004, and their fee schedule amounts were implemented on July 1, 2004. However, the Centers for Medicare & Medicaid Services has determined that the fee schedule amounts for codes K0630, K0631, K0632, K0634, K0635, K0636, K0637, K0639, K0640, K0642, K0644, K0645, and K0646 were based on incorrect pricing information and has recalculated those fee schedule amounts. The revised amounts will be implemented on October 4, 2004, as part of this update.

- Codes K0650 thru K0669 were added to the HCPCS effective July 1, 2004. Because data is not yet available, implementation of the fee schedule amounts for these items will be delayed until the January 2005 update.

Implementation

Implementation date for this instruction is October 4, 2004.

Additional Information

To view the official instruction issued to your DMERC or intermediary on this issue, please see: *http://www.cms.hhs.gov/manuals/pm_trans/R272CP.pdf*.

Also, the quarterly update process for the DMEPOS fee schedule is located in Section 60 of Chapter 23 of the Medicare Claims Processing Manual, which may be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

If you have any questions, please contact your DMERC or intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3377
Related CR Release Date: August 10, 2004
Related CR Transmittal Number: 272
Effective Date: January 1, 2004 for revised 2004 fee schedule amounts
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 272, CR 3377

October 2004 HCPCS Update for Home Health Consolidated Billing

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, practitioners, and suppliers billing Medicare carriers for services

Provider Action Needed

STOP – Impact to You

HCPCS code **G0329** is being added to home health (HH) consolidated billing enforcement.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes subject to the consolidated billing provision of the home health prospective payment system (HH PPS). This article reflects the October 2004 update.

GO – What You Need to Do

Affected providers should be aware that **G0329** will not be separately payable for beneficiaries in a home health episode as of October 1, 2004.

Background

The Balanced Budget Act of 1997 required consolidated billing of all HH services while a beneficiary is under a HH plan of care authorized by a physician. As a result, billing for all such items and services is to be made to a single HHA overseeing that plan. This HHA is known as the primary agency for home health prospective payment system (HH PPS) for billing purposes.

Medicare periodically publishes routine update notifications which contain updated lists of nonroutine supply and therapy codes that must be included in HH consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS codes which Medicare also publishes annually. The lists may also be updated as frequently as quarterly if required by the creation of new HCPCS codes mid-year.

In this update, G0329, Electromagnetic Tx for ulcers, is being added to enforcement of HH consolidated billing to reflect a mid-year update to the HCPCS lists. Claims for this code for services on or after October 1, 2004, will be subject to this enforcement.

Additional Information

This recurring update notification provides the quarterly HH consolidated billing update effective October 1, 2004. Quarterly updates were not needed for April or July 2004. This is the only quarterly update for calendar year 2004. The next changes to the HH consolidated billing code list will come with the annual update for calendar year 2005.

The full descriptor for G0329 is:

G0329 Electromagnetic therapy, to one or more areas for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care.

A home health CB master code list available on the CMS Web site: *http://www.cms.hhs.gov/providers/hhapps/#billing*.

For official instructions issued to the contractor access: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3350 in the CR NUM column on the right, and click on the file for that CR.

Related Change Request (CR) Number: 3350
Related CR Release Date: July 9, 2004
Related CR Transmittal Number: 226
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 226, CR 3350

MSN Messages and Reason Codes for Mammography

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Providers and suppliers who bill for mammography services.

Provider Action Needed

Suppliers and providers should note that this article discusses changes in Medicare summary notices (MSNs), which are sent to Medicare beneficiaries, and remittance advice messages sent to providers and suppliers regarding mammography claims.

Background

Revised instructions for the Medicare Claims Processing Manual have been issued regarding which MSN message and ANSI X-12 835[1] adjustment reason code will be used on the remittance advice when Medicare processes mammography claims. The Spanish translation for each new MSN message has also been added to the revised manual.

Remittance Advice Messages

For providers/suppliers who bill carriers, the remittance advice messages will be as follows:

- For claims submitted by a facility not certified to perform digital mammographies, the remittance advice will contain reason code *B6 "This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty,"* along with remark code *N92 "This facility is not certified for digital mammography."*
- For claims submitted by a facility not certified to perform film mammographies, carriers will use existing reason code B6, *"This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty" along with remark code N110 "This facility is not certified for film mammography."*
- For claims that were submitted with an invalid or missing FDA identification number, use existing reason code *16 "Claim/service lacks information which is needed for adjudication,"* along with remark code *MA128 "Missing/incomplete/invalid six digit FDA approved identification number."*

Implementation

The implementation date of these changes is September 25, 2004.

Related Instructions

The Medicare Claims Processing Manual (Pub 100-4), Chapter 18 (Preventive and Screening Services), Section 20 (Mammography Services), Subsection 20.8 (Beneficiary and Provider Notices), Subsubsections 20.8.1 (MSN Messages) and 20.8.2 can be found on the CMS web site at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

The official instruction issued to your contractor regarding this change may be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that web page, look for CR2617 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 2617
Related CR Release Date: June 25, 2004
Related CR Transmittal Number: 214
Effective Date: September 25, 2004
Implementation Date: September 25, 2004

Source: CMS Pub 100-4 Transmittal 298, CR 2617

[1] American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 transactions are part of the *Transactions and Code Sets Rule* selected by HIPAA.

Handling Request for Additional Medical Documentation Due to the Hurricane Aftermath of 2004

If you receive a request for additional medical documentation (e. g., operative report, progress notes, hospital records, office records, admission and discharge records, etc) and you are unable to provide the requested additional documentation within the timeframes specified by Medicare because the facility/practice location has been impacted by recent hurricanes, contact the appropriate provider customer service representatives at the following numbers:

Part A Provider Customer Service Center – 1-877-602-8816

Part B Provider Customer Service Center – 1-866-454-9007

Part A and Part B Provider Customer Service Center TTY – 1-877-666-1759

These special handling guidelines apply **only** to services where the requested documentation is required to establish the medical necessity for the service in question. **Do not call** the provider customer service lines if the request for additional information/documentation is due to missing or incorrect claim filing requirements (e.g., invalid health insurance claim number, invalid procedure code, entitlement issues, etc). Providers need to provide this information/documentation so that the claim can be processed correctly.

CMS and FCSO Offer Help to Address Potential Medicare Billing and Payment Impacts Due to 2004 Hurricanes

The hurricanes that hit Florida in 2004 severely impacted many of First Coast Service Options' (FCSO) Medicare customers. In response to the devastating impacts and potential damage, and in keeping our promise to provide superior customer service, FCSO is working closely with the Centers for Medicare & Medicaid Services (CMS) to determine how best to help impacted health care providers and beneficiaries as they recover. FCSO and CMS have established a response team to assist providers impacted by these hurricanes. Here are some helpful tips related to communication, benefit payments and operational processes that may warrant special consideration:

- First, we encourage impacted health care providers to communicate billing and payment concerns by calling our Medicare Part A Customer Service Center at 1-877-602-8816 or our Medicare Part B Customer Service Center at 1-866-454-9007.
- Hospitals and skilled nursing facilities whose cash flow has been or will be adversely impacted by the 2004 hurricanes may be granted an accelerated payment. FCSO and CMS have implemented a process to expedite these requests. Medicare Part A impacted providers who need to pursue an accelerated payment should contact Provider Audit and Reimbursement Specialist, Jeff Guy at 904-791-6695.
- Providers unable to submit electronic claims can reduce claims to paper. However, we are unable to issue payments within 14 days. Payments will be issued after the 27th day following receipt of the claim for clean claims.
- In filing an appeal request, the 2004 hurricanes are an example of "good cause" in asking for a time extension.
- If you cannot receive mail at your present location, you may set up a temporary "pay to" address.
- This can be accomplished with the CMS-855 form by faxing to the Provider Enrollment specially designated hurricane fax line at 904-301-1827.
- Impacted providers may use another physician's computer to transmit claims; however, someone from FCSO Medicare EDI must be involved in order to maintain the security of the records. If you are an impacted provider who needs to explore the feasibility of this option, please contact Medicare EDI Manager, Jim Gray at 904-791-8288.
- The CMS Atlanta regional office has also established a response team whose members are ready and available to assist providers at 1-404-562-7390.
- If you were under a mandatory evacuation notice and had to be transported by ambulance, Medicare will consider payment under certain conditions. Here's a link to the August 18, 2004, CMS-approved policy on "Ambulance Transport Due to Disasters."

(http://www.floridamedicare.com/provider/content/special/Amb-Transport-due-to-Disater.pdf)

Additional information is available at *http://www.floridamedicare.com*. If you have additional questions, please contact our Medicare Part A Customer Service Center at 1-877-602- 8816 or our Medicare Part B Customer Service Center at 1-866-454-9007, as we have designated points-of-contact for various types of issues related to the 2004 hurricanes.

Use of Group Health Plan Payment System for Chronic Care Medicare Fee-for-Service Beneficiaries

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Providers Affected

Physicians, providers, and suppliers

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) will be conducting large-scale programs under the Voluntary Chronic Care Improvement Program (Section 721 of the Medicare Modernization Act (MMA) of 2003) in which private organizations will contract with CMS to provide chronic care services to beneficiaries enrolled in the traditional fee-for-services (FFS) Medicare program.

CAUTION – What You Need to Know

With the exception of how CMS is paying these private organizations, beneficiaries enrolled in these programs will be considered covered under the traditional Medicare FFS program for all other purposes. Beneficiaries will only receive coordinated care/disease management services from these chronic care organizations and they are not restricted in any way on how they receive their other Medicare services.

GO – What You Need to Do

See the *Background* and *Additional Information* sections for more information on this notification.

Background

This instruction notifies providers that CMS will be conducting large-scale programs under the Voluntary Chronic Care Improvement Program (Section 721, MMA) in which private organizations will contract with CMS to provide chronic care services to beneficiaries enrolled in the traditional FFS Medicare program.

In order to implement these large programs most efficiently, CMS plans to accomplish the following:

- Each program will be assigned a new option code (designated as "Option Code 4" in this instruction); and
- Each organization will be set up as an "Option 4 Chronic Care Organization" in Medicare's Group Health System/PICS, which is otherwise used for Medicare Advantage (formerly Medicare + Choice) health plans.

Use of Group Health Plan Payment System for Chronic Care Medicare Fee-for-Service Beneficiaries (continued)

By enrolling beneficiaries in these "Option Code 4" Chronic Care Organizations, CMS will be able to pay the organizations a fixed monthly amount for each beneficiary. Also, as an "Option Code 4" Chronic Care Organization," CMS can continue processing all FFS claims under traditional Medicare payment rules.

With the exception of how CMS is paying these organizations, beneficiaries enrolled in these programs will be considered covered under the traditional Medicare FFS program for all other purposes. Beneficiaries will only receive coordinated care/disease management services from these chronic care organizations.

They are not restricted in any way on how they receive their other Medicare services.

Because the Group Health Plan system/MMCS is being used to pay demonstration sites, when a provider makes an inquiry to certain common working file (CWF) screens, it appears that the beneficiary is enrolled in a health maintenance organization (HMO), when they are eligible for coverage under the traditional Medicare FFS program.

To avoid this confusion about a beneficiary's access to services when providers or others check beneficiary eligibility on CWF provider inquiries, this instruction directs the CWF to suppress any reference to HMO information on provider inquiries for beneficiaries enrolled in these programs.

In the event the provider is advised by the beneficiary or through some other means that the beneficiary is enrolled with one of these chronic care organizations, the providers should treat the beneficiary as an ordinary FFS beneficiary who requires no referral from the chronic care organizations to receive services in a FFS setting.

Implementation

The implementation date for this instruction is January 3, 2005.

Additional Information

For complete details, please see the official instruction issued to your carrier or fiscal intermediary regarding this change. That instruction may be viewed by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3410 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your contractor at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3410
Related CR Release Date: July 30, 2004
Related CR Transmittal Number: 256
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 256, CR 3410

Medicare Replacement Drug Demonstration

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Important: This is an updated version of this article. The article has been revised to reflect two additional drugs (Somavert and Mesnex) that are covered under this demonstration, as noted in the revised table that starts on page 4, and to announce that there are still many enrollment slots available. **It is not too late to request or submit an application!** The information on the original article was published in the Fourth Quarter 2004 Medicare A Bulletin (pages 22-23).

The Centers for Medicare & Medicaid Services (CMS) needs your help to reach beneficiaries who could benefit from this demonstration. These beneficiaries include people who have been diagnosed with rheumatoid arthritis, multiple sclerosis, osteoporosis, pulmonary hypertension, secondary hyperparathyroidism, Paget's Disease, hepatitis C, CMV retinitis, or certain kinds of cancer. If you treat Medicare beneficiaries who currently use or could benefit from the drugs listed in the table, Medicare may be able to help them pay for these drugs.

Provider Types Affected

All Medicare physicians and providers **but we are especially interested in reaching out to physician specialists in family practice, internal medicine, geriatrics, rheumatology, oncology and neurology, as well as pharmacists, nurse practitioners, hospital outpatient departments, cancer and infusion centers, and group practice administrators.**

Provider Action Needed
STOP – Impact to You

A new demonstration mandated under Section 641 of the Medicare ModernizationAct allows up to 50,000 people with Medicare who have certain life-threatening diseases to obtain specified drugs they can take themselves at home for their condition.

CAUTION – What You Need to Know

A signed physician certification will need to be filled out for any of your patients who are: applying to participate in this demonstration. By signing this certification, you are certifying that the patient has the condition indicated and you have prescribed or intend to prescribe a coverable drug for this condition in accordance with the demonstration requirements. Your signed certification is necessary for the patient's application to participate in the demonstration to be considered complete. **For your convenience, physician certification forms may also be faxed to (410) 683-2933.**

Medicare Replacement Drug Demonstration (continued)

Please note that nurse practitioners who write prescriptions for these coverable drugs may also sign the certification form.

GO – What You Need to Do

Review the list below of coverable conditions and drugs available under this demonstration. If you have any patients you think might be interested and eligible to apply, **let them know**. Be aware that both fee-for-service and Medicare Advantage beneficiaries are eligible to apply for the demonstration. If they would like to request an application or have any questions related to the demonstration, or need assistance completing the application, they can call a toll-free number: 1-866-563-5386 (TTY number: 1-866-563-5387). There is also helpful information on our web site (*www.medicare.gov*), including an application package that can be downloaded.

Note to Hospitals: Please share this information with staff who come into contact with Medicare beneficiaries who may be eligible for this demonstration (e.g., social workers or staff who assist with Medicaid eligibility determinations).

Background

The Medicare Replacement Drug Demonstration is a time-limited Medicare demonstration that will cover certain drugs and biologicals that are prescribed as replacements for existing covered Medicare drugs and biologicals before Medicare's prescription drug program begins in 2006. This demonstration was authorized by Section 641 of the Medicare Modernization Act.

The Centers for Medicare & Medicaid Services (CMS) has contracted with TrailBlazer Health Enterprises, a Medicare carrier, to assist in implementing the demonstration. TrailBlazer will manage the eligibility determination and enrollment process as well as coordinate outreach efforts to beneficiary advocacy groups, physicians, and others interested in this demonstration. TrailBlazer has subcontracted with Caremark to administer the drug benefit.

Medicare realizes the important role drugs play in treating serious diseases. When Medicare first began, drugs played a much smaller role in medical care. Only drugs that are administered in a physician's office have been covered under Medicare Part B. In recent years, many new medications have been developed that replace some of these drugs, allowing patients with serious and life-threatening illnesses to take these drugs in their own home. For a beneficiary to be eligible for this demonstration, he or she must meet the following criteria:

- Beneficiary must have Medicare Part A and Part B.
- Medicare must be the beneficiary's primary health insurance.
- Beneficiary must reside in one of the 50 states or the District of Columbia.
- Beneficiary must have a signed certification form from his/her doctor stating that he/she has prescribed or intends to prescribe for the beneficiary one of the covered medications for the specified condition.
- The beneficiary may not have any other insurance that has comprehensive drug coverage (such as Medicaid, an employer or union group health plan, or TRICARE) that would cover this medication.

The table below shows the drugs and conditions that will be covered under the demonstration.

Drugs Covered Under Medicare Replacement Drug Demonstration

(Updated August 9, 2004)

Demonstration Covered Indication	Drug/Biological—Compound Name (Brand Name)
Rheumatoid Arthritis	Adalimumab (Humira) Anakinra (Kineret) Etanercept (Enbrel)
Multiple Sclerosis	Glatiramer acetate (Copaxone) Interferon beta –1a (Rebif, Avonex) Interferon beta –1b (Betaseron)
Osteoporosis (patient must be homebound)	Calcitonin – nasal (Miacalcin – nasal)
Pulmonary Hypertension	Bosentan (Tracleer)
Secondary Hyperparathyroidism	Doxercalciferol (Hectoral)
Paget's Disease	Alendronate (Fosamax) Risedronate (Actonel)
Hepatitis C	Pegylated interferon alfa-2a (Pegasys) Pegylated interferon alfa-2a (PEG-Intron)
CMV Retinitis	Valcyte (Valganciclovir)
Acromegaly	Pegvisomant (Somavert)
Anti-Cancer	
Cutaneous T-cell Lymphoma	Bexarotene (Targretin)
Non-small cell lung cancer	Gefitinib (Iressa)
Epithelial ovarian cancer	Altretamine (Hexalen)
Chronic Myelogenous Leukemia	Imatinib Mesylate (Gleevec)

Medicare Replacement Drug Demonstration (continued)

Drugs Covered Under Medicare Replacement Drug Demostration (continued)
(Updated August 9, 2004)

Demonstration Covered Indication	Drug/Biological—Compound Name (Brand Name)
GI Stromal Tumor	Imatinib Mesylate (Gleevec)
Multiple Myeloma	Thalidomide (Thalomid)
Breast Cancer	Hormonal therapy
Stage 2-4 only	Anastrozole (Arimidex) Exemestane (Aromasin) Letrozole (Femara) Tamoxifen (Nolvadex) Toremifene (Fareston)
Prophalactic agent to reduce ifosfamideinduced hemorrhagic cystitis	Mesna-oral tablest (Mesnex)

For more information on this demonstration, please visit *www.medicare.gov* or call our toll-free number: 1-866-563-5386 (TTY number: 1-866-563-5387) between 8 am and 7:30 pm Eastern time, Monday – Friday.

You can also use the toll-free number if you have questions about the demonstration or the application.

We also have a beneficiary brochure available that describes the demonstration and its benefits. Copies of the brochure can be requested at: *outreach.mrdd@trailblazerhealth.com*.

Related Change Request (CR) Number: N/A
Related CR Release Date:
Related CR Transmittal Number:
Effective Date: Immediately
Implementation Date: Immediately

Source: CMS Medlearn Matters Special Edition SE0443

Medicare-Approved Drug Discount Cards and Transitional Assistance Program

A Summary of New Initiative of Interest to Physicians and Other Health Care Professionals

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians and other health care professionals

Provider Action Needed

This instruction provides important information on a new initiative to increase enrollment of low-income Medicare beneficiaries in a Medicare-approved drug discount card and a $600 credit.

Background

In an earlier Medlearn Matters article, an overview of the Medicare-Approved Drug Discount Card Program was provided.

(See SE0422 at: *http://www/cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0422_1pdf*.

Information related to the Special Edition Medlearn Matters article SE0422 was published in the Fourth Quarter 2004 *Medicare A Bulletin* (pages 7-8).

This program is authorized by the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). The program is designed to help people who are covered by Medicare with the cost of prescription drugs, and the regulation outlining the new drug discount card program is the first action resulting from the MMA. It emphasizes the importance of eliminating the practice of Medicare beneficiaries having to pay full price for prescription drugs. Beginning in May 2004, individuals began enrolling in the program.

Seniors and individuals with disabilities will be able to use these cards to save 10 to 15 percent on their total drug costs, with savings of up to 25 percent or more on individual prescriptions. All Medicare beneficiaries, except those who already have Medicaid outpatient drug coverage, will be able to enroll in Medicare-approved drug discount card programs with benefits beginning in June 2004, and continuing until the Medicare prescription drug benefit is implemented in 2006.

Medicare beneficiaries will be allowed to enroll in only one drug card program at a time. The cost of enrollment can be no more than $30 annually, and beneficiaries can change cards during an open enrollment period prior to 2005 or under special circumstances. Beginning in 2006, all people with Medicare will have access to a voluntary prescription drug benefit.

Transitional Assistance Program

A key part of the Medicare-approved prescription drug discount card program is a **subsidy of up to $600 a year** for eligible low-income beneficiaries. Individuals may qualify for the $600 credit on their discount card to help pay for prescription drugs if they:

- Have an annual income in 2004 of no more than $12,569 if single or $16,862 if married; and
- Receive help from their state in paying their Medicare premiums or cost sharing.

Medicare-Approved Drug Discount Cards and Transitional Assistance Program (continued)

Note that these income limits can change every year. Also, residents of Puerto Rico or a U.S. territory are not eligible for the $600 credit from Medicare. However, they may be eligible for similar assistance provided by the territory in which they reside. Beneficiaries cannot qualify for the $600 if they already have outpatient prescription drug coverage from certain other sources.

Current Initiative

CMS current initiative creates a streamlined Medicare-approved drug discount card enrollment process for about 1.1 million beneficiaries who receive help from their state in paying their Medicare premiums or cost sharing. These state programs are called Medicare savings programs. Starting in mid-October, these beneficiaries will receive an enrollment kit in the mail from a Medicare-approved drug discount card sponsor. The enrollment kit will contain a discount card with a Medicare-approved logo, a member handbook, a discount drug list, and pharmacy directory. An enclosed letter will explain to the beneficiary his or her assignment to a Medicare-approved drug discount card and eligibility for a $600 credit, and information about the right to decline or switch to a different Medicare-approved drug discount card. The letter instructs the beneficiary to call either the company offering the discount card or 1-800-MEDICARE (1-800-633-4227).

On November 1, 2004, the beneficiary can begin using the card to obtain discounts. In order to get the $600 credit, the beneficiary must call 1-800-MEDICARE or to the card sponsor's toll free number. On the call, the beneficiary completes the attestation for the $600 credit.

Beneficiaries who wish to choose a different card can call 1-800- MEDICARE to learn about their other choices.

If a beneficiary is not eligible for the $600 credit because of other prescription drug coverage, he or she has the option to keep the drug card and benefit from any associated discounts. In this instance, the beneficiary would be responsible for paying the enrollment fee.

Beneficiaries who wish to decline enrollment in the card must call the drug card sponsor at the toll free number.

As a result of this new program for enrollment in the drug card program, all beneficiaries in Medicare Savings Programs can start getting large savings on their drug costs.

Additional Information

Where to Refer Medicare Beneficiaries for Information on Prescription Drug Discount Programs

In addition to the Medicare-approved drug discount cards, there are other programs available that provide assistance in paying for prescription drugs. Alternatives such as individual state pharmacy assistance programs and manufacturers' discount programs may be a better fit for certain individuals. Medicare recognizes that physicians and other health care professionals have limited time available to counsel patients. Therefore, the following resources are available to help individuals with questions about the Medicare-approved drug discount cards:

- **The 1-800-MEDICARE (1-800-633-4227) Toll-Free Call Center:**
  Beneficiaries can get information about how the discount drug card program operates, who can qualify and how to join, as well as some comparative information on card sponsors at 1-800 MEDICARE (1-800-633-4227; TTY users should call 1-877-486-2048). This call center is available 24 hours per day, 7 days per week, and connects beneficiaries with customer service representatives who can answer questions and perform price comparisons for discount cards and other assistance programs. Beneficiaries should prepare a list of current prescription drugs and dosages prior to contacting the call center. Also, beneficiaries may request a copy of their individualized price comparison results.
- **The Prescription Drug and Other Assistance Programs Website at:** *http://www.medicare.gov/AssistancePrograms/home.asp*.
  For beneficiaries who use the Internet, this site features eligibility, enrollment, and price comparison information for each available discount card in a particular area, as well as their state pharmacy assistance programs. It also has a tool that helps beneficiaries determine the best savings program based on their prescription drug needs.
- **Medicare's Guide to Choosing a Medicare-Approved Drug Discount Card**
  This resource can be found at: *http://www.medicare.gov/publications*. It provides beneficiaries with information on choosing a card, enrolling, and submitting complaints. This guide also features sample enrollment forms and worksheets to assist beneficiaries in selecting the discount card that is right for them.
- **State Health Insurance Counseling and Assistance Programs (SHIP):**
  Beneficiaries may also contact their SHIP counselor for information on prescription drug cost assistance programs. To find the telephone number for the nearest SHIP, call 1-800-MEDICARE (1-800-633-4227) or visit: *http://www.medicare.gov/contacts/Static/SHIPs.asp?dest=NAV*.

For More Information

The following information resources are available for physicians and other health care professionals:

- Download a free patient-education brochure at: *http://www.medicare.gov* (or call 1-800-MEDICARE to order a limited number of free copies).
- Read the materials on the Medicare-Approved Drug Discount Cards and Transitional Assistance Program Web page, at *http://www.cms.hhs.gov/medlearn/drugcard.asp*. This page includes a variety of useful publications.
- Attend CMS Open Door Forums in person or by telephone (toll-free). These forums address concerns and issues of physicians, nurses, and allied health professionals. Visit: *http://www.cms.hhs.gov/opendoor* for further details.
- Visit: *http://www.cms.hhs.gov/medicarereform* for the latest information on MMA.

Related Change Request (CR) Number: N/A
Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Matters SE0457
CMS Special Edition Medlearn Matters SE0458

Medicare Advantage Organizations for National Coverage Determination Services

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, providers, and suppliers billing for the services mentioned below.

Provider Action Needed
STOP – Impact to You

Medicare Advantage (MA) rates were recently adjusted to account for three national coverage determination (NCD) services. These services are implantable automatic defibrillators (effective 10/1/03), ventricular assist devices (effective 1/1/04), and lung volume reduction surgery (effective 1/1/04). MA organizations are liable for payment for these NCD services beginning January 1, 2005.

CAUTION – What You Need to Know

For services rendered prior to January 1, 2005, payment for services relating to the three NCD services mentioned above are paid by Medicare on a fee-for-service basis for MA plan enrollees. Note that, prior to January 1, 2005, beneficiaries are not responsible for Part A or Part B deductibles associated with these services, although they are responsible for coinsurance amounts appropriate under Medicare fee-for-service rules.

GO – What You Need to Do

Be aware that these services will not be paid on a fee-for-service basis for dates of service on or after January 1, 2005. Instead, the MA plan will be responsible for making payment. Note also that MA enrollees receiving services for lung volume reduction surgery services must receive these services in designated hospitals.

Background

When Medicare initially issued these NCDs, new coverage was introduced and the cost of that coverage was not reflected in the rates paid to MA plans. Thus, Medicare paid for these services separately on a fee-for-service basis until such time as the cost could be considered in determining MA rates. The Centers for Medicare & Medicaid Services (CMS) will factor these costs into the MA payment rates as of January 1, 2005. At that time, Medicare will no longer pay for these services on the fee-for-service basis.

Additional Information

If you have any questions regarding this issue, please contact your carrier or intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3301 Medlearn Matters Number: MM3301
Related CR Release Date: N/A (CR is not available)
Related CR Transmittal Number: N/A
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-20 Transmittal 116, CR 3465

MEDICARE SECONDARY PAYER

Clarification of Medicare Secondary Payer Rules in Relation to a Temporary Leave of Absence

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All providers.

Provider Action Needed
STOP – Impact to You

Medicare Secondary Payer (MSP) rules state that if an employee retains their employment status, Medicare remains the secondary payer.

CAUTION – What You Need to Know

There has been confusion regarding MSP rules when an employee takes a company-approved leave of absence. Because the employee still has employee status, health coverage through their employer is retained.

GO – What You Need to Do

Stay current with rules pertaining to employees and retained employment rights to ensure accurate billing and claims processing. This article clarifies that Medicare remains a secondary payer for employees on an approved leave of absence.

Background

Examples of retained employment rights can include: company-approved temporary leave of absence for any reason, furlough, temporary layoff, sick leave, short-term or long-term disability, leave for teachers and seasonal workers who normally do not work year round, and for employees who have health coverage that extends beyond or between

Clarification of MSP Rules in Relation to a Temporary Leave of Absence (continued)

active employment periods. The employees in the latter category are sometimes referred to as having an "hours bank" arrangement.

Additional Information

You may also refer to the revised Publication 100-05, Chapter 1, Section 50B, which is part of the official instruction issued to your carrier/intermediary regarding this change. That instruction may be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR 3447. Click on the link to open and view the file for the CR.

If you have questions regarding this issue, you may also contact your carrier or fiscal intermediary at their toll free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3447
Related CR Release Date: September 24, 2004
Related CR Transmittal Number: 19
Effective Date: October 25, 2004
Implementation Date: October 25, 2004

Source: CMS Pub 100-5 Transmittal 19, CR 3447

Medicare Secondary Payer Application to Former Spouses and Certain Family Members with Coverage Under the Federal Employees Health Benefits Program

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All Medicare providers

Provider Action Needed

This is an informational article to alert providers that former spouses of certain federal employees, former employees, or annuitants, may qualify to enroll in a health benefits plan under the Federal Employees Health Benefit Plan (FEHB) and the correct order of payment.

A determination has been made that Medicare will be the primary payer for such former spouses, once they are entitled to Medicare based on age or disability.

Background

Certain former spouses of people who have Federal Employees Health Benefits are entitled to coverage under the Spouse Equity Act because their divorce decree gives them the right to a portion of a future retirement annuity and/or to a survivor annuity, and because their former spouse is either an active worker, someone who is entitled to a future annuity, or is an annuitant.

The Medicare law in Section 1862 (b)(1)(A) of the Social Security Act, states that Medicare is secondary payer for individuals age 65 or over who have group health coverage by virtue of their own or a spouse's current employment status. The question was raised as to whether FEHB coverage provided to former spouses under the Spouse Equity Act is secondary to Medicare under this provision. Also, the question has been raised as to whether FEHB coverage provided to the spouse and family members under the Spouse Equity Act is secondary to Medicare under the disability provision.

Under the Spouse Equity Act, the individual is no longer on the former spouse's policy. The coverage is considered to be a separate, self-only policy, i.e., not dependent coverage but a policy separate from the former spouse. The employer makes no contributions to the coverage. Since the language in the Spouse Equity Act gives the former spouse the right to enroll in FEHB whether or not the spouse himself or herself is enrolled, the FEHB former spouse coverage is not considered employment based. Consequently, Medicare is the primary payer for the former spouse, once they are entitled to Medicare under the working aged provision. Under the Medicare secondary for the disabled provision, Medicare would be primary for the former spouse as well as any covered family members since the coverage is not considered employment based.

Additional Information

The official instruction issued to your intermediary regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that web page, look for CR 3120 in the CR NUM column on the right, and click on the file for that CR.

Related Change Request (CR) Number: 3120
Related CR Release Date: August 27, 2004
Related CR Transmittal Number: 18
Effective Date: November 29, 2004
Implementation Date: November 29, 2004

Source: CMS Pub 100-5 Transmittal 18, CR 3120

AMBULANCE SERVICES

Ambulance Transports Related to Hurricane Evacuations

Ambulance transports resulting from recent hurricane evacuations should be billed to Medicare. These transports will be covered providing medical necessity requirements are met (i.e., patient could not have been safely transported by other means) and the transport is to an eligible destination. These claims should be billed as non-emergency ALS or non-emergency BLS transports. Medicare will not require a PCS on these claims.

Medicare does not cover ambulance transports to or from an evacuation shelter. These claims need to be filed with the Federal Emergency Management Agency (FEMA). Medicare will consider payment on transports from an evacuation shelter in the event of injury or sudden onset of illness, provided the service meets the medical necessity guidelines established by the Medicare coverage.

FEMA website address: *http://www.fema.gov*

FEMA telephone numbers: **1-800-621-FEMA (3362)** or **TTY 1-800-462-7585** (speech and hearing impaired)

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.*

Ambulance Services—Bonus Payment Calculations on Low Population Density Rural Area Services

The Medicare Prescription Drug, Improvements and Modernization Act of 2003 (MMA) makes important changes to Medicare payment for ambulance services furnished **on or after July 1, 2004.** During the five-year period of July 1, 2004, to December 31, 2009, the fee schedule portion of the reimbursement includes certain increases in payment. These payment increases apply to ground transportation **only** and the percentage increases are cumulative. Air and water transport remain unchanged.

These changes are:

- A 25 percent increase applies to the appropriate fee schedule for ground ambulance miles 51 or greater. This increase applies to rural and urban point of pickup (POP).
- A 22.6 percent increase applies to the fee schedule portion of the base payment for ground ambulance services when the POP originates in a low population density rural area. Theses areas can be identified on the national ZIP code file with a "B" indicator.

Adjustment for Ambulance Miles 51 or Greater

For services furnished **on or after July 1, 2004,** through **December 31, 2008,** Medicare share maintainer systems will apply 25 percent increase based on HCPCS code A0425, the date of service, and the number of miles. Therefore, the allowance for a rural ZIP code POP is:

- The first 17 miles transported times 1.5 urban rate of A0425.
- The number miles transported from 18 to 50 times the rural rate of A0425.
- The number of miles transported from 51 or greater times the 1.25 rural rate of A0425.

Adjustment for Low Population Density Rural Areas

For services furnished **on or after July 1, 2004,** through **December 31, 2009,** Medicare share maintainer systems will apply 22.6 percent increase on ambulance ground transportation originated in designated low population density rural areas to the payment base allowance. The payment base allowance comprises the blend of the appropriate reasonable charge portion and the appropriate fee schedule portion based on the date the ground transportation service is furnished.

For example, based on a claim billed for HCPCS code A0428, furnished on July 6, 2004, for a $300.00 charge, the Medicare systems will calculate the allowance as follows:

Reasonable Charge Portion of the Blend Allowance

- The system multiplies the submitted charge ($300.00) times 0.26 (this is 26 percent of the provider interim rate file for code A0428). The result is $78.00.
- Based on the date of service, the reasonable cost is 40 percent. Therefore, the system multiplies $78.00 times 0.40. The result is $31.20 for the reasonable charge portion of the blend allowance.

Fee Schedule Portion of the Blend Allowance

- The fee schedule for HCPCS code A0428 in a **rural** area is $172.77. Based on the date of service, the fee schedule portion of the blend allowance is 60 percent. Therefore, $172.77 times 0.60 results in $103.66.
- Since the 22.6 percent low population density rural area bonus applies to the fee schedule portion, $103.66 times 22.6 percent results in an increase of $23.43.
- Adding the low population density rural area bonus of $23.43 to the fee schedule portion allowance of $103.66 results in an adjusted fee schedule portion of $127.09.
- Adding the reasonable cost portion of $31.20 to the adjusted fee schedule portion of $127.09 results in $158.29 fee schedule blended allowance.
- Medicare allows 80 percent of $158.29 or $126.63 for ambulance ground transportation where the POP was originated in a designated low population density rural area.

GENERAL COVERAGE

Positron Emission Tomography Scans for Dementia and Neurodegenerative Diseases

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians and providers.

Provider Action Needed

This instruction notifies physicians and providers that Medicare will provide coverage for 2-deoxy-2- [F-18] fluoro-D-glucose (FDG)-positron emission tomography (PET) scans for beneficiaries with a recent diagnosis of dementia and documented cognitive decline of at least six months duration. This service may be covered:

- When the patient meets diagnostic criteria for both fronto-temporal dementia (FTD) and Alzheimer's disease (AD) under specific requirements, **or**
- For use in a Centers for Medicare & Medicaid Services (CMS)-approved practical clinical trial focused on the utility of FDG-PET in the diagnosis or treatment of dementing neurodegenerative diseases.

Background

Effective for dates of service on or after September 15, 2004, Medicare will provide coverage for FDG-PET for one of the following:

- When the patient meets diagnostic criteria for both fronto-temporal dementia (FTD) and Alzheimer's disease; **or**
- When used in a CMS-approved practical neurodegenerative disease clinical trial.

Clinical trial results are expected to help in determining if PET scans contribute to the effective diagnosis and treatment of Medicare beneficiaries with mild cognitive impairment or early dementia, and add information that will help monitor, evaluate, and improve clinical outcomes of patients with this disease.

Refer to the Medicare Claims Processing Manual, Publication 100-04, Chapter 13, Section 60, for general Medicare coverage and billing requirements for PET scans for dementia and neurodegenerative diseases.

Also, refer to the Medicare National Coverage Determinations (NCD) Manual, Publication 100-03, Section 220.6 for complete coverage policy and clinical trial requirements. The revision to the NCD Manual, Pub. 100-03, Section 220.6 is an NCD. NCDs are binding on all, fiscal intermediaries, carriers, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans.

Under 42 Code of Federal Regulations (CFR) 422.256(b), an NCD that expands coverage is also binding on Medicare Advantage organizations. In addition, an administrative law judge may not review an NCD.

(See section 1869(f)(1)(A)(i) of the Social Security Act.)

Key portions of these revised manuals are as follows:

FDG-PET Requirements for Use in the Differential Diagnosis of AD and FTD

According to the NCD on this issue, Medicare covers FDG-PET scans for either a) the differential diagnosis of both FTD and Alzheimer's disease (AD) under specific requirements **or,** b) its use in a CMS-approved practical clinical trial focused on the utility of FDG-PET in the diagnosis or treatment of dementing neurodegenerative diseases.

For use in the differential diagnosis of FTD and AD, an FDG-PET scan is considered reasonable and necessary for patients with a recent diagnosis of dementia and documented cognitive decline of at least six months, who meet diagnostic criteria for both AD and FTD. These patients have been evaluated for specific alternative neurodegenerative diseases or causative factors, but the cause of the clinical symptoms remains uncertain.

The following additional conditions must be met before an FDG-PET scan can be ordered:

a. The patient's onset, clinical presentation, or course of cognitive impairment is such that FTD is suspected as an alternative neurodegenerative cause of the cognitive decline. Specifically, symptoms such as social disinhibition, awkwardness, difficulties with language, or loss of executive function are more prominent early in the course of FTD than the memory loss typical of AD.

b. The patient has had a comprehensive clinical evaluation (as defined by the American Academy of Neurology) encompassing a medical history from the patient and a well-acquainted informant (including assessment of activities of daily living), physical and mental status examination (including formal documentation of cognitive decline occurring over at least six months) aided by cognitive scales or neuropsychological testing, laboratory tests, and structural imaging such as magnetic resonance imaging (MRI) or computed tomography (CT).

c. The evaluation of the patient has been conducted by a physician experienced in the diagnosis and assessment of dementia.

d. The evaluation of the patient did not clearly determine a specific neurodegenerative disease or other cause for the clinical symptoms, and information available through FDG-PET is reasonably expected to help clarify the diagnosis between FTD and AD and help guide future treatment.

e. The FDG-PET scan is performed in a facility that has all the accreditation necessary to operate nuclear medicine equipment. The reading of the scan should be done by an expert in nuclear medicine, radiology, neurology, or psychiatry, with experience interpreting such scans in the presence of dementia.

Positron Emission Tomography Scans for Dementia and Neurodegenerative Diseases (continued)

f. A brain single photon emission computed tomography (SPECT) or FDG-PET scan has not been obtained for the same indication.

The indication can be considered to be different in patients who exhibit important changes in scope or severity of cognitive decline, and meet all other qualifying criteria listed above and below (including the judgment that the likely diagnosis remains uncertain). The results of a prior SPECT or FDG-PET scan must have been inconclusive or, in the case of SPECT, difficult to interpret due to immature or inadequate technology. In these instances, an FDG-PET scan may be covered after 1 year has passed from the time the first SPECT or FDG-PET scan was performed.

g. The referring and billing provider(s) have documented the appropriate evaluation of the Medicare beneficiary. Providers should establish the medical necessity of an FDG-PET scan by ensuring that the following information has been collected and is maintained in the beneficiary medical record:

- Date of onset of symptoms
- Diagnosis of clinical syndrome (normal aging; mild cognitive impairment or MCI; mild, moderate or severe dementia)
- Mini mental status exam (MMSE) or similar test score
- Presumptive cause (possible, probable, uncertain AD)
- Any neuropsychological testing performed
- Results of any structural imaging (MRI or CT) performed
- Relevant laboratory tests (B12, thyroid hormone)

Number and name of prescribed medications.

- The billing provider must furnish a copy of the FDG-PET scan result for use by CMS and its contractors upon request.

These services should be billed with HCPCS code of G0336 (Pet imaging, brain imaging for the differential diagnosis of Alzheimer's disease with aberrant features vs. FTD).

FDG-PET Requirements for Use in the Context of a CMS-Approved Neurodegenerative Disease Practical Clinical Trial Utilizing Specific Protocol

With regard to use of the FDG-PET in the context of a CMS-approved clinical trial, the clinical trial must compare patients who do and those who do not receive an FDG-PET scan and have as its goal to monitor, evaluate, and improve clinical outcomes. In addition, it must meet the following basic criteria:

- Written protocol on file
- Institutional Review Board review and approval
- Scientific review and approval by two or more qualified individuals who are not part of the research team
- Certification that investigators have not been disqualified.

Physicians should note that modifier **QV** must be used when billing Medicare carriers for a CMS-approved neurodegenerative disease practical clinical trial.

When billing Medicare fiscal intermediary for a CMS-approved neurodegenerative disease practical clinical trial, providers must enter ICD-9-CM **V70 7** as the second diagnosis code**,** along with the appropriate principal diagnosis code, and HCPCS code **G0336** on Form CMS-1450 or its electronic equivalent.

Once the clinical trial facilities have been identified, a participating facilitt list will be available on CMS website.

Implementation

Implementation date for this instruction is October 4, 2004.

Additional Information

The Medicare Claims Processing Manual (Pub. 100-04), Chapter 13 (Radiology Services), Section 60 (Positron Emission Tomography (PET) Scans) is being updated by this instruction. It includes billing and claim processing requirements for PET scans for beneficiaries with a recent diagnosis of dementia and documented cognitive decline of at least six months duration who meet diagnostic criteria for both FTD and AD, or its use in a CMS-approved practical clinical trial focused on the utility of FDG-PET in the diagnosis or treatment of dementing neurodegenerative diseases.

In addition, the Medicare NCD Manual (Pub. 100-03), Chapter 1 (Coverage Determinations) Section 220 (Radiology), Subsection 6 (Positron Emission Tomography (PET) Scans), is being updated by this instruction to include complete coverage policy and requirements for related clinical trials. These updated manual instructions are included in the official instruction issued to your intermediary/carrier, which can be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***.**

From that Web page, look for CR 3426 in the CR NUM column on the right, and click on the file for that CR.

If you have questions, please contact your intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3426
Related CR Release Date: October 1, 2004
Related CR Transmittal Number: 24
Effective Date: September 15, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-3 Transmittal 24, CR 3426
CMS Pub 100-4 Transmittal 310, CR 3426

Percutaneous Transluminal Angioplasty

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals, physicians, and suppliers.

Provider Action Needed

Effective October 12, 2004, Medicare will expand its coverage to include percutaneous transluminal angioplasty (PTA) of the carotid artery concurrent with placement of a Food and Drug Administration (FDA)-approved carotid stent. This must be for an FDA-approved indication when furnished in accordance with FDA-approved protocols governing post-approval studies. This is an addition to coverage in the context of an FDA-designated category B investigational device exemption (IDE) clinical trial.

Background

Percutaneous transluminal angioplasty involves inserting a balloon catheter into a narrow or occluded blood vessel to recanalize and dilate the vessel by inflating the balloon. The objective of a PTA is to improve the blood flow through the diseased segment of a vessel so that vessel patency is increased and embolization is decreased. PTA (with and without the placement of a stent) is used for dilating lesions of peripheral, renal, and coronary arteries.

PTA is covered to treat atherosclerotic obstructive lesions:

- in the lower extremities, and the upper extremities not including head or neck vessels;
- in treatment of a single coronary artery for patients for whom the likely alternative treatment is coronary bypass surgery and who exhibit certain characteristics;
- of the renal arteries for patients in whom there is an inadequate response to a thorough medical management of symptoms and for whom surgery is the likely alternative; and
- of arteriovenous dialysis fistulas and grafts when performed through either a venous or arterial approach.

PTA treatments that are **not** covered include:

- in the carotid artery when used to treat obstructive lesions outside of FDA-approved protocols governing category B IDE clinical trials and outside of FDA-required post approval studies;
- to treat obstructive lesions of the vertebral and cerebral arteries;
- for all other indications for which CMS has not specifically indicated coverage.

Additional Information

All providers should note that fiscal intermediaries (FIs) and carriers will follow the same procedures for processing post-approval study devices that are currently in place for category B IDEs. For example, a letter of verification that the device is a post-approval study device should be sent to the intermediary or carrier before billing for the device.

For providers billing FIs need to:

- Place no more than one pre-market approval (PMA) number (that begins with a "P") in form locator 43 of claim Form CMS-1450 or in 2300 IDE Number Ref Segment, data element REF02 (REF01=LX) of the 837i
- Use revenue code 0624 for post-approval study devices in form locator 42 of claim Form CMS-1450, or 2400 Institutional Service Line SV201 Segment, data element 234 of the 837i
- Use 433.10 as the diagnostic code
- Use the inpatient procedure codes of 39.50 (angioplasty or atherectomy of non-coronary vessel) and 39.90 (insertion of non-coronary artery stent or stents)

In addition, providers billing carriers need to:

- Place no more than one PMA number (that begins with a "P") in either item 23 of claim Form CMS-1500, or in the 2300 Investigational Device Exemption (IDE) Number Ref Segment, data element REF02 (REF01=LX) of the 837p claim format
- Use modifier QA to reflect PTA post-approval study devices claim
- Use 37799, unlisted procedure, vascular surgery, as the procedure code
- Use 433.10 as the diagnostic code

The official instruction issued to your contractor regarding this change may be found at: *http://www.cms.hhs.gov/manuals/transmittals.comm_date_dsc.asp*.

From that Web page, look for CR 3489 in the CR NUM column on the right, and click on the file for the desired CR. For additional information relating to this issue, please call your intermediary or carrier at their toll free number at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3489
Related CR Release Date: October 15, 2004
Related CR Transmittal Number: 314 and 25
Effective Date: October 12, 2004
Implementation Date: October 12, 2004

Source: CMS Pub 100-4 Transmittal 314, CR 3489

Magnetic Resonance Spectroscopy for Diagnosing Brain Tumors

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

This instruction notifies physicians, providers and suppliers that upon reconsideration, the Centers for Medicare & Medicaid Services (CMS) determined that magnetic resonance spectroscopy (MRS) used as a diagnostic tool for distinguishing indeterminate brain lesions and/or as an aid in conducting brain biopsies is not reasonable and necessary, and CMS reaffirms its existing noncoverage policy for all indications of MRS.

Background

Magnetic resonance spectroscopy (MRS) is an application of magnetic resonance imaging (MRI). It is a noninvasive diagnostic test that uses strong magnetic fields to measure and analyze the chemical composition of human tissues. On March 22, 1994, CMS considered MRS an investigational procedure and issued a national noncoverage determination for all indications of MRS.

Upon thorough review and reconsideration of the existing noncoverage policy, as well as the available evidence for the use of MRS as a diagnostic tool for distinguishing indeterminate brain lesions, and/or as an aid in conducting biopsies, CMS determined that the evidence is not adequate to conclude that MRS is reasonable and necessary under Section 1862(a)(1)(A) of the Social Security Act.

Therefore, CMS reaffirms its existing noncoverage policy at Section 220.2.1 (Magnetic Resonance Spectroscopy) of the National Coverage Determinations (NCD) Manual for all indications of MRS. This addition to Section 220.2.1 is a national coverage determination (NCD), and NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans. In addition, an administrative law judge may not review an NCD (see Section 1869(f)(1)(A)(i) of the Social Security Act).

Implementation

The implementation date for this reaffirmation of the NCD is September 10, 2004.

Additional Information

In addition to the updated manual instructions found at Section 220.2.1 (MRS) of the Medicare NCD Manual (Pub 100-03), Chapter 1, as outlined above, Sections 220.2 (MRI), and 220.3 (Magnetic Resonance Angiography) are being reprinted with clerical/technical edits/clarifications. There are no substantive revisions and no changes to existing NCD policy. The updated manual instructions are included in the official instruction issued to your contractor, and it can be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3425 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier or intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3425
Related CR Release Date: September 10, 2004
Related CR Transmittal Number: 21
Effective Date: September 10, 2004
Implementation Date: September 10, 2004

Source: CMS Pub 100-3 Transmittal 21, CR 3425

Autologous Blood-Derived Products for Chronic Non-Healing Wounds

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All Medicare providers

Provider Action Needed

No action is necessary. This article is informational only. The Centers for Medicare & Medicaid Services (CMS) has determined, upon reconsideration of existing policy, that autologous blood-derived products for chronic non-healing cutaneous wounds, both platelet-derived growth factor (PDGF) in platelet-poor plasma and platelet-rich plasma (PRP), **will remain noncovered** as CMS continues to believe that the clinical effectiveness of these autologous blood-derived products is not adequately proven in scientific literature.

Background

Patient-donated blood is centrifuged to produce an autologous gel for the treatment of chronic non-healing cutaneous wounds that persist for 30 days or longer and fail to complete the healing process properly.

Autologous blood-derived products for chronic non-healing wounds include both PDGF products, such as Procuren and more recent products, and PRP products.

PRP differs from previous products because it contains whole cells, including white cells, red cells, plasma, platelets, fibrinogen, stem cells, macrophages, and fibroblasts. Physicians use PRP in clinical settings. PDGF does not contain cells and was marketed as a product to be used by patients at home.

In 1992 CMS issued a national Medicare noncoverage determination in relation to platelet-derived wound healing formulas containing growth factors in the treatment of non-healing wounds. The determination was based on a lack of sufficient published data to determine the safety and efficacy of such formulas, and a public health service technology assessment.

Autologous Blood-Derived Products for Chronic, Non-Healing Wounds (continued)

Recently, CMS reconsidered the 1992 decision and concluded that the clinical effectiveness of autologous PDGF products continues to be inadequately proven in scientific literature, and it remains non-covered for treatment of chronic, non-healing cutaneous wounds. Additionally, the clinical evidence does not support a benefit in the application of autologous PRP for the treatment of chronic, non-healing wounds, and CMS has determined it is not reasonable and necessary and is nationally non-covered.

It will remain at the local contractor's discretion whether to pay for becaplermin, a non-autologous growth factor product approved by the FDA for the treatment of chronic non-healing subcutaneous wounds. Also, the routine costs of autologous PRP products for the treatment of chronic non-healing wounds associated with category B investigational device exemption clinical trials are covered by Medicare in accordance with 42 CFR 405.201 – 405.215, 411.15, and 411.406 or section 310.1 of the National Coverage Determinations Manual.

Additional Information

The official instruction issued to your carrier/intermediary regarding this change may be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3384 in the CR NUM column on the right and click on the file for that CR.

Also if you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: MM3384
Related CR Release Date: July 30, 2004
Related CR Transmittal Number: 19
Effective Date: July 23, 2004
Implementation Date: July 23, 2004

Source: CMS Pub 100-3 Transmittal 19, CR 3384

National Coverage Determinations Edit Module Questions and Answers

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All providers

Provider Action Needed

This instruction provides responses to commonly asked questions regarding the negotiated laboratory national coverage determinations (NCDs) and the edit module used to implement the NCDs uniformly. Carriers and fiscal intermediaries (FIs) may elect to use this language in responding to inquiries in their organization to help further standardize action nationally related to clinical diagnostic laboratory services.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published as a final rule on November 23, 2001. Nationally uniform software has been developed by Computer Sciences Corporation (CSC) and incorporated in the Medicare claim processing systems, known as shared systems, so that laboratory claims subject to one of the 23 laboratory NCDs are processed uniformly throughout the nation. In an effort to further standardize the action of Medicare carriers and intermediaries regarding claims subject to one of the NCDs, CSC has developed language that can be used to respond to inquiries related to the NCDs and the edit module used to implement them.

Implementation

The implementation date for this instruction is October 4, 2004.

Additional Information

The frequently asked questions (FAQs) and their answers are as follows:

1. **What Is a National Coverage Determination (NCD)?**
   The Centers for Medicare & Medicaid Services (CMS) makes NCDs granting, limiting, or excluding Medicare coverage for a specific medical service, procedure, or device. NCDs are made under section 1862(a) (1) of the Social Security Act (the Act) or other applicable provisions of the Act. The national coverage decisions apply nationwide and are binding on all Medicare carriers, FIs, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans for purposes of Medicare coverage.

2. **What Is a Clinical Laboratory Edit Table, and What Is Its purpose?**
   The Clinical Laboratory NCD Edit Table is a diagnosis-to-procedure code edit table used by all Medicare contractors to process Medicare claims. The purpose of the edit table is to ensure that the Medicare claims subject to one of the negotiated laboratory NCDs are processed uniformly throughout the nation.

3. **When Did the Clinical Laboratory Edit Table Become Effective?**
   The Clinical Laboratory Edit Table became effective January 1, 2003. The negotiated laboratory NCDs became effective on November 25, 2002.

4. **How Often and Why is the Clinical Laboratory NCD Edit Table Updated?**
   The Clinical Laboratory NCD Edit Table is updated quarterly as necessary to reflect coding updates, ministerial coding changes, and substantive changes to the NCDs developed through the NCD process. Updates to the International Classification of Diseases,

National Coverage Determinations Edit Module Questions and Answers (continued)

Ninth Revision, Clinical Modification (ICD-9-CM) and Current Procedural Terminology (CPT) are incorporated into the edit module so as not to substantively change the NCDs. Codes that flow from the narrative indications of the NCDs, but that were not initially included, may be added through coding analyses that are published on the coverage Internet site for public comment. Substantive policy changes resulting from new or modified NCDs for clinical laboratory services may also be developed and incorporated in the edit module quarterly updates.

5. **Why Were the Negotiated Laboratory NCDs Initiated?**
The negotiated laboratory NCDs were initiated to promote program integrity and national uniformity and to simplify administrative requirements for clinical diagnostic services.

6. **Where Can I Find the List of Clinical Laboratory NCD Procedure Codes and Coverage Documentation?**
There is a complete list of procedure codes and coverage information available on the CMS web site. The link to access the NCD Coding Policy Manuals, Federal Register Final Rules, and related CMS program memoranda is as follows:
http://www.cms.hhs.gov/ncd/labindexlist.asp.

7. **How Should a Laboratory Bill for Services that Are Noncovered for Reasons Other than Medical Necessity?**
Healthcare Common Procedure Coding System (HCPCS) coding provides for a GY modifier to be used to indicate an item or service that is statutorily excluded or does not meet the definition of any Medicare benefit. The list of non-covered codes for laboratory procedures subject to the negotiated NCDs can be found in the coding manuals in the "Non-covered ICD-9-CM Codes for All NCD Edits" section. These are the only codes that should be billed with the GY modifier for services subject to the negotiated laboratory NCDs. For information go to:
http://www.cms.hhs.gov/ncd/labindexlist.asp.

8. **Is There a Procedure to Follow if I Disagree with the Coverage Policy of Any of the Negotiated Laboratory NCDs?**
If you are requesting a substantive change in an NCD, you must follow the NCD process that requires scientific evidence. Information regarding the NCD process is available on the Internet at:
http://www.cms.hhs.gov/coverage.

Click on the coverage process link.
CMS has developed a streamlined process for making coding changes that flow from the narrative indication of the negotiated lab NCDs. This was announced in the Federal Register on December 24, 2003 (68 FR 74607). Under this process, a coding analysis may be performed after a 30-day public comment period to determine if codes are appropriately listed in NCD code lists. Coding analyses do not require scientific evidence, as the substance of the NCD is not altered. To request a coding analysis, you must submit a request identifying the provision in the NCD narrative you believe supports the code. Send the request to the Coverage and Analysis Group, CMS, C1-09-06, 7500 Security Boulevard, Baltimore, MD 21244-1850

9. **What Diagnosis Codes Are Used for the Negotiated Laboratory NCDs?**
Every ICD-9-CM code falls into one of the three possible lists used in the edit module for the negotiated laboratory NCDs. The three code lists include: ICD-9-CM Codes Covered by Medicare, ICD-9-CM Codes Not Covered by Medicare, and ICD-9-CM Codes That Do Not Support Medical Necessity.

10. **What Causes an Invalid Code?**
A code is invalid if it has not been coded to the full number of digits required for that code (Coding Clinic 1995 4th Quarter). Any series of numbers that is not linked to a description in the ICD-9-CM book is an invalid code.

11. **How Are Probable, Suspected, Questionable, Rule-out, or Working Diagnoses Coded?**
Diagnoses documented as probable, suspected, questionable, rule-out, or working should not be coded as though they exist. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as signs, symptoms, and abnormal test results, exposure to communicable disease or other reasons for the visit.

12. **How Can I Bill for a Preoperative Test for Patients About to Undergo Surgery now that the NCDs Have Removed the V72 Series of ICD-9-CM Codes?**
Testing prior to any medical intervention associated with a risk of bleeding and thrombosis (other than thrombolytic therapy) will generally be considered medically necessary only when there are signs or symptoms of a bleeding or thrombotic abnormality or a personal history of bleeding, thrombosis, or a condition associated with a coagulopathy. Hospital/clinic-specific policies, protocols, etc., in and of themselves cannot alone justify coverage.
Assign the ICD-9-CM codes describing the signs, symptoms, or conditions that justify the need for the test.
If the signs, symptoms or conditions are not on the ICD-9-CM Codes Covered by Medicare list, they can still be submitted with the appropriate medical necessity documentation to substantiate the test. If no underlying signs, symptoms, or conditions are present, a screening code must be used. In this instance, Medicare does not cover the screening code test, and payment will be the responsibility of the beneficiary.

13. **I Can't Find the List of Covered Diagnoses for Blood Counts. Where Is It?**
The blood counts policy lists the ICD-9-CM Codes Not Covered by Medicare and the ICD-9-CM Codes That Do Not Support Medical Necessity. The list of ICD-9-CM Codes Covered by Medicare for blood counts is any diagnosis code not listed in either non-covered or not medically necessary lists.

National Coverage Determinations Edit Module Questions and Answers (continued)

14. **I'm Concerned that My Claims for Sensitivity Testing for Specimens Other than Urine Will Deny as the Covered List for Codes 87184 and 87186 Include only Diagnoses that Support Urine Culture Sensitivities.**
    Claims for sensitivity testing on specimens other than urine will not deny as not medically necessary if they do not have a diagnosis from the ICD-9-CM Codes Covered by Medicare list of covered diagnoses for urine cultures. The edit module does not edit for these CPT codes. Rather, the NCD is intended to educate providers as to the appropriate indications to perform a urine culture sensitivity test.

15. **Why Doesn't Medicare Cover a Prostate Specific Antigen (PSA) Test for My Patients with Benign Prostatic Hypertrophy (BPH)?**
    The code for BPH, 600.00, is not on the ICD-9-CM Codes Covered by Medicare listing for a diagnostic PSA. Medicare does, however, cover an annual screening PSA test for men over 50. Men with BPH receiving an annual PSA screening should have their claims coded with procedure code G0103 in lieu of CPT code 84153. This screening procedure code requires a diagnosis code of V76.44 that must appear on the claim form. If the patient has symptoms of prostate carcinoma along with the BPH, such as hematuria, nocturia, urinary frequency, and slow stream, a diagnostic PSA can be covered. More detailed information can be found in Program Memorandum AB-03-132 at: *http://www.cms.hhs.gov/manuals/pm_trans/AB03132.pdf*.

16. **My Contractor Retired a Local Coverage Determination (LCD) Related to One of the NCDs. Can I still Get Payment for the Diagnoses Covered in the LCD?**
    NCDs are binding on all Medicare claim processing contractors. Carriers and FIs may not have local policies that conflict with an NCD. Since the NCDs for the lab tests that were negotiated are specific to the code level, it is not possible for a local policy to deviate from the ICD-9-CM Codes Covered by Medicare list of diagnoses without being in conflict. However, contractors are authorized to pay for diagnoses on the ICD-9-CM Codes That Do Not Support Medical Necessity list if the laboratory submits satisfactory documentation along with the claim. In addition, contractors may develop local policies in areas where the NCD is silent.

Related Change Request (CR) Number: 3374
Related CR Release Date: July 23, 2004
Related CR Transmittal Number: 234
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 234, CR 3374

Treatment of Obesity

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All providers.

Provider Action Needed

No action is necessary. This article is informational only. Current language in the National Coverage Determinations (NCD) Manual states that "obesity itself cannot be considered an illness." The Secretary of Health and Human Services is removing this language as a result of a recent decision. The change in the manual language will not directly affect current Medicare coverage of obesity treatments.

Treatments for obesity alone remain noncovered and treatments of diseases resulting in or exacerbated by obesity remain unchanged.

Providers should note, however, that removal of the language does permit interested parties to submit NCD requests for anti-obesity interventions to the Centers for Medicare & Medicaid Services (CMS) to determine if scientific and medical evidence demonstrate their effectiveness in improving Medicare beneficiaries' health outcomes.

Background

Nationally Covered Indications

Medicare covers services performed in connection with the treatment of obesity only when such services are an integral and necessary part of a course of treatment for diseases such as hypothyroidism, Cushing's disease, hypothalamic lesions, cardiovascular diseases, respiratory diseases, diabetes, and hypertension.

Nationally Noncovered Indications

The treatment of obesity alone (i.e., where obesity cannot be shown to be an integral part of a disease process) is not considered reasonable and necessary for the treatment of an illness or injury and is not covered under the Medicare program. Supplemental fasting is not covered under the Medicare program as a general treatment for obesity.

Other

Supplemented fasting with adequate monitoring of the patient is eligible for a local coverage determination at the discretion of your Medicare contractor where weight loss is necessary before surgery to ameliorate the complications posed by obesity when it coexists with pathological conditions such as cardiac and respiratory diseases, diabetes, or hypertension (and other more conservative techniques to achieve this end are not regarded as appropriate).

Implementation

The implementation date for this instruction is October 1, 2004.

Treatment of Obesity (continued)

Additional Information

The official instruction issued to your Medicare contractor regarding this change may be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3502 in the CR NUM column on the right and click on the file for that CR.

Attached to CR 3502 is the actual revised language for the Medicare NCD Manual.

If you have any questions, please contact your Medicare contractor at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3502
Related CR Release Date: October 1, 2004
Related CR Transmittal Number: 23
Effective Date: October 1, 2004
Implementation Date: October 1, 2004

Source: CMS Pub 100-3 Transmittal 23, CR 3502

Islet Cell Transplantation for Beneficiaries in a National Institute of Health Clinical Trial

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All providers involved in a National Institute of Health (NIH) sponsored clinical trial

Provider Action Needed

STOP – Impact to You

In the specific context of an NIH sponsored clinical trial:

For services performed on or after October 1, 2004, Medicare will cover islet cell transplantation for trial participants (patients) with type I diabetes. The islet cell transplant may be done alone or in combination with a kidney transplant.

Immunosuppressive therapy to prevent rejection of the transplanted islet cells and routine follow-up care will be necessary for each trial participant.

CAUTION – What You Need to Know

Partial pancreatic tissue transplantation or islet cell transplantation performed outside the context of a clinical trial continues to be noncovered.

GO – What You Need to Do

Please stay current on instructions pertaining to NIH sponsored clinical trials to ensure accurate claims processing.

Background

As a result of Section 733 of the Medicare Modernization Act (MMA) of 2003, for services performed/discharged on or after October 1, 2004, Medicare will cover islet cell transplantation for patients with type I diabetes who are participating in an NIH sponsored clinical trial.

For dates of service on and after October 1, 2004, for such beneficiaries, Medicare carriers will accept claims for islet cell transplantation with a type of service code of 2 and HCPCS code G0341 (Percutaneous islet cell trans), G0342 (Laparoscopy islet cell trans), or G0343 (Laparotomy islet cell transp). Physicians should also use modifier QV for islet cell transplantation and routine follow-up care related to this NIH trial.

Where beneficiaries are enrolled in a Medicare Advantage (MA) plan, Medicare carriers or intermediaries should make payment directly to providers of these islet cell transplants in accordance with Medicare payment rules, except that MA beneficiaries receiving the services are not responsible for the Part A and Part B deductibles. Such beneficiaries will be liable, however, for any applicable coinsurance amounts that the MA organization has in place for clinical trial benefits.

Providers billing Medicare intermediaries for these services should do so on a type of bill 11x. Such claims will be paid by the intermediary only for inpatient prospective payment system hospitals participating in the trial, and claims for beneficiaries in MA plans should also include condition code 30 so the deductible will not be applied.

For fee-for-service beneficiaries, deductibles and coinsurance will apply.

Additional Information

The official instruction issued to the intermediary regarding this change can be found online, referenced via CR 3385, at: *http://www.cms.hhs.gov/manuals/pm_trans/R261Cp.pdf*.

If you have questions regarding this issue, you may also contact your fiscal intermediary or carrier at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3385
Related CR Release Date: July 30, 2004
Related CR Transmittal Number: 261
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 261, CR 3385

HOSPITAL SERVICES

Fiscal Year 2005 Inpatient Prospective Payment System Update

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Inpatient hospitals, long term care hospitals (LTCH), and other types of bill related to inpatient prospective payment system (IPPS).

Provider Action Needed

This instruction outlines important policies in the IPPS final rule. These include new tech add-ons, postacute care diagnosis related groups (DRGs), core-based statistical areas (CBSAs), hospital quality initiative, low volume hospitals, long term care hospitals within hospitals (HwH), and other changes related to capital payments.

Background

This instruction outlines changes for IPPS hospitals for fiscal year (FY) 2005. The changes for FY 2005 were published in the *Federal Register* on August 11, 2004. All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2004, unless otherwise noted.

This instruction also addresses new GROUPER and DRG changes that are effective October 1, 2004 for hospitals paid under the LTCH prospective payment system (PPS) as well as information on the HwH provision. LTCH PPS rate changes occurred on July 1, 2004. For other LTCH policy changes, please also refer to:

- Transmittal 208, Change Request (CR) 3335, published on June 18, 2004, Long Term Care Hospital Prospective Payment System (LTCH PPS) Fiscal Year 2005-Update, at: *http://www.cms.hhs.gov/manuals/pm_trans/R208CP.pdf*.
- Transmittal 240, CR 3279, published on July 23, 2004, Expansion of the Existing Interrupted Stay Policy Under Long Term Care Hospital (LTCH) Prospective Payment System, at *http://www.cms.hhs.gov/manuals/pm_trans/R240CP.pdf*.
- Transmittal 267, CR 3391, published on July 30, 2004, Crossover Patients in New Long Term Care Hospitals, at *http://www.cms.hhs.gov/manuals/pm_trans/R267CP.pdf*.

Key changes are as follows:

International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Changes

ICD-9-CM coding changes are effective October 1, 2004, and the new ICD-9-CM codes are listed, along with their DRG classifications in Tables 6a and 6b of the August 11, 2004 *Federal Register.* The ICD-9-CM codes that have been replaced by expanded codes or other codes or that have been deleted are included in Tables 6c and 6d. The revised code titles are in Tables 6e and 6f. The August 11, 2004 *Federal Register* can be found at the following CMS website: *http://www.cms.hhs.gov/providerupdate/regs/cms1428f.pdf*.

Furnished Software Changes

The following software programs were issued to Medicare claim processing system maintainers for FY 2005:

- GROUPER 22.0 assigns each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (age, sex, and discharge status) and is effective with discharges occurring on or after October 1, 2004.
- Medicare code editor (MCE) 21.0 and Outpatient code editor (OCE) versions 20.0 and 5.3 use the new ICD-9-CM codes to validate coding for hospital discharges and outpatient services effective October 1, 2004.

IPPS PRICER 05.0

IPPS PRICER 05.0 is for discharges occurring on or after October 1, 2004.

1. Rates:

Standardized Amount Update Factor	1.033
Hospital Specific Update Factor	1.033
Common Fixed Loss Cost Outlier Threshold	$2,5800.00
Federal Capital Rate	$416.53
Puerto Rico Capital Rate	$199.01
Outlier Offset-Operating National	0.948978
Outlier Offset-Operating Puerto Rico	0.973183
Outlier Offset-Operating National PR blend	0.955029
IME Formula	1.42*[1 + resident-to-bed ratio**.405-1]
MDH/SCH Budget Neutrality Factor *	0.999876

* Replace the 2004 update with 1.002608 (average of FY 2004).

Quality = 1 / Wage Index >	**1 Full Update and .711 Labor Share**	
	Labor Share	Non-Labor Share
National	3238.07	1316.18
PR National	3238.07	1316.18
PR Specific	1554.79	625.84

Quality <> 1 / Wage Index > 1	**Lower Update and .711 Labor Share**	
	Labor Share	Non-Labor Share
National	3225.53	1311.08
PR National	3225.53	1311.08
PR Specific	1548.77	623.42

Quality = 1 / Wage Index <= 1	**Full Update and .62 Labor Share**	
	Labor Share	Non-Labor Share
National	2823.64	1730.62
PR National	2823.64	1730.62
PR Specific	1351.99	828.64

Fiscal Year 2005 Inpatient Prospective Payment System Update (continued)

Quality <> 1 / Wage Index <= 1		Lower Update and .62 Labor Share
	Labor Share	Non-Labor Share
National	2812.70	1723.91
PR National	2812.70	1723.91
PR Specific	1346.76	825.43

Please be advised that the numbers in the above two tables do not match the August 11, 2004 *Federal Register*, however these are the most current numbers.

The revised hospital wage indices and geographic adjustment factors are contained in Tables 4a2 (urban areas), 4b2 (rural areas), and 4c2 (redesignated hospitals) of the August 11, 2004 *Federal Register*. These tables can be found at the following CMS website: *http://www.cms.hhs.gov/providers/hipps/ippswage.asp*.

The August 11, 2004 Federal Register can be found at: *http://www.cms.hhs.gov/providerupdate/regs/cms1428f.pdf*.

2. Postacute Care Transfer Policy

On October 1, 1998, CMS established a postacute care transfer policy that paid as transfers all cases assigned to one of 10 DRGs if the patient is discharged to a psychiatric hospital or unit, an inpatient rehabilitation hospital or unit, an LTCH, a children's hospital, a cancer hospital, a skilled nursing facility, or a home health agency. On October 1, 2003, that list was expanded to 29 DRGs.

Effective for discharges on or after October 1, 2004, CMS is adding two more DRGs to this list (541 and 542) and removing 483 from the list.

3. New Technology Add-On Payment

Effective for discharges on or after October 1, 2004, there are three "new" new technology add-on payments, 1) the OP-1 Implant, 2) CRT-D and 3) Kinetra®, in addition to InFUSE™, which was effective October 1, 2003. Xigris is no longer included.

The maximum add-on payment for InFUSE™ (ICD-9-CM procedures of 84.51 and 84.52 must both be present AND codes 81.05, 81.08, 81.35, and 81.38 MUST NOT be present) is $1,955.00. The maximum add-on payment for OP-1 (ICD-9_CM code of 84.52 MUST be present and at least one of 81.05, 81.08, 81.35, or 81.38 must also be present) is also $1,955.00. For both of these add-ons, the DRG must also be 497 or 498. The maximum add-on payment for CRT-D (ICD-9-CM code of 00.51 or 00.54 must be present) is $16,262.50 and the maximum for Kinetra® (ICD-9-CM codes 02.93 AND 86.95 must be present) is $8,285.00.

It is possible to have multiple new technologies on the same claim. Should multiple new technologies be present, PRICER will calculate each separately and then total the new technology payments.

Low Volume Hospitals

Hospitals considered low volume shall receive a 25 percent bonus to the operating final payment. To be considered "low volume" the hospital must have fewer than 200 discharges and be located at least 25 miles from another hospital. The discharges are determined from the latest cost report. The final rule identifies the process for determining which hospitals are low volume on page 49101 and 49244. Please contact your FI if you think you are a "low volume" hospital.

Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at the following website: *http://www.qnetexchange.org*. Please select 'HDC', then 'List of Providers' under the heading 'Reporting Hospital Quality Data for Annual Payment Update' or 'What's New'. The actual CR contains a list of the providers (by provider number) that are not receiving the quality initiative bonus.

Core-Based Statistical Area (CBSA)

Effective October 1, 2004, inpatient acute hospitals are no longer classified into a metropolitan statistical area (MSA). A CBSA is now used. The CR includes two attachments. These attachments will assist your FI in determining the correct CBSA.

Disproportionate Share (DSH) Adjustment for Urban to Rural Providers

42 CFR 412.102 provides for a transition to a rural payment amount from an urban payment amount under the operating PPS over two years. There are a few hospitals with a DSH adjustment near or greater than 12 (the cap on the operating DSH adjustment for certain groups of providers) that were considered urban under the MSA definition, but are now considered rural under the CBSA definition. These providers shall receive an adjustment to their operating DSH payment over the next two years and have been coded into the PRICER in an attempt to most closely approximate the DSH payment they will receive upon cost report settlement. The adjustment gives these hospitals ? of the difference between the urban and rural operating DSH for FY 05 and ? of the difference between the urban and rural operating DSH for FY 06 Based on the best available data, CMS has identified the following providers:

Medicare Provider Identification Numbers

18-0049	19-0044	19-0144
19-0191	33-0047	34-0085
37-0016	37-0149	42-0043

Capital PPS Payments to Hospitals Located in Puerto Rico

Currently, section 412.374 of the regulations provide that capital PPS payments to hospitals located in Puerto Rico are based on a blend of 50 percent of the capital federal rate (derived from the costs of all acute care hospitals participating in the IPPS, including those located in Puerto Rico) and 50 percent of the Puerto Rico capital rate (derived from the costs of Puerto Rico acute care hospitals only). In the August 11, 2004 IPPS final rule, CMS revised section 412.374 of the regulations to provide that, for discharges occurring on or after October 1, 2004, capital PPS payments to hospitals located in Puerto Rico will be based on a blend of 75 percent of the capital federal rate and 25 percent of the Puerto Rico capital rate. This change parallels the change in payments to Puerto Rico hospitals under the operating PPS provided for by section 504 of Pub. L. 108-173 for discharges occurring on or after October 1, 2004, which increases the national portion of the operating PPS payment for Puerto Rico hospitals from 50 percent to 75 percent and decreases the Puerto Rico portion of the operating PPS payments from 50 percent to 25 percent.

Fiscal Year 2005 Inpatient Prospective Payment System Update (continued)

Capital PPS Payments to Hospitals Previously Reclassified for the Operating PPS Standardized Amounts

Previously, the standardized amounts varied under the operating PPS based on a hospital's geographic location (large urban versus other urban and rural areas). In addition, previously, a hospital could be reclassified to a large urban area by the Medicare Geographic Classification Review Board (MGCRB) for the purpose of the standardized amount if certain criteria were met. Also, in the past, if a rural or other urban hospital was reclassified to a large urban area for purposes of the operating PPS standardized amount, under the capital PPS the hospital was also eligible for a large urban add-on payment under section 421.316, as well as a DSH payment adjustment under section 412.320.

With the permanent equalization of the operating PPS standardized amounts provided for by various pieces of legislation (Public Laws 108-7, 108-89 and 108-173), all hospitals are now paid based on the large urban standardized amount, regardless of geographic location or MGCRB redesignation. Because there are no longer differences in standardized amounts due to geographic classification as a result of this legislation, hospitals are not eligible to reclassify solely for standardized amount purposes. Accordingly, the MGCRB denied all FY 2005 standardized amount reclassification requests.

In the August 11, 2004 IPPS final rule, CMS explained that because of the changes to the operating PPS described above, rural and other urban hospitals that were previously eligible to receive the large urban add-on and DSH payments under the capital PPS because they reclassified to a large urban area for the purpose of the standardized amount under the operating PPS, are no longer able to reclassify, and therefore, will not be eligible to receive those additional capital PPS payment adjustments beginning in FY 2005. For discharges occurring on or after October 1, 2004, only hospitals geographically located in a large urban area (as defined in section 412.63(c)(6)) are eligible for large urban add-on payments provided for under section 412.312(b)(2)(ii) and section 412.316(b). Similarly, for discharges occurring on or after October 1, 2004, only hospitals serving low-income patients that are geographically located in an urban area (as defined in section 412.64) and that meet all other requirements of section 412.320 will be eligible for capital PPS DSH payments provided for under section 412.320.

Geographic Classification and Definition of Large Urban Area under the Capital PPS

Currently, under the capital PPS the large urban location adjustment provided for under section 412.316(b) and the DSH payment adjustment for certain urban hospitals provided for under section 412.320 are based on the existing geographic classifications set forth at section 412.63. Beginning in FY 2005 and thereafter, a hospital's geographic classification (MSA) will be based on OMB's new CBSA designations, as set forth under new section 412.64. Because of this change in the MSA definitions (under new section 412.64), CMS has revised section 412.316(b) and section 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the large urban location adjustment (412.316(b)) and the DSH payment adjustment (section 412.320) will be based on the geographic classifications at section 412.64.

A large urban area is defined at section 412.63(c)(6) as an MSA with a population of more than 1,000,000 or a New England county metropolitan area with a population of more than 970,000 based on the most recent available population data published by the Bureau of the Census. Beginning in FY 2005, based on the new MSA definitions established under section 412.64 and the 2000 census data, there are a total of 62 large urban areas, which are denoted in Tables 4A2 and 4B2 in the Addendum of the August 11, 2004 IPPS final rule. In that same final rule, CMS revised sections 412.312(b)(2)(ii) and 412.316(b) to clarify that for discharges occurring on or after October 1, 2004, the definition of large urban area set forth at section 412.63(c)(6) continues to be in effect under the capital PPS for the large urban add-on adjustment.

LTCH Changes

LTCH PPS Cost-To-Charge Ratios

To ensure that the distribution of outlier payments remains equitable, for FY 2005 a LTCH's overall Medicare cost-to-charge ratio is considered not to be reasonable if the value exceeds the combined (operating plus capital) upper (ceiling) cost-to-charge ratio thresholds calculated annually by CMS under the hospital inpatient PPS and published in the *Federal Register.* Effective for discharges occurring on or after October 1, 2004, the combined operating and capital upper limit (ceiling) on cost-to-charge ratios is 1.409 (1.240 plus 0.169). The appropriate (combined) statewide average cost-to-charge ratios for FY 2005 can be found in Tables 8A and 8B of the IPPS final rule.

LTCH PRICER, DRGs, and Relative Weights

The annual update of the LTC-DRGs, relative weights and GROUPER software for FY 2005 are published in the annual IPPS final rule. The same GROUPER software developed for the hospital inpatient PPS will be used for the LTCH PPS.

Version 22.0 of the hospital inpatient PPS GROUPER will be used for FY 2005, but with LTCH-specific relative weights reflecting the resources used to treat the medically complex LTCH patients.

The annual update of the LTC-DRGs, relative weights, (geometric) average length of stay and 5/6th of the average length of stay (for short-stay outlier cases) for FY 2005 was determined using the most recent available LTCH claims data (FY 2003).

The LTC-DRGs, relative weights, (geometric) average length of stay and 5/6th of the average length of stay effective for discharges on or after October 1, 2004 can be found in Table 11 of this final rule and are in the LTCH PPS PRICER program.

LTC Hospital Within Hospital (HwH) Provision

Effective for discharges from LTCHs as described in section 412.23(e)(2)(i) meeting the criteria in section 412.22(e)(2), or satellite facilities of long-term care hospitals that meet the criteria in section 412.22(h), CMS has finalized the following revisions to separateness and control regulations at 412.22(e) and added new payment policy regulation at 412.534 for cost reporting periods beginning on or after October 1, 2004.

Fiscal Year 2005 Inpatient Prospective Payment System Update (continued)

- The policies will also be applicable if the host hospital is a hospital other than an acute care hospital but only applicable if the HwH is an LTCH.
- For existing LTCH HwHs, the three performance of basic hospital functions qualifications for HwHs at 412.22(e)(5) (i), (ii), and (iii) are eliminated for cost reporting periods beginning on or after October 1, 2004. (Note provisions of "hold harmless year 10/1/04 – 10/1/05 below)
- If an LTC HwH meets existing separateness and control of administrative and medical governance provisions at 412.22(e)(1) through (e)(4), payment will be made under the LTCH PPS as specified in 412.534.

Basic Payment Formula

Please note the new regulations at 42 CFR 412.534 limit the relevant percentage of patients to only Medicare patients.

- Under 412.534, if an LTC HwH's admissions from its host hospital exceed 25 percent (or the applicable percentage) of its discharges for the HwH's cost reporting period, an adjusted payment will be made of the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise pay under the IPPS (including capital, DSH, IME, outliers, etc.).
- In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host's allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)

Specific Circumstances

- For rural acute care hospitals with HwHs, instead of the 25 percent criterion, the majority, (i.e., at least 51 percent) of the patients would have to be from the hospitals other than the host. In addition, in determining the percentage of patients admitted from the host, any patient that had been Medicare outliers at the host and then transferred to the HwH would be considered as if they were admitted from a non-host hospital.
- For urban single or MSA dominant hospitals, CMS would allow the HwH to admit from the host up to the host's percentage of total Medicare discharges in the MSA. CMS would apply a floor of 25 percent and a ceiling of 51 percent to this variation.

Transition Period

CMS has established a four-year phase-in of this policy for existing LTC HwHs and also for LTCHs-underformation that satisfy the following two-prong requirement:

- On or before October 1, 2004 they have certification as acute care hospitals, under Part 489
- Before October 1, 2005 designation as a LTCH.

For purposes of full payment under the LTCH PPS during the transition period, the percentage of discharges from the LTC HwH originating from the host hospital for each applicable cost reporting period, may not exceed the percentage of discharges during the provider's 2004 cost reporting period that were admitted from the host hospital. Payments under this policy will be based on reconciliation at cost report submission in order to determine the total number of discharges from the LTCH in a cost reporting period.

- **Year 1** – (cost reporting periods beginning on or after October 1, 2004 through September 30, 2005) a "hold harmless"
  - If the percentage of LTC HwH discharges originating from the host does not exceed the percentage for such patients established the provider's 2004 cost reporting period, payments will be made under the LTCH PPS.
  - If the percentage of such discharges exceeds the number of such discharges from the host hospital in its 2004 cost report period, for those discharges in excess of that percentage, Medicare will pay under the basic payment formula specified above.
- **Year 2** – (cost reporting periods beginning on or after October 1, 2005 through September 30, 2006)
  - LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the lesser of the percentage of those patients for their 2004 cost reporting period or 75 percent.
  - For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.
- **Year 3** – (cost reporting periods beginning on or after October 1, 2006 through September 30, 2007)
  - LTC HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the lesser of the percentage of those patients for their 2004 cost reporting period or 50 percent.
  - For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.
- **Year 4** – (cost reporting periods beginning on or after October 1, 2007 (full phase-in)
  - LTC HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the 25 percent of the applicable percentage described for "specific circumstances above."
  - For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Fiscal Year 2005 Inpatient Prospective Payment System Update (continued)

Implementation

The implementation date for this instruction is October 4, 2004.

Additional Information

For complete details, please see the official instruction issued to your fiscal intermediary regarding this change at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3459 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your FI at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3459
Related CR Release Date: October 1, 2004
Related CR Transmittal Number: 309
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 309, CR 3459

Implementation of Patient Status Code 65 and Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals and other facilities that bill Medicare fiscal intermediaries

Provider Action Needed

This instruction implements patient status code 65, "discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital."

Background

Field locator 22 on the UB-92 or electronic equivalent is a **required field** for all Part A inpatient, skilled nursing facility, hospice, home health agency, and outpatient hospital bills. This code indicates a patient's status as of the "through" date of the billing period.

Currently, hospitals are using patient status code 05 for patients discharged/transferred to a psychiatric hospital or psychiatric distinct unit of a hospital, because psychiatric hospitals and psychiatric distinct part units have been included in patient status code 05 (previously defined as "discharged/transferred to another type of facility").

This instruction removes these types of hospitals from patient status code 05 and assigns them separately identifiable patient status code 65.

Also, Medicare identifies psychiatric hospitals by provider number xx-4xxx and psychiatric distinct part units by provider number xx-Sxxx. Payment can be affected when an acute inpatient prospective payment hospital transfers a patient to a psychiatric hospital because psychiatric hospitals are included in the postacute care transfer policy. Thus, correct coding of this field, which is also a required field, is very important for all providers.

Implementation

The implementation date for this instruction is January 3, 2005, but the change is effective for claims with a discharge date of April 1, 2004 or later.

Additional Information

For complete details, please see the official instruction issued to your fiscal intermediary regarding this change. That instruction may be viewed by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that web page, look for Change Request (CR) 3364 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3364
Related CR Release Date: July 23, 2004
Related CR Transmittal Number: 237
Effective Date: April 1, 2004
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 237, CR 3364

Revision of Common Working File Editing for Same-Day, Same-Provider Acute Care Readmissions

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Inpatient hospitals

Provider Action Needed

Effective January 1, 2004:

- When a patient is discharged/transferred from an acute care prospective payment system (PPS) hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms **related** to, or for evaluation and management of, the prior stay's medical condition, **hospitals will adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.** Please be aware that services rendered by other institutional providers during a combined stay must be paid by the acute care PPS hospital as per common Medicare practice.
- When a patient is discharged/transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms **unrelated to**, and/or not for evaluation and management of, the prior stay's medical condition, **hospitals will place condition code (CC) B4 on the readmitting claim for the subsequent readmission.** Please be aware that upon request of the quality improvement organization (QIO), hospitals will be required to submit medical records pertaining to the readmission.

Background

The Office of the Inspector General (OIG), in a report titled "Review of Medicare Same-Day, Same-Provider Acute Care Readmissions in Pennsylvania During the Calendar Year 1998," recommended the establishment of an edit check in the Medicare claims processing system to identify for review all same day, same-provider acute care readmissions where the beneficiary was coded as being discharged to another provider before being readmitted.

Such an edit was established in the Medicare claims processing system used by your fiscal intermediary (FI) effective January 1, 2004. This is in line with Medicare's policy to make only one diagnosis-related group (DRG) payment for same-day, same-provider admissions. However, it is possible for a patient to be readmitted on the same day to the same provider for symptoms unrelated to the original condition.

As a result, Medicare will allow the use of a condition code (CC) **B4** on the readmitting claim when a patient is discharged/transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms **unrelated** to, and/or not for evaluation and management of, the prior stay's medical condition.

By February 1, 2005, FIs must receive claims with CC B4 and with discharges before January 1, 2005, in order to apply interest. For non-PPS acute care hospitals, such as Maryland waiver hospitals, the readmission bill (if related to original admission) does not have to be combined with the original bill if the stay spans a month.

However, the original bill would have to be adjusted to change the patient status code to 30 (still a patient).

Subsequent monthly bills for this admission would be billed as interim bills 112, 113, or 114.

Implementation

The implementation date for this instruction is January 3, 2005. Hospitals with claims that were rejected improperly because of the previous edits (i.e., claims where the readmission was for an unrelated condition) can resubmit those claims with condition code of B4.

Additional Information

The official instruction issued to your Medicare contractor regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3389 in the CR NUM column on the right, and click on the file for that CR.

Also, if you have any questions, please contact your FI at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3389
Related CR Release Date: July 30, 2004
Related CR Transmittal Number: 266
Effective Date: January 1, 2004
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 266, CR 3494

Guidelines for ADVATE rAHF-PFM on Medicare Claims

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals, providers, and independent (ESRD) facilities

Provider Action Needed

STOP – Impact to You

This is a one-time notification to ensure that providers, hospitals, and independent ESRD facilities are aware of the correct HCPCS code to use when billing for ADVATE.

CAUTION – What You Need to Know

ADVATE rAHF-PFM was approved by the Food and Drug Administration (FDA) on July 25, 2003; the payment limit that should be used for ADVATE is the same payment limit that is currently assigned to HCPCS code **J7192**. This payment limit will apply to all ADVATE claims submitted for services from January 1, 2004 through December 31, 2004. Also, effective for dates of services on or after July 25, 2003, claims submitted to Medicare fiscal intermediaries for ADVATE will be rejected if reported with any other code except J7192**.** Claims submitted to carriers for dates of service on or after July 25, 2003, without J7192 will be adjusted to reflect J7192 and carriers will append modifier "CC" to reflect adjustment.

GO – What You Need to Do

Make sure that your billing staff knows that HCPCS code J7192 must be used when billing for the drug ADVATE, effective for dates of services **on or after July 25, 2003.**

Background

Beginning January 1, 2004, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides that the payment limits for most drugs and biologicals not paid on a cost or prospective payment basis are based on 85 percent of the average wholesale price (AWP) reflected in the published compendia as of April 1, 2003, for those drugs and biologicals furnished on and after January 1, 2004.

However, one of the exceptions to this general rule is the payment limit for blood clotting factors. Specifically, the payment limits for blood clotting factors are 95 percent of the AWP reflected in the published compendia as of September 1, 2003.

ADVATE is a blood-clotting factor that was approved by the FDA on July 25, 2003 for the treatment of persons with hemophilia A. ADVATE should be reported using the existing HCPCS code J7192.

Implementation Date

This change was implemented in Medicare claim processing systems on September 27, 2004.

Additional Information

For the calendar year 2004, the ADVATE payment limit for providers and for independent ESRD facilities can be found in the 2004 MMA drug-pricing file that was issued in CR 3105. A *Medlearn Matters* article on this CR can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3105.pdf*.

The MMA drug payment limits pricing files for dates of service January 1, 2004 and after are available at: *http://cms.hhs.gov/providers/drugs/default.asp***.**

For the hospital outpatient prospective payment system (OPPS), the payment rate for ADVATE can be found in the latest quarterly update of the OPPS outpatient code editor that is posted on the CMS OPPS website. CMS hospital outpatient prospective payment system website can be found at: *http://www.cms.hhs.gov/providers/hopps/***.**

If you have any questions regarding this issue, please contact your intermediary or carrier at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp***.**

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3331
Related CR Release Date: August 27, 2004
Related CR Transmittal Number: 112
Effective Date: July 25, 2003
Implementation Date: September 27, 2004

Source: CMS Pub 100-20 Transmittal 112, CR 3331

Billing Instructions for ADVATE rAHF-PFM on Medicare Claims

Effective July 25, 2003, the Food and Drug Administration (FDA) approved the blood clotting factor ADVATE rAHF-PFM for the treatment of hemophilia A. CMS has established HCPCS code J7192 – factor VIII (antihemophilic factor, recombinant) per IU, for billing ADVATE rAHF-PFM to Medicare.

Action Required by Providers

Providers billing for ADVATE rAHF-PFM on type of bills 12x, 13x, 14x, 22x, 23x, 34x and 72x (for independent facilities only) must use HCPCS J7192. If other HCPCS codes (i.e., J3490, J3590, J7199) are used, the claim will be returned to the provider.

The revenue code for billing ADVATE rAHF-PFM is 0636.

Claims for ADVATE rAHF-PFM not billed with HCPCS code J7192 will be returned to the provider under reason code 75070.

These instructions are effective for claims processed **on or after September 27, 2004** for services furnished **on or after July 25, 2003.**

For additional information on billing for ADVATE rAHF-PFM, see the revised Medlearn Matters MM3331.

Source: CMS Pub 100-20 Transmittal 112, CR 3331

Extension of Interrupted Stay Policy Under Long Term Care Hospital PPS

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Long term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and swing beds and acute care hospitals, both inpatient and outpatient bills

Provider Action Needed

STOP – Impact to You

Effective July 1, 2004, Medicare will pay only one long-term care DRG (diagnosis related group) if one of your patients is discharged from your LTCH and then readmitted within three days (regardless of the discharge venue).

Note: **The only exception to this policy is a discharge to an acute care hospital for surgical DRGs.**

CAUTION – What You Need to Know

Effective July 1, 2004, in addition to the in-place LTCH prospective payment system (PPS) interrupted stay policy, there is a new three-day interrupted stay policy that pertains to your patients, regardless of their discharge venue *(see note above)*. This new policy requires that if a patient is readmitted to the LTCH within three days of discharge, Medicare will pay only one LTC DRG.

GO – What You Need to Do

Make sure that your billing staffs are aware of this new LTCH three-day interrupted stay policy.

Background

Medicare considers an "interrupted stay" to be part of the first LTCH admission (or, a single discharge from the LTCH). Further, Medicare will only make a **single** LTCH PPS payment for an interrupted patient stay.

For example, if the LTCH discharges the patient on July 1, 2004 and the patient is readmitted to the same LTCH on July 3, 2004, this is an interrupted stay and should be billed as one claim with an occurrence span code 74 from July 1, 2004, through July 2, 2004. The occurrence span code 74 cannot be used for days where other services were performed in another facility, however, because these should be performed the patient returns to the same LTCH within three days of being discharged.

Reminder: The occurrence span code 74 (located in field position 36 of the UB-92 or electronic equivalent) reflects the "span code from date" equal to the date of discharge from the LTCH and the "span code through" date equal to the last day the patient was not present at midnight.

Following is a short review of the general "interrupted stay" policy. An interruption of stay is defined as an LTCH stay during which a Medicare inpatient is discharged to an acute care hospital, an IRF, or an SNF/swing bed for treatment or services that are not available in the LTCH and returns to the same LTCH within applicable fixed-day periods.

- The day-counts of the applicable fixed-day period begin on the day of discharge from the LTCH (which is also the day of admission to the other site of care) and vary depending on the discharge venue. The applicable fixed-day period for discharge to an acute care hospital is 9 days, 27 days for discharge to an IRF, and 45 days for discharge to an SNF/swing bed.
- Remember that if the patient is readmitted to the LTCH within the fixed-day threshold, the return to the LTCH is considered part of the first admission, and Medicare will make only a single LTCH PPS payment.

So, the original interrupted stay policy is as follows:

- When a patient is discharged to an acute care hospital and is readmitted to the same LTCH within 4-9 days (occurrence span code 74 shows 8 days or less);
- When a patient is discharged to an IRF and is readmitted to the same LTCH within 4-27 days (occurrence span code 74 shows 26 days or less);
- When a patient is discharged to an SNF and is readmitted to the same LTCH within 4-45 days (occurrence span code 74 shows 44 days or less); and
- When a patient is discharged to a swing-bed and is readmitted to the same LTCH within 4-45 days (occurrence span code 74 shows 44 days or less).

Medicare will reject inpatient claims (non-surgical DRG acute care hospital, both IPPS and non-IPPS, IRF, SNF, and swing bed) for services during the three day interruption of the LTCH claim with dates of interruption on or after July 1, 2004.

Implementation

- If a patient's stay qualifies as an interrupted stay, the LTCH should adjust the claim generated by the original LTCH stay and submit one claim for the entire stay (LTCH plus the other site of care) with an occurrence span code 74 demonstrating the interrupted stay days; but
- If the stay does not qualify as an interrupted stay (because the time at another facility before being readmitted to the LTCH exceeds the total fixed-day threshold), you can receive two separate payments.

To summarize again, effective July 1, 2004, in addition to the original policies regarding interrupted stays, there is a special three-day interrupted stay policy that applies regardless of the patient's discharge venue.

This policy requires that if a patient is readmitted to the LTCH within three days of the discharge, Medicare will pay only one LTC DRG. Medicare will not pay separately for claims submitted by other providers (acute hospital, SNF/swing bed, IRF, or any outpatient bill) for the patient's care during this three-day interruption.

This policy will cover readmissions following an outpatient treatment; an inpatient stay at another provider; and a discharge and readmission with an intervening patient-stay at home. Further, payment for any nonsurgical test or procedure procured during the interruption at an outpatient setting or for treatment in an inpatient setting is the LTCH's responsibility and should be considered a service provided "under arrangements."

"Under arrangements" means that the LTCH will bill and be paid for those services performed in another setting

Extension of Interrupted Stay Policy Under Long Term Care Hospital PPS (continued)

and no separate payment will be made to another facility during the three days. The LTCH is responsible for paying the other providers.

There is an exception for surgical DRGs in an acute care hospital. Medicare will issue a separate payment to the acute hospital if the patient stay is grouped to a surgical DRG. A list of surgical DRGs, effective through September 30, 2004, is attached to the instruction issued to your Medicare contractor. That instruction, which is CR 3279 can be found at:
http://www.cms.hhs.gov/manuals/pm_trans/R240CP.pdf.

Also, when the interruption exceeds three days, LTCH payment is determined under the original interrupted stay policy (now referred to as a "greater than three-day interruption of stay"), but the day count for purposes of determining the length of stay away from the LTCH begins on the day that the patient was discharged from the LTCH.

Providers should make every effort to bill their claims correctly now, so that their claims are not rejected or cancelled next January when the editing for this is in place.

Additional Information

You can find more information about the extension of the LTCH interrupted stay policy by reviewing the official instruction issued to your intermediary, which can be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R240CP.pdf*.

Or you can contact your intermediary at their toll-free number, which may be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3279
Related CR Release Date: July 23, 2004
Related CR Transmittal Number: 240
Effective Date: July 1, 2004
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 240, CR 3279

Crossover Patients in New Long Term Care Hospitals (LTCH)

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

New long-term care facilities

Provider Action Needed

STOP – Impact to You

Previously, when a facility operating as an acute care hospital was converted to a LTCH, patients were discharged under the IPPS (acute care) provider number and readmitted under the LTCH provider number, although the patient never left the facility.

CAUTION – What You Need to Know

This new policy will pay one discharge payment to the discharging LTCH for patients that were admitted prior to the effective date of a hospital's transition to a LTCH.

Such patients are referred to as "crossover patients."

GO – What You Need to Do

You must bill the patient's entire stay under the new LTCH provider number. You must cancel any bills paid under the acute hospital provider number for patients that are still in your facility.

Background

When a hospital changes designation and provider number, the policy has been to discharge the patient under the "old" provider number and readmit the patient under the "new" provider number (Pub. 100-04, Chapter 3, section 100.4.1 and 150.14.1). This has resulted in two payments to a facility for the same patient.

When a hospital undergoes a change in ownership or a change in classification from an acute care hospital to an LTCH, payment issues arise for "crossover" patients who were admitted prior to the change in classification and who are still hospitalized under the new provider number. Since all LTCHs are required to be certified as acute hospitals and generally be paid under the IPPS for six months prior to designation as a LTCH, in 42 CFR 412.23(e), there are "crossover patients" who were admitted to the facility when it was an acute care hospital and are still patients when the conversion to the LTCH occurs. Medicare pays twice in those cases for what was really one episode of care since separate payments are made to both the acute hospital and the LTCH.

The Centers for Medicare & Medicaid Services (CMS) is establishing a consistent policy for such situations to avoid this situation. Therefore, Medicare will issue one discharge-based payment to the hospital that discharges the patient under the applicable payment system. The payment methodology used will consider all the days of the patient stay in the facility (both prior to and following the date of LTCH designation) to be a single episode of LTCH care.

Payment for this single episode of care will include the day and cost data for that patient at both the acute care hospital and the LTCH in determining the payment to the LTCH under the LTCH PPS. Further, the days of the patient's stay both prior to and following designation as a LTCH are counted in determining the patient's total length of stay at the LTCH, both for payment purposes as well as for the LTCH's average length of stay (ALOS) calculation under 42 CFR 412.23(e)(2) and (3).

This policy applies only to a patient stay in an acute care hospital that is designated as a LTCH on or after October 1, 2004.

Implementation

These instructions will be implemented on January 3, 2005.

Crossover Patients in New Long Term Care Hospitals (LTCH) (continued)

Additional Information

The revised section of the *Medicare Claims Processing Manual (Pub. 100-04, Chapter 3, section 100.4.1 and 150.14.1)* are attached to the instruction issued by CMS to your intermediary. That instruction may be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

Once at that page, scroll down the CR NUM column on the right to CR 391 and click on the file for that CR.

If you should have questions, contact your intermediary on their toll free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3391
Related CR Release Date: July 30, 2004
Related CR Transmittal Number: 267
Effective Date: October 1, 2004
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 267, CR 3391

Use of Transmission Date in the Service Date Field for Inpatient Rehabilitation Facility Prospective Payment System Claims

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Inpatient rehabilitation facilities

Provider Action Needed

This instruction is a notification that the Centers for Medicare & Medicaid Services (CMS) will now require that the date of the transmission of the IRF patient assessment lnstrument (PAI) be recorded in the "Service Date/Assessment Date" field of the UB-92 (Field Locator 45 of the revenue code 0024 line) or electronic equivalent (on the 837i, the field is located in 2400 ASSESSMENT DATE DTP). Should this transmission date be 28 or more calendar days from the discharge date of the claim, the 25 percent penalty will be applied to the payment rate associated with the case mix group for such claim. **Failure to supply a valid date will cause the claim to be returned unprocessed to the provider.**

Background

When the IRF PPS was implemented January 1, 2002, CMS did not require a "service" date on the revenue code 0024 line of the IRF PPS claim (Change Request (CR) 1921, Transmittal A-01-131, dated November 1, 2001).

At that time, CMS stated that this field was optional and a date could be entered if the IRF PAI record was submitted more than 28 calendar days after discharge. If so, a 25 percent penalty would be applied to the claim.

CMS will now require that the date of the transmission of the IRF PAI be recorded in the "Service Date" field of the UB-92 (Field Locator 45) or electronic equivalent (on the 837i, the field is located in 2400 ASSESSMENT DATE DTP). The requirement is effective for discharges on or after October 1, 2004.

Should this transmission date be 28 or more calendar days from the discharge date of the claim, the 25 percent penalty will be applied. The total payment amount field will then be reduced by the penalty amount so that the final total payment amount will be 75 percent of the payment rate associated with the case mix group for that claim.

Implementation

The implementation date for this instruction is January 3, 2005 and it will apply to discharges on or after October 1, 2004.

Related Instructions

The Medicare Claims Processing Manual (Pub 100-04), Chapter 3 (Inpatient Hospital Billing) Section 140 (Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)), Subsection 140.3.4 (Payment Adjustment for Late Transmission of Patient Assessment Data) is being revised. The updated manual instructions are included in the official instruction issued to your intermediary that can be found at the following CMS websites: *http://www.cms.hhs.gov/manuals/transmittals/com_date_dsc.asp*.

From that web page, look for CR 3433 in the CR NUM column on the right, and click on the file for that CR.

CR1921, Transmittal A-01-131, dated November 1, 2001, "Additional Instructions for Implementing the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)" can be reviewed at the following CMS web site*: http://cms.hhs.gov/manuals/pm_trans/A01131.pdf*.

Additional Information

If you have any questions, please contact your intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3433
Related CR Release Date: August 27, 2004
Related CR Transmittal Number: 291
Effective Date: Effective for discharges on or after October 1, 2004
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 291, CR 3433

Cryosurgery of the Prostate

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals and ambulatory surgery centers

Provider Action Needed

Affected providers should note that this instruction corrects the revenue code for cryosurgery of the prostate, which was reported previously in CR 1632 as ***034X***. The revenue code should be ***036X***. This instruction also incorporates changes to Chapter 18 (Preventive and Screening Services), including Section 51 (Cryosurgery of the Prostate Gland), into the Medicare Claims Processing Manual (Pub 100-04).

Background

This instruction corrects the revenue code: instead of ***034X***, the revenue code should be ***036X***. Medicare will pay for this cryosurgery on an inpatient or outpatient basis.

Implementation

The implementation date of this instruction is January 3, 2005.

Additional Information

The *Medicare Claims Processing Manual* (Pub 100-4), Chapter 18 (Preventive and Screening Services), Section 51 (Cryosurgery of the Prostate Gland) was revised and the revisions are attached to the official instruction issued to your fiscal intermediary regarding this change. That instruction, CR 3168, may be found by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R260CP.pdf*.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3168
Related CR Release Date: July 30, 2004
Related CR Transmittal Number: 260
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 260, CR 3168

Hospital Dialysis Due To Hurricanes

Hospitals providing intermittent dialysis as a result of the 2004 hurricanes in Florida can receive payment from Medicare under the outpatient prospective payment system (OPPS). CMS Program Memorandum A-02-129 (Change Request 2503) addresses this policy. In certain medical situations in which the end-stage renal disease (ESRD) patient cannot obtain regularly scheduled dialysis treatment at a certified ESRD facility, the 2003 OPPS rule 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 when it is emergency dialysis for ESRD patients who would otherwise have to be admitted as inpatients in order for the hospital to receive payment.

Medicare can pay claims under OPPS in situations where a hospital is providing intermittent dialysis for a patient who is displaced due to the hurricane or for a patient whose usual facility has been disabled due to the hurricane under this policy.

Should the need to use the hospital as emergency back up be extended to weeks rather than days, CMS may also consider certification of one or more sites as "Special Purpose Dialysis Facilities." This is a certification category, which allows certification of sites for emergency or disaster on a temporary basis. If as a hospital provider you believe you may meet this criterion, please contact Glenda Payne, RN at (214) 767-3350.

Non-ESRD certified hospitals should use the appropriate revenue code for the site of service when billing HCPCS G0257. Examples include but are not limited to the following:

Type of Bill	HCPCS	Revenue Code
13x	G0257	760 – Treatment/observation room
13x	G0257	821 – Hemodialysis
13x	G0257	450 – Emergency room

Also, the hospital performing non-routine dialysis should notify the ESRD provider that the patient received dialysis services in the hospital outpatient department. The hospital and dialysis facility should work together in providing adequate documentation. The ESRD facility will continue to be responsible for ensuring continuity of care.

Payment for Emergency Medical Treatment and Labor Act (EMTALA)–Mandated Screening and Stabilization Services

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals, including critical access hospitals (CAHs)

Provider Action Needed

While voluntary, it is to the provider's benefit to bill presenting symptoms or complaints in addition to the principal diagnosis. To ensure you are paid appropriately for your services, you may use form locator (FL) 76 of the UB-92 claim form to bill for the ICD-9-CM code that represents the patient's reason for the visit.

Although only one diagnosis code for the reason for the visit may be recorded in FL 76, at the provider's discretion additional diagnoses not inherent in the final diagnosis may be reported in FLs 68 through 75. Providers may use these fields when billing for items or services, including diagnostic tests, performed under EMTALA, and/or when billed with revenue codes 45x, 0516, or 0526 to ensure appropriate payment. We support hospitals' efforts to educate physicians on documentation to support correct coding, and contractors should assist hospitals in providing this education when requested.

This instruction is pursuant to Section 1867of the Social Security Act (EMTALA) for services provided on or after January 1, 2004.

Background

This instruction addresses implementation of provisions contained in the Medicare Modernization Act of 2003 (MMA) regarding payment for EMTALA-mandated screening and stabilization services.

The MMA (Section 944(a)) requires that determinations of whether items and services provided in emergency departments (EDs) are reasonable and necessary 1) be made on the basis of information available to the treating physician or practitioner at the time the item or service was ordered or furnished by the physician or practitioner, and 2) take into consideration the patient's presenting symptoms or complaint, and not only on the patient's principal diagnosis. The frequency with which a patient receives a service may not be considered.

To ensure that current local medical review policies (LMRPs)/local coverage determinations (LCDs) do not inappropriately deny ED claims, fiscal intermediaries (FIs) have been instructed as a result of the related change request to discontinue LMRP/LCD frequency edits for items or services, including diagnostic tests, performed under EMTALA, and/or when billed with revenue codes 45x, 0516, or 0526 to ensure appropriate payment.

While the frequency with which a patient receives a service before and after admission may not be considered, medical review can be targeted at potentially aberrant ED billing, but decisions must be based on the information available to the ED physician, including the patient's presenting conditions, as required by the MMA provision.

In the past some hospitals have been hesitant to submit the full array of diagnosis codes, believing they conflict with existing coverage policies. Consistent with the law, hospitals may now submit the codes related to the patient's presenting symptoms or complaints. For further discussion of when a claim would be considered fraudulent, see *http://www.cms.hhs.gov/manuals/108_pim/pim83c04.pdf*.

In summary, providers should be aware that Medicare FIs will, as of the implementation date of the related instruction:

- Consider the diagnoses in FLs 76 and 68-75 for payment decisions and may target medical review at ED billing, when data indicates there may be a problem
- Make decisions based on the information available to the ED physician or practitioner, including the patient's presenting conditions, when performing medical review
- Discontinue automated frequency edits resulting from LMRPs/LCDs with a 45x, 0516, or 0526 revenue code, or for items or services, including diagnostic tests, performed under EMTALA, to ensure that current LMRPs/LCDs do not inappropriately deny ED claims
- Reopen claims for ED services provided on or after January 1, 2004 that were denied prior to the issuance of this instruction if the provider so requests.

Implementation

The implementation date for this instruction is November 22, 2004.

Additional Information

Hospitals should be aware that the Medicare Program Integrity Manual (Pub 100-08), Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 5.1.1 (Prepayment Edits), is being revised. The updated manual instructions are attached to the official instruction released to your intermediary. You may view that instruction at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3437 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, contact your intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3437
Related CR Release Date: October 22, 2004
Related CR Transmittal Number: 84
Effective Date: November 22, 2004
Implementation Date: November 22, 2004

Source: CMS Pub 100-8 Transmittal 84, CR 3437

Waiver of Annual Deductible and Coinsurance for Ambulatory Surgery Centers and ASC/Hospital Outpatient Department Physician Services

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals outpatient departments billing for physician services, ASCs, and physicians.

Provider Action Needed

STOP – Impact to You

The Omnibus Budget Reconciliation Act (OBRA) of 1986 and OBRA 1987 rescinded the waiver of the Medicare Part B coinsurance and deductible requirements for ambulatory surgical centers (ASC) services and ASC/hospital outpatient department physician services.

CAUTION – What You Need to Know

Medicare is updating language in its manuals to ensure consistency with these legislative changes and this change.

GO – What You Need to Do

ASCs and hospital outpatient department billing staffs are reminded to be familiar with these policies.

Background

Effective April 1, 1988, section 4054 of OBRA 1987 (Public Law 100-203) imposed the Medicare Part B coinsurance and deductible requirements for physician services in connection with an ASC covered procedure that is performed in an ambulatory setting.

For any physician services furnished on or after April 1, 1988, in connection with an ASC covered procedure, performed in an ASC or in a hospital on an outpatient basis, Medicare pays 80 percent of the physician fee schedule amount. After the beneficiary deductible is met, the beneficiary is responsible for 20 percent of the Medicare physician fee schedule amount.

Section 9343(e) of OBRA 1986 (Public Law 99-509) imposed that for any procedure on the ASC list furnished in an ASC, Medicare pays 80 percent of the applicable ASC fee schedule amount for such services furnished to Medicare patients. After the beneficiary's deductible is met, the beneficiary is responsible for 20 percent of the applicable facility fee schedule amount for that facility service. This provision was made for services furnished on or after July 1, 1987.

Additional Information

If you have additional questions, please contact your contractor at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A customer service representatives is 1-877-602-8816.

Related Change Request (CR) Number: 3471
Related CR Release Date: October 22, 2004
Related CR Transmittal Number: 11
Effective Date: November 22, 2004
Implementation Date: November 22, 2004

Source: CMS Pub 100-1 Transmittal 11, CR 3471

CRITICAL ACCESS HOSPITAL SERVICES

Proposed Implementation of the Physician Scarcity Bonus and Revision to the Health Professional Shortage Area

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Special Note: The language contained in this Medlearn article reflects proposed billing and claims processing guidance consistent with the health care professional shortage area (HPSA) and physician scarcity area (PSA) requirements discussed in the notice of proposed rulemaking (NPRM) for the 2005 Medicare physician fee schedule, which was published on August 5, 2004. This language reflects CMS current implementation efforts and is subject to change consistent with publication of the final rule. Additional information will be posted when the final rule is published.

Provider Types Affected

Critical access hospitals (CAHs) located in a designated PSA/HPSA that have elected method II payment.

Provider Action Needed

STOP – Impact to You

Sections 413a and 413b of the Medicare Modernization Act of 2003 (MMA) requires payment of an additional five percent bonus for physician services furnished in a CAH that has elected method II payment and is located in a designated PSA.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) has issued an NPRM describing how CMS **may** implement this provision, but the requirements of the NPRM are subject to change depending on publication of the final rule for the 2005 Medicare physician fee schedule (MPFS).

GO – What You Need to Do

Refer to the remainder of this article for how this section of MMA may be implemented, subject to publication of the final rule for the 2005 MPFS.

Background

CMS has issued an NPRM describing how CMS **may** implement this provision, but the requirements of the NPRM are subject to change depending on publication of the final rule for the 2005 MPFS.

Physician Scarcity Area Provision

The MMA, section 413a, requires that an additional five percent bonus be paid to physicians in designated PSAs. This bonus is in addition to the amount of payment that would be made for services furnished by designated physicians.

Based on the amount actually paid (not the Medicare approved payment amount for each service) and on date of service, Medicare will pay a five percent physician scarcity bonus on a quarterly basis. A single service may be eligible for both the new physician scarcity bonus and the current HPSA bonus payment.

Payment will be based on the ZIP code of the location where the service was performed.

Also, please note that the physician scarcity bonus will be paid for only the primary care designations of general practice, family practice, internal medicine, and obstetrics/gynecology for services within the designated areas. The bonus will also be paid for services in those areas for all physician provider specialties except the following: oral surgery (dentist only), chiropractic, optometry, and podiatry.

One of the following modifier(s) must accompany the HCPCS code to indicate the type of physician:

- AG – Primary physician
- AF – Specialty physician

Also, if the CAH is aware that their area is now considered a PSA, but the area was designated as such after the designated PSA file was created, the CAH should include modifier AR. The CAH should also include modifier AK if the physician is a nonparticipating physician.

HPSA Provision

Section 413b of the MMA requires that for ZIP codes that fall fully into counties designated as HPSAs, the HPSA bonus payment will be automatically paid for services furnished in locations with those ZIP codes.

CMS will also automatically pay a bonus for those ZIP codes that are considered to fall fully in the county based on a determination of dominance made by the United States Postal Service (USPS), and for those ZIP codes that fall fully within partial county HPSAs. CAHs will no longer have to include modifier QB or QU on claims from these locations to receive the bonus payment for physician services.

For ZIP codes that do not fall within a full county HPSA or fully within a non-full county HPSA, the CAHs must continue to place HCPCS modifier QB or QU on the claim to receive the bonus. In addition, they will need to submit the modifier for new HPSA designations made by the Health Resources and Services Administration (HRSA) throughout the year and for any designated areas not included in the automated file of such designations because of the cutoff date of the data used to create that file.

In brief, the modifier is required only if the ZIP code of the location where the services are provided is not already on the list of ZIP codes that will automatically receive the payment. Designations can be identified by accessing the HPSA designations on the CMS website. The bonus will be effective for services furnished on or after the date of designation by HRSA.

CAHs are advised to investigate the census tract data on the U.S. Census Bureau website at: *http://www.census.gov* to see if they qualify for the HPSA bonus in the event the bonus cannot be paid automatically. Where the CAH has elected method II payment, the CAH

Proposed Implementation of the Physician Scarcity Bonus and Revision to the HPSA (continued)

will be requested to supply their fiscal intermediary with a list of physicians, by specialty, for all physicians who have reassigned payment to the CAH.

Intermediaries will continue to pay the bonus on the amount actually paid, not the Medicare-approved payment amount for each service, on a quarterly basis. A single service may be eligible for both the HPSA bonus payment and the new physician scarcity bonus. Payment will be based on the ZIP code of the location where the service was performed. In this case, it would be the location of the CAH or service location.

Psychiatrists who provide services in a CAH in a primary medical care HPSA are eligible to receive bonus payments. Psychiatrists rendering service in a CAH located in a mental health HPSA are also eligible to receive bonus payments. Please note that psychiatrists may receive either the primary medical care HPSA bonus or the mental health HPSA bonus for a service, but they cannot receive both bonuses for one service.

Effective Date

January 1, 2005 is the proposed effective date for this change.

Additional Information

Note that the physician scarcity bonus will be paid only for primary care designations of:

- General Practice – 01
- Family Practice – 08
- Internal Medicine – 11
- Obstetrics/Gynecology – 16.

In addition, the bonus will be paid for all physician provider specialties, **except for:**

- Oral Surgery (dentist only) – 19
- Chiropractic – 35
- Optometry – 41
- Podiatry – 48.

For further reading, CAH staff may wish to review Medlearn Matters article SE0449, which may be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0449.pdf*.

The article accessed at the above website is directed at physicians, but may be of interest to CAHs as they bill for services of physicians who have reassigned their benefits to the CAH. SE0449 contains extensive information on how to determine if an area is an HPSA/PSA. **As with this article, however, SE0449 states what may happen, but final guidance is dependent on publication of the final rule for the 2005 MPFS.**

If you have questions, contact your intermediary at their toll free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: N/A
Effective Date: January 1, 2005

Source: CMS Special Edition Medlearn Matters SE0453

Distinct Part Units of Critical Access Hospitals—Further Information Related To CR 3175

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Critical access hospitals (CAHs)

Provider Action Needed

STOP – Impact to You

CAHs were informed in CR 3175 that they could establish psychiatric and rehabilitation distinct part units.

CAUTION – What You Need to Know

This instruction addresses the new provider numbers and how payment should be made to psychiatric and rehabilitation distinct part units.

GO – What You Need to Do

Be sure to code claims correctly for services in these distinct part units, which are identified by the presence of an R (rehabilitation) or M (psychiatric) in position 3 of the provider number.

Background

The Medicare Modernization Act (MMA) of 2003, PL 108-173, Section 405(g), stated that CAHs may establish psychiatric and rehabilitation distinct part units effective for cost reporting periods beginning on or after October 1, 2004.

CR 3175 (Transmittal 144, dated April 23, 2004, Subject: Distinct Part Units for Critical Access Hospitals) informed CAHs that they could establish psychiatric and rehabilitation distinct part units. It also included the following requirements:

- CAHs may establish psychiatric and rehabilitation distinct part units, and the distinct part unit must meet the conditions of participation requirement for hospitals.
- The distinct part unit must also meet the requirements other than conditions of participation that would apply if the unit were established in an acute care hospital.
- Services provided in these distinct part units will be paid under the payment methodology that would apply if the unit were established in an acute care (non-CAH) hospital paid under the hospital inpatient prospective payment system.
- Inpatient rehabilitation facilities (IRFs) are paid under the inpatient rehabilitation facility PPS (see Pub 100-04, Chapter 3, Section 140 for billing requirements), and the inpatient psychiatric units are paid on a reasonable cost basis until a PPS is created (expected in 2005).

Distinct Part Units of Critical Access Hospitals—Further Information Related To CR 3175 (continued)

- Beds in these distinct part units are excluded from the 25 total bed count limit for CAHs, and the bed limitation for each distinct part unit is 10.
- If a distinct part unit does not meet applicable requirements with respect to a cost reporting period, no payment may be made to the CAH for services furnished in the unit during that period. Payment may resume only after the CAH has demonstrated that the unit meets applicable requirements.

This instruction addresses new provider numbers and how payment should be made to established psychiatric and rehabilitation distinct part units as follows:

- **IRFs** located in a CAH will be paid under the inpatient rehabilitation facility PPS (see Pub 100.4, Chapter 3, Section 140 for billing requirements) and will be **identified by provider number xx-Rxxx**.
- **Inpatient psychiatric units** located in a CAH will be paid on a reasonable cost basis until the inpatient psychiatric facility PPS is created (expected in 2005). These units are **identified by provider number xx-Mxxx**.

Payment for services provided in the distinct part units will be made according to the payment method that would apply if the unit was established in an acute care (non-CAH) hospital paid under the hospital inpatient PPS.

Note: This change in policy is driven by the MMA of 2003, PL 108-173, Section 405(g), and is effective for cost reporting periods beginning on or after October 1, 2004.

Implementation

Implementation date for this instruction is January 3, 2005.

Additional Information

CR 3175, Transmittal: 144, dated April 23, 2004, Subject: Distinct Part Units for Critical Access Hospitals can be reviewed at the following CMS website: *http://www.cms.hhs.gov/manuals/pm_trans/r144cp.pdf*.

Also, the Medlearn Matters article for CR 3175 may be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3175.pdf*.

For complete details, please see the official instruction issued to your fiscal intermediary regarding this change. That instruction may be viewed by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3399 in the CR NUM column on the right, and click on the file for that CR.

If you have questions, please contact your intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3399
Related CR Release Date: August 13, 2004
Related CR Transmittal Number: 276
Effective Date: October 1, 2004
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 276, CR 3399

October Update to the Medicare Outpatient Code Editor (Version 20.0) for Non-Outpatient Prospective Payment System Hospitals

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals that are not paid under the OPPS

Provider Action Needed

This change informs hospitals not paid under the OPPS of new additions, changes, and deletions to HCPCS codes, diagnosis codes, and procedure codes. Ensure that your billing staff is aware of these changes and bills accordingly.

Background

The October update of the OCE used for processing hospital claims not paid under the OPPS includes a number of code additions, deletions, and changes. These are summarized as follows:

- Over 170 new ICD-9-CM diagnosis codes have been added to the list of valid diagnosis codes, **effective October 1, 2004.**
- Twenty-five diagnosis codes have been deleted from the list of valid ICD-9-CM diagnosis codes, **effective October 1, 2004.**
- Over 150 diagnosis codes will have revised short descriptors effective on **October 1, 2004.**
- Hundred codes have been deleted from the list of adult diagnosis codes **effective on October 1, 2004.**
- Thirty-three new codes have been added to the list of codes allowed for females only as of **October 1, 2004.**

To view the specific diagnosis codes and their descriptors in the above categories, see the actual CR 3396, which may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R255CP.pdf*.

In addition to the extensive list changes mentioned above, the following changes are also noted:

- One code (V8403, Genetic susceptibility to malignant neoplasm of prostate) has been added to the list of diagnoses allowed for males only as of **October 1, 2004**.
- HCPCS code C9219 (Mycophenolic acid, oral) has been added to the valid code list **effective January 1, 2004.**

October Update to the Medicare Outpatient Code Editor (Version 20.0) for Non-OPPS Hospitals (continued)

- HCPCS code C9218 (Injection, azacitidine) has been added to the list of valid codes, **effective as of April 1, 2004.**
- HCPCS code G0336 (PET imaging brain Alzheimer's) has been added to the list of valid codes **effective as of July 1, 2004.**
- The following five HCPCS codes have been added to the list of valid codes **effective on October 1, 2004:**

  G0330 PET image initial dx cervical

  G0331 PET image restage ovarian ca

  G0341 Percutaneous islet cell trans

  G0342 Laparoscopy islet cell trans

  G0343 Laparotomy islet cell transp)
- Three codes (C9408, C9416, and C9434) have been deleted from the list of valid HCPCS, **effective January 1, 2004.**
- One new diagnosis code (7966, Nonspecific abnormal findings on neonatal screening) has been added to the list of maternity diagnoses, **effective October 1, 2004.**
- HCPCS code C9219 has been added to the list of nonreportable procedures, **effective January 1, 2004.**
- HCPCS code C9218 has been added to the list of nonreportable procedures, **effective April 1, 2004.**
- Two codes (Q4054 and Q4055) have been removed from the list of non-reportable procedures, **effective January 1, 2004.**

Implementation

Implementation date for this instruction is October 4, 2004.

Additional Information

For complete details, please see the official instruction issued to your fiscal intermediary, which includes additional details regarding the changes made to version 19.2 of the non-OPPS OCE including:

- New ICD-9-CM Diagnosis Codes
- Deleted ICD-9-CM Diagnosis Codes
- Revised ICD-9-CM Diagnosis Code Descriptions
- New HCPCS/CPT Procedure Codes
- Deleted HCPCS Procedure Codes
- Medicare Outpatient Code Edits
- Non-Reportable Procedures

This instruction may be viewed at: *http://www.cms.hhs.gov/manuals/pm_trans/R255CP.pdf*.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3396
Related CR Release Date: July 30, 2004
Related CR Transmittal Number: 255
Effective Date: Various dates as described in the CR
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 255, CR 3396

Addition of Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists as Emergency On-Call Providers

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Critical access hospitals (CAHs)

Provider Action Needed

Be aware of the changes, introduced by Section 405 of the Medicare Modernization Act of 2003 (MMA), that allow CAHs to include physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs) as CAH emergency room on-call providers, effective with dates of service on or after January 1, 2005.

Background

Section 405 of the MMA introduces the following changes for CAHs beginning with cost reporting periods that start on or after January 1, 2005:

- CAHs may include PAs, NPs and CNSs specialists as CAH emergency room on-call providers.
- CAHs may include amounts for reasonable compensation and related costs of these nonphysician practitioners who are on call, and payment will be made via the cost report settlement process.
- Nonphysician practitioners who are on call do not have to be present on the premises of the CAH involved.
- Nonphysicians practitioners who are on call cannot be furnishing physician services at another site while on call.
- Nonphysician practitioners who are on call cannot be on call at any other provider or facility while on call.

The Medicare Claims Processing Manual is being revised as a result of the Change Request (CR 3228), on which this article is based. Section 30.1.3 of Chapter 3 of that manual is revised, and CAHs should note that the revision requires that, for the costs associated with these nonphysician practitioners to be allowable, the costs must be incurred under a written contract that requires the on-call provider to come to the CAH when the provider's presence is medically required.

Additional Information

To view the entire instruction issued to your intermediary, go to:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

Addition of PAs, NPs, and CNSs as Emergency On-Call Providers (continued)

Once at that site, look for CR 3228 in the CR NUM column on the right and click on the file for that CR.

If you have any questions, please contact your Medicare fiscal intermediary at their toll free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3228
Related CR Release Date: August 27, 2004
Related CR Transmittal Number: 285
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 285, CR 3228

Ambulatory Surgical Center Payment Rates and Wage Index Values

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Ambulatory surgical centers

Provider Action Needed

This instruction advises that the **current** ambulatory surgical center (ACS) payment rates and wage index values **remain** in effect for fiscal year (FY) 2005.

Background

Section 626(a) of the Medicare Modernization Act (MMA) mandates a zero percent increase for inflation in FY 2005, the last quarter of calendar year 2005, and each calendar year from 2006 through 2009. The implementation of new wage index values for FY 2005 is deferred until CMS has had an opportunity to determine the impact of changes in the FY 2005 inpatient hospital wage index on payment amounts for individual ASCs. Therefore, **payments to ASCs for services furnished on or after October 1, 2004 will not change.**

Until further notice, carriers will continue to use the FY 2004 wage index to calculate payments to ASCs and the payment rates that were effective for services furnished on or after April 1, 2004.

The labor-related portion of ASC payment rates is defined currently as 34.45 percent of the payment rate.

Carriers are currently using the FY 2004 hospital inpatient wage index to calculate payments for ASC services.

Transmittal AB-03-116 (CR 2871), issued August 8, 2003, updated ASC facility payment rates for inflation and updated the wage index values used to adjust ASC payments for geographic wage differences effective for services furnished on or after October 1, 2003.

CR 2871 may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/AB03116.pdf*.

Transmittal 51 (CR 3082), issued February 4, 2004, notified contractors about a change in ASC payment rates effective April 1, 2004, resulting from enactment of section 626(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). CR 3082 may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R51OTN.pdf*.

Effective **for services furnished on or after October 1, 2004,** the ASC payment group rates will remain as follows:

Group 1 $333

Group 2 $446

Group 3 $510

Group 4 $630

Group 5 $717

Group 6 $826 [$676 + $150 for intraocular lenses (I0Ls)]

Group 7 $995

Group 8 $973 ($823 + $150 for IOLs)

Group 9 $1,339

Additional Information

The Centers for Medicare & Medicaid Services (CMS) website for ambulatory surgical center information can be found at: *http://www.cms.hhs.gov/suppliers/asc*.

The official instruction issued to your intermediary/carrier regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3394 in the CR NUM column on the right, and then click on the file for that CR.

If you have any questions regarding this issue, please contact your carrier/intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3394
Related CR Release Date: August 27, 2004
Related CR Transmittal Number: 288
Effective Date: October 1, 2004
Implementation Date: October 1, 2004

Source: CMS Pub 100-4 Transmittal 288, CR 3394

LOCAL COVERAGE DETERMINATIONS

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

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

Effective and Notice Dates

Effective dates are provided in each policy, and are based on the date services are furnished unless otherwise noted in the policy. Medicare contractors are required to offer a 45-day notice period for LMRPs/LCDs; the date the LMRP/LCD is posted to the provider education Web site is considered the notice date.

Electronic Notification

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

More Information

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

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

Local Coverage Determination Table of Contents

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

NEW LCD IMPLEMENTATION

A11000: Debridement Services—New Policy

Debridement is the removal of necrotic or damaged tissue, exudates, metabolic waste, or foreign material from a wound. Several methods of debridement are utilized to promote wound healing by exposing healthy tissue and allowing adequate epitheliazation and the formation of good granulation tissue. Methods of wound debridement include autolytic, chemical, mechanical, surgical, and biological.

According to Medicare statistical data obtained from January 1, 2003, to June 1, 2003, debridement services were determined to be aberrant in Florida; therefore, a local coverage determination (LCD) has been developed to define the indications and limitations of coverage.

The LCD defines coverage for the following *CPT* codes:

11000 *Debridement of extensive eczematous or infected skin; up to 10% of body surface*

11001 *Debridement of extensive eczematous or infected skin; each additional 10% of the body surface*

11040 *Debridement; skin, partial thickness*

11041 *Debridement; skin, full thickness*

11042 *Debridement; skin, and subcutaneous tissue*

11043 *Debridement; skin, subcutaneous tissue, and muscle)*

11044 *Debridement; skin, subcutaneous tissue, muscle, and bone*

97601 *Removal of devitalized tissue from wound(s); selective debridement, without anesthesia, including topical application(s), wound assessment, and instruction(s) for ongoing care, per session*

97602 *Removal of devitalized tissue from wound(s); non-selective debridement, without anesthesia, including topical application(s), wound assessment, and instruction(s) for ongoing care, per session)*

In addition, this LCD has identified a procedure to diagnosis relationship and documentation requirements with an LCD attachment that includes coding guidelines.

Effective Date

This policy is effective for services furnished **on or after January 1, 2005**. The full-text for this policy will be available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

AAPBI: Accelerated Partial Breast Irradiation—New Policy

Survival after breast-conservation therapy is equivalent to survival after mastectomy for patients diagnosed with tumors categorized as stage I or II. The standard of care for local management is breast-conserving surgery to excise the tumor with adequate margins (lumpectomy), followed by whole-breast external-beam radiation therapy (WB-EBRT).

Accelerated partial breast irradiation (APBI) differs from WB-EBRT in two ways. First, the radiation targets only a segment surrounding the tumor rather than the entire breast. Second, since the duration of treatment is four to five days rather than five to six weeks, radiation is delivered in fewer fractions at larger doses per fraction. APBI comprises several techniques, including interstitial brachytherapy via catheters, the MammoSite radiation treatment system, accelerated external beam radiotherapy, and intra-operative radiotherapy delivery.

When compared with whole breast irradiation, APBI offers the potential advantages of convenience and decreases radiation dose to healthy breast tissue. However, published studies are limited in patient size and follow-up period. Given access to care issues, a local coverage determination (LCD) has been developed to define the indications and limitations of coverage, establish a procedure to diagnosis relationship, and clarify the appropriate use of APBI after breast-conserving surgery for early stage breast cancer. In addition, a coding guideline has also been developed to assist in billing this type of service.

APBI after breast-conserving surgery is considered medically necessary for patients with early stage breast cancer when all of the following criteria are met:

- Diagnosis: Invasive carcinoma or ductal carcinoma in situ
- Size: Greater than or equal to 3 cm.
- Margin status: Negative – at least 2 mm in all directions
- Nodal status: Negative axillary lymph node dissection or sentinel lymph node evaluation

Effective Date

This policy is effective for services furnished **on or after January 1, 2005**. The full-text for this policy will be available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

ADDITIONS/REVISIONS TO LMRPs/LCDs

A90804: Individual Psychotherapy—Revision to Policy

The local medical review policy (LMRP) for individual psychotherapy became effective September 29, 2003. Change request 3194, transmittal 167, dated April 30, 2004 instructed providers to discontinue the use of revenue code 0910 (Psychiatric/Psychological Services-General Classification) effective October 1, 2004. Change request 3343, transmittal 98, dated July 23, 2004 changed the effective date of CR 3194 for claims with dates of service on or after October 16, 2003.

This LMRP revision is being made to delete revenue code 0910. Revenue code 0900 (Psychiatric/Psychological Treatments, general classification) will be used in place of revenue code 0910.

The policy has also been converted to the local coverage decision (LCD) format.

Effective Date

This revision is effective for services furnished **on or after October 16, 2003**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

A90847: Family Psychotherapy—Revision to Policy

The local medical review policy (LMRP) for family psychotherapy became effective July 22, 1999. Change request 3194, transmittal 167, dated April 30, 2004 instructed providers to discontinue the use of revenue code 0910 (Psychiatric/Psychological Services-General Classification) effective October 1, 2004. Change request 3343, transmittal 98, dated July 23, 2004 changed the effective date of CR 3194 for claims with dates of service on or after October 16, 2003.

This LMRP revision is being made to delete revenue code 0910. Revenue code 0900 (Psychiatric/Psychological Treatments, general classification) will be used in place of revenue code 0910.

The policy has also been converted to the local coverage decision (LCD) format.

Effective Date

This revision is effective for services furnished **on or after October 16, 2003**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

A90810: Interactive Individual Psychotherapy—Revision to Policy

The local medical review policy (LMRP) for interactive individual psychotherapy became effective September 29, 2003. Change request 3194, transmittal 167, dated April 30, 2004 instructed providers to discontinue the use of revenue code 0910 (Psychiatric/Psychological Services-General Classification) effective October 1, 2004. Change request 3343, transmittal 98, dated July 23, 2004 changed the effective date of CR 3194 for claims with dates of service on or after October 16, 2003.

This LMRP revision is being made to delete revenue code 0910. Revenue code 0900 (Psychiatric/Psychological Treatments, general classification) will be used in place of revenue code 0910.

The policy has also been converted to the local coverage decision (LCD) format.

Effective Date

This revision is effective for services furnished **on or after October 16, 2003**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

A90853: Group Psychotherapy—Revision to Policy

The local medical review policy (LMRP) for group psychotherapy became effective September 29, 2003. Change request 3194, transmittal 167, dated April 30, 2004 instructed providers to discontinue the use of revenue code 0910 (Psychiatric/Psychological Services-General Classification) effective October 1, 2004. Change request 3343, transmittal 98, dated July 23, 2004 changed the effective date of CR 3194 for claims with dates of service on or after October 16, 2003.

This LMRP revision is being made to delete revenue code 0910. Revenue code 0900 (Psychiatric/Psychological Treatments, general classification) will be used in place of revenue code 0910.

The policy has also been converted to the local coverage decision (LCD) format.

Effective Date

This revision is effective for services furnished **on or after October 16, 2003**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

A90857: Interactive Group Psychotherapy—Revision to Policy

The local medical review policy (LMRP) for interactive group psychotherapy became effective September 29, 2003. Change request 3194, transmittal 167, dated April 30, 2004 instructed providers to discontinue the use of revenue code 0910 (Psychiatric/Psychological Services-General Classification) effective October 1, 2004. Change request 3343, transmittal 98, dated July 23, 2004 changed the effective date of CR 3194 for claims with dates of service on or after October 16, 2003.

This LMRP revision is being made to delete revenue code 0910. Revenue code 0900 (Psychiatric/Psychological Treatments, general classification) will be used in place of revenue code 0910.

The policy has also been converted to the local coverage decision (LCD) format.

Effective Date

This revision is effective for services furnished **on or after October 16, 2003**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

A90901: Biofeedback—Revision to Policy

The local medical review policy (LMRP) for biofeedback became effective January 5, 2004. Change request 3194, transmittal 167, dated April 30, 2004 instructed providers to discontinue the use of revenue code 0910 (Psychiatric/Psychological Services-General Classification) effective October 1, 2004. Change request 3343, transmittal 98, dated July 23, 2004 changed the effective date of CR 3194 for claims with dates of service on or after October 16, 2003.

This LMRP revision is being made to delete revenue code 0910. Revenue code 0900 (Psychiatric/Psychological Treatments, general classification) will be used in place of revenue code 0910.

The policy has also been converted to the local coverage decision (LCD) format.

Effective Date

This revision is effective for services furnished **on or after October 16, 2003**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

A90901: Biofeedback—Revision to Policy

The local medical review policy for biofeedback was previously revised on October 1, 2004, for the 2005 ICD-9-CM diagnosis code annual update. Since that time, additional ICD-9-CM codes 344.00-344.09 (quadriplegia and quadriparesis), 728.85 (spasm of muscle), and 728.87 (muscle weakness) were added to biofeedback training by any modality (*90901*). Revenue codes 0420, 0430, 0440 were changed to 042x, 043x, and 044x, respectively.

In addition, this policy has been converted to the local coverage determination (LCD) format.

Effective Date

This revision is effective for services furnished **on or after December 6, 2004**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

A92135: Scanning Computerized Ophthalmic Diagnostic Imaging—Revision to Policy

The latest revision to the local medical review policy for scanning computerized ophthalmic diagnostic imaging was effective April 21, 2003. Scanning computerized ophthalmic diagnostic imaging allows for early detection of glaucomatous damage to the nerve fiber layer or optic nerve of the eye. It is the goal of these diagnostic imaging tests to discriminate among patients with normal intraocular pressures (IOP) who have glaucoma, patients with elevated IOP who have glaucoma, and patients with elevated IOP who do not have glaucoma. These tests can also provide more precise methods of observation of the optic nerve head and can more accurately reveal subtle glaucomatous changes over the course of follow-up exams than visual field and/or disc photos. This can allow earlier and more efficient efforts of treatment toward the disease process.

Retinal disorders are the most common causes of severe and permanent vision loss. Scanning computerized ophthalmic diagnostic imaging is also used for the evaluation and treatment of patients with retinal disease, especially certain macular abnormalities. It details the microscopic anatomy of the retina and the vitreo-retinal interface.

Many forms of scanning computerized ophthalmic diagnostic imaging tests currently exist, e.g., confocal laser scanning ophthalmoscopy (topography), scanning laser polarimetry, optical coherence tomography (OCT), and retinal thickness analysis. Although these techniques are different, their objective is the same.

The following sections of this policy have been revised:

- Indications and Limitations of Coverage and/or Medical Necessity
- Type of Bill Code
- Documentation Requirements
- ICD-9 Codes that Support Medical Necessity

The following ICD-9-CM codes have been removed from the policy:

364.73 364.74 364.77 377.9

This policy has also been converted into the local coverage determination (LCD) format.

Effective Date

These revisions are effective for services furnished **on or after January 1, 2005.** The full-text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* on or after this effective date.

A93303: Transthoracic and Doppler Echocardiography and Doppler Color Flow Velocity Mapping—Revision to Policy

The local medical review policy for transthoracic and Doppler echocardiography and Doppler color flow velocity mapping was last revised effective October 1, 2003. Since that time, a major revision to the policy has been made. The original policy has been replaced with this new revision.

The policy was revised to update the indications and limitations based on the current American College of Cardiology/ American Heart Association (2003) Guideline Update for the Clinical Application of Echocardiography.

In addition, the policy title has been changed to Transthoracic Echocardiography (TTE).

The policy has also been converted to the local coverage decision (LCD) format.

Effective Date

This revision is effective for services furnished **on or after January 1, 2005**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

A97003: Occupational Therapy Policy for Rehabilitation Services—Addition to Policy

The local medical review policy for occupational therapy policy for rehabilitation services was last revised effective March 28, 2002. Since that time, coverage guidelines have been added to the policy for electrical stimulation for the treatment of wounds, per program memoranda AB-02-161 and AB-03-093. These changes are effective for services performed **on or after April 1, 2003.**

In addition, language changes were made to the policy to reflect clarifications per CMS Change Request 2859 and 2779. These changes clarify the time period when a physician must evaluate the patient and corrects omission of nonphysician practitioners. These changes are effective for services performed **on or after February 11, 2004.**

Additionally, revenue codes and type of bill codes have been updated.

The policy has also been converted to the local coverage decision (LCD) format.

The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com*.

AEPO: Epoetin alfa—Revision to Policy

The local coverage determination (LCD) for epoetin alfa (EPO) was last revised June 1, 2004. Since then, the coding guidelines for EPO were updated as a result of CMS Transmittal 197, Change Request 3184. Coverage for EPO has been expanded to allow end stage renal disease (ESRD) patients who come to the hospital for a medical emergency and require treatment for their dialysis related anemia to be treated with EPO. Hospitals can bill for EPO at the time of the medical emergency visit, before the patient can be treated during his/her regularly scheduled dialysis appointment. The fiscal intermediary will only make payment for EPO to the hospital when revenue code 045x is billed with any one *CPT* code *99281* through *99285* on the same claim.

Effective Date

This revision is effective for services furnished **on or after January 1, 2004**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

AG0166: External Counterpulsation —Revision to Policy

The local medical review policy for external counterpulsation was last revised effective August 1, 2000. Since that time, the policy has been revised to clarify indications and limitations of service and documentation requirements for subsequent treatments. In addition, this policy has been converted to the local coverage decision (LCD) format.

Effective Date

This revision is effective for services furnished **on or after January 1, 2005**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

AJ0640: Leucovorin (Wellcovorin®)—Revision to Policy

The local coverage determination for leucovorin (Wellcovorin®) was last revised September 23, 2003. Since then, the following revision has been made to this policy. Under the off-labeled indications section of this policy for gastric and esophageal carcinoma, fluorouracil can be used in combination with leucovorin. A revision was made to also allow floxuridine to be used in combination with leucovorin for these indications. This revision is based on the antineoplastic drugs policy (J9000) that allows floxuridine (J9200) to be used in combination with cisplatinum, taxol, and leucovorin.

Effective Date

This addition is effective for services furnished **on or after September 29, 2003**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

AJ2792: Rho (D) Immune Globulin Intravenous—Revision to Policy

The local medical review policy for Rho (D) immune globulin intravenous became effective on July 17, 2000. Recent data identified extraordinary utilization of HCPCS code J2792 (Rho D immune globulin intravenous, human, solvent detergent, 100 IU) among Florida providers.

This policy revision is being made to clarify indications and limitations when administering Rho (D) for its FDA approved indications. Medicare will consider Rho (D) immune globulin intravenous medically necessary for the following Food and Drug Administration (FDA) approved indications:

- The suppression of Rh isoimmunization
- The treatment of immune thrombocytopenic purpura (ITP) for non-splenectomized Rho (D) positive individuals in clinical situations requiring an increase in platelet count to prevent excessive hemorrhage.

This policy revision includes the addition of two HCPCS codes:

J2788 Injection, Rho d immune globulin, human, minidose, 50 mcg
J2790 Iinjection, Rho d immune globulin, human, full dose, 300 mcg

Guidelines for initial and subsequent dosing are defined.

In addition,the policy has also been converted to the local coverage decision (LCD) format.

Effective Date

This revision is effective for services furnished **on or after January 1, 2005**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

AJ2430 Pamidronate (Aredia®, APD)—Revision to Policy

The local medical review policy for pamidronate (Aredia®, APD) was last updated on January 23, 2003. A review of this policy revealed an inconsistency between the FDA approved indications and dual diagnosis requirements. The current policy only required a dual diagnosis for osteolytic lesions related to breast cancer. The policy is being revised to require a dual diagnosis for osteolytic lesions related to myeloma as well. In addition, the dual diagnosis language has been revised to more accurately reflect the FDA approved indications.

The policy has also been converted to the local coverage decision (LCD) format.

Effective Date

This revision is effective for services furnished **on or after January 1, 2005**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

AMAHD/ER: Metabolically Active Human Dermal/Epidermal Replacements—Revision to Policy

The local medical review policy for metabolically active human dermal/epidermal replacements (MAHD/ER) was effective March 24, 2003. This policy has been revised to include indications and limitations for Xenograft and Allograft. In addition, the name of this policy has been changed to SKINSUB: Skin Substitutes.

This policy has been converted to a local coverage determination (LCD) format and includes coding guidelines for services associated with graft site preparation and the application of grafts.

Effective Date

This revision is effective for services furnished **on or after January 1, 2005**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

ANESP: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])—Revision to Policy

The local coverage determination (LCD) for Aranesp® was last revised June 3, 2004. Since then, the coding guidelines for darbepoetin alfa (Aranesp®) were updated as a result of CMS Transmittal 197, Change Request 3184. Coverage for Aranesp has been expanded to allow end stage renal disease (ESRD) patients who come to the hospital for a medical emergency and require treatment for their dialysis related anemia to be treated with Aranesp. Hospitals can bill for Aranesp at the time of the medical emergency visit, before the patient can be treated during his/her regularly scheduled dialysis appointment. The fiscal intermediary will only make payment for Aranesp to the hospital when revenue code 045x is billed with any one HCPCS code 99281 through 99285 on the same claim.

This revision is effective for services furnished **on or after January 1, 2004.**

In addition, under HCPCS code Q0137, coding guidelines were changed to state patients with CRF not on a regular course of dialysis, need bill type 13x with charges under revenue code 0636, with HCPCS code Q0137, without value codes 48, 49, and 68. Payment will be made under the outpatient prospective payment system (OPPS).

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

The full-text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* on or after these effective dates.

APHPPROG: Psychiatric Partial Hospitalization Program—Revision to Policy

The local medical review policy (LMRP) for psychiatric partial hospitalization program was last revised January 1, 2004. Change request 3194, transmittal 167, dated April 30, 2004 instructed providers to discontinue the use of revenue code 0910 (Psychiatric/Psychological Services-General Classification) effective October 1, 2004. Change request 3343, transmittal 98, dated July 23, 2004 changed the effective date of CR 3194 for claims with dates of service on or after October 16, 2003.

This LMRP revision is being made to delete revenue code 0910. Revenue code 0900 (Psychiatric/Psychological Treatments, general classification) will be used in place of revenue code 0910.

The policy has also been converted to the local coverage decision (LCD) format.

Effective Date

This revision is effective for services furnished **on or after October 16, 2003**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

APULMDIAGSVCS: Pulmonary Diagnostic Services—Revision to Policy

The new local coverage determination (LCD) for pulmonary diagnostic services was effective on July 6, 2004. Since that time, it was determined that type of bill 75x – comprehensive outpatient rehabilitation facility (CORF) was inadvertently added to this LCD as an allowable type of bill. Per CORF guidelines, pulmonary diagnostic services would not be billed by a CORF; therefore, this type of bill has been removed from the LCD.

Effective Date

This revision is effective for services furnished **on or after July 6, 2004**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

AVISCO Viscosupplementation Therapy For Knee—Revision to Policy

The local medical review policy for viscosupplementation therapy for knee was last updated on August 29, 2003. This policy has been revised to incorporate and define the indications and limitations of coverage and/or medical necessity, to clarify the appropriate ICD-9-CM codes to use when billing Orthovisc® (J3590) and to provide access to care. Orthovisc® is a sterile, non-pyrogenic, clear, viscoelastic solution of hyaluronan which was approved by the FDA on 02/04/2004 for the treatment of osteoarthritis of the knee joints in patients who have failed to respond, or who have had inadequate responses to other treatment.

In addition, this policy has been converted to a local coverage determination (LCD) format and includes coding guidelines to assist with coding issues when billing these services.

Effective Date

This revision is effective for services furnished **on or after January 1, 2005**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

CORRECTION TO PUBLISHED ARTICLES

A93701: Cardiac Output Monitoring by Thoracic Electrical Bioimpedance—Correction to Previously Published Article

An article revising the local coverage determination for cardiac output monitoring by thoracic electrical bioimpedance was published in the Fourth Quarter 2004 *Medicare A Bulletin* (page 48) to include additional diagnoses that support the indications and limitations of coverage and/or medical necessity for this service. However, ICD-9-CM code 996.03 was published incorrectly. The correct ICD-9-CM code is **996.83.** Florida Medicare apologizes for any inconvenience this may have caused.

The revised full-text for this LCD is available on the provider education website *http://www.floridamedicare.com*.

AJ9000: Antineoplastic Drugs—Correction to Previously Published Article

An article revising the local coverage determination for antineoplastic drugs was published in the Fourth Quarter 2004 *Medicare A Bulletin* (page 50). The revision to the policy included updating multiple drug codes with the addition of ICD-9-CM codes based on the Compendia-Based Drug Bulletin and/or the Antineoplastic Drugs Workgroup. ICD-9-CM code 158.9 (Peritoneum, unspecified) was added to Doxorubicin HCI (J9000) but was inadvertently left out of the article. Also, the article indicated that ICD-9-CM codes 154.2 and 154.3 were added to Mitomycin (J9280, J9290, and J9291), however, these diagnosis codes were already included in the policy for this drug.

The revised full-text for this LCD will be available on the provider education website *http://www.floridamedicare.com*.

RETIREMENT OF EXISTING LMRPs/LCDs

Multiple Policies Being Retired

The following local medical review policies were retired effective for services furnished on or after September 30, 2004. The decision to retire these policies was based on data analysis and standards of local practice, or the existence of national coverage determinations (NCDs).

Policy Number	Policy Name
A51784	Anal or Urethral Sphincter Electromyography
A59840	Elective Abortion (Coverage is addressed in the Medicare National Coverage Determination Manual.)
A61885	Vagus Nerve Stimulation (Coverage is addressed in the Medicare National Coverage Determination Manual.)
A78267	Breath Test For Helicobacter Pylori (H. PYLORI)
A82435	Chloride
A82607	Vitamin B-12 (Cyanocobalamin) Assay
A82746	Folic Acid
A84155	Serum Protein
A85044	Reticulocyte Count
A86003	Allergen Specific IGE
A86235	Extractable Nuclear Antigen
A86353	Lymphocyte Transformation
A86430	Rheumatoid Factor
A86592	Syphilis Testing
A86812	Histocompatibility Testing
A87621	Human Papillomavirus DNA Assay, Amplified Probe Technique
A88142	Pap Smears
A88230	Cytogenetic Studies
A88348	Electron Microscopy; Diagnostic
A93930	Duplex Scan of Upper Extremity Arteries or Arterial By-Pass Grafts
A94642	Aerosolized Pentamidine Isethionate
AG0102	Prostate Cancer Screening
ARSFNFR	Medicare A Coverage of Routine Services For Nursing Facility Residents

A95805: Sleep Testing—Retirement of Policy

The latest revision for local medical review policy for sleep testing was effective January 15, 2004. Based on data analysis and standards of local practice, it has been determined that this policy should be retired.

Effective Date

The retirement of this policy is effective for services furnished **on or after September 30, 2004**.

ADDITIONAL INFORMATION ON LCDs

Self-Administered Drugs and Biologicals—Addition to Established List

The Center for Medicare & Medicaid Services (CMS) issued instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. Guidelines provide contractors a process for determining if an injectable drug is *usually self-administered* and therefore, not covered by Medicare. Providers may read the instructions in its entirety in Change Request 2200 and CR 2311.

Contractors are also required to establish a self-administered drug (SAD) list on their website, listing drugs that have been evaluated and determined to be usually self-administered.

The following drug has been added to the Florida Medicare Part A SAD list:

J3490 Enfuvirtide (Fuzeon™)

The evaluation of drugs for addition to the SAD list is an on-going process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs. The Florida Medicare Part A SAD list is located at *http://www.floridamedicare.com*.

Effective Date

This addition is effective for services furnished **on or after November 26, 2004**.

2005 ICD-9-CM Changes

The 2005 update to the ICD-9-CM diagnosis coding structure is effective October 1, 2004. Providers are required to use the 2005-updated ICD-9-CM coding effective for all hospital discharges and outpatient services occurring **on or after October 1, 2004.**

Due to the direct relationship between coding and reimbursement, it is particularly important that providers reimbursed under the outpatient prospective payment system (OPPS) used the appropriate ICD-9-CM coding. Other providers that code diagnoses and procedures (non-OPPS providers) are also affected. In addition, the new diagnosis coding is used in hospital outpatient billing.

Florida Medicare has revised the LMRPs/LCDs, for procedure codes with specific diagnosis criteria that are affected by the 2005 ICD-9-CM update. The following table lists the LMRPs/LCDs affected and the specific conditions revised as a result of the 2005 ICD-9-CM update:

LMRP/LCD Title	2005 Changes
A43235 – Diagnostic and Therapeutic Esophagogastroduodenoscopy	Change descriptor for 307.51 (Bulimia nervosa) and 307.53 (Rumination disorder) for procedure codes 43235, 43236, 43237, 43238, 43239, 43241, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255, and 43258.
A70450 – Computed Tomography Scans	Change descriptor for 290.0-290.9 (Dementias), 293.0 (Delirium due to conditions classified elsewhere), 293.81 (Psychotic disorder with delusions in conditions classified elsewhere), 293.82 (Psychotic disorder with hallucinations in conditions classified elsewhere), 293.83 (Mood disorder in conditions classified elsewhere), 294.0-294.9 (Persistent mental disorders due to conditions classified elsewhere), and 310.0-310.9 (Specific nonpsychotic mental disorders due to brain damage) for proce-dure codes 70450, 70460, and 70470.
A70551 – Magnetic Resonance Imaging of the Brain	Change descriptor for 310.0-310.9 (Specific nonpsychotic mental disorders due to brain damage) for procedure codes 70551, 70552, and 70553.
A76070 – Bone Mineral Density Studies	Change 252.0 to 252.00-252.08 (Hyperparathyroidism) for procedure codes G0130, 76070, 76071, 76075, 76076, 76078, 76977, and 78350.
A82108 – Aluminum	Change descriptor for 294.8 (Other persistent mental disorders due to conditions classified elsewhere) for procedure code 82108.
A82310 – Total Calcium	Change 252.0 to 252.00-252.08 (Hyperparathyroidism) for procedure code 82310. Change descriptor for 293.0 (Delirium due to conditions classified elsewhere) for procedure code 82310.
A82330 – Ionized Calcium	Change 252.0 to 252.00-252.08 (Hyperparathyroidism) and 588.8 to 588.81-588.89 (Other specified disorders resulting from impaired renal function) for procedure code 82330.
A83735 – Magnesium	Change 252.0 to 252.00-252.08 (Hyperparathyroidism) and 588.8 to 588.81-588.89 (Other specified disorders resulting from impaired renal function) for procedure code 83735. Change descriptor for 293.0 (Delirium due to conditions classified elsewhere) and 307.51 (Bulimia nervosa) for procedure code 83735.
A83970 – Parathormone (Parathyroid Hormone)	Change 252.0 to 252.00-252.08 (Hyperparathyroidism) and 588.8 to 588.81-588.89 (Other specified disorders resulting from impaired renal function) for procedure code 83970.
A84100 – Serum Phosphorus	Change 252.0 to 252.00-252.08 (Hyperparathyroidism) for procedure code 84100. Change descriptor for 293.0 (Delirium due to conditions classified elsewhere) for procedure code 84100.
A86706 – Hepatitis B Surface Antibody and Surface Antigen	Change V01.7 to V01.71-V01.79 (Other viral diseases) for procedure codes 86706 and 87340.
A90901 – Biofeedback	Add 788.38 (Overflow incontinence) for procedure code 90911.
A93965 – Non-Invasive Evaluation of Extremity Veins	Add 453.40-453.42 (Venous embolism and thrombosis of deep vessels of lower extremity) for procedure codes 93965, 93970, and 93971.

2005 ICD-9-CM Local Medical Review Policy/Local Coverage Determination Changes (continued)

LMRP/LCD Title	2005 Changes
A95115 – Allergen Immunotherapy	Add 477.2 (Allergic rhinitis due to animal (cat) (dog) hair and dander) for procedure codes 95115, 95117, and 95165.
A95250 – Continuous Glucose Monitoring System (CGMS)	Change descriptor for 250.02, 250.12, 250.22, 250.42, 250.52, 250.62, 250.72, and 250.82. ([non-insulin dependent type] [NIDDM type] [adult-onset type] **was taken out of the descriptor**) for procedure code 95250.
ABOTULINUM TOXINS – (Botulinum Toxins)	Change descriptor for 780.8 (Generalized hyperhidrosis) for procedure code J0585.
AG0245 – Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes	Change descriptor for 250.60 and 250.62 ([non-insulin dependent type] [NIDDM type] [adult-onset type] **was taken out of the descriptor**) and 250.61 ([non-insulin dependent type] [IDDM] **was taken out of the descriptor**) for procedure codes G0245, G0246, and G0247.
AJ0636 – Vitamin D Analogs in Chronic Renal Disease	Change 588.8 to 588.81-588.89 (Other specified disorders resulting from impaired renal function) for procedure codes J0636, J1270, and J2501.
AJ7190 – Hemophilia Clotting Factors	Change descriptor for 286.5 (Hemorrhagic disorder due to intrinsic circulating anticoagulants) for procedure codes J7190, J7191, J7192, J7193, J7194, J7195, J7198, Q0187, Q2022, and J7199.
AJ9212 – Interferon	Change descriptor for 070.41 (Acute hepatitis C with hepatic coma) and 070.51 (Acute hepatitis C without mention of hepatic coma) for procedure codes J9213 and J9214.

WIDESPREAD MEDICAL REVIEW PROBES

Inpatient Psychiatric Hospital Services—Widespread Probe Review Results

Overview

A widespread probe was performed on inpatient psychiatric hospital services based on comprehensive data analysis, which showed that several providers exceeded the national average for length of stay and to gain medical review experience with this provider type. Another purpose of this probe was to determine if the services were reasonable and necessary for the patient's condition, and determine if it was reasonable and necessary to furnish these services on an inpatient basis. The widespread probe consisted of 100 claims from 46 providers for the time period from July 1, 2003, to December 31, 2003.

Summary

The summary of findings is as follows:

- Out of 100 claims reviewed, 89 claims required inpatient psychiatric services and the documentation supported the need for inpatient psychiatric hospital services.
- Eleven out of 100 claims reviewed were denied, as follows:
  - Six of the claims were denied as the documentation did not include a certification for inpatient psychiatric services and/or an active treatment plan addressing a psychiatric condition.
  - Four of the claims were denied as no documentation was received to support that the services were performed.
  - One of the claims was denied as the documentation did not support the medical necessity for inpatient psychiatric services.

Based on these widespread probe findings, a local coverage determination (LCD) will be developed to further define the indications and limitations of coverage and/or medical necessity. In addition, the LCD will clarify guidelines and documentation requirements, including the certification and re-certification for inpatient psychiatric services; as well as, guidelines for an individualized treatment plan. Payments made for services deemed not medically necessary will be recovered.

CPT Codes 72100, 72170, 73030, and 73510—Widespread Probe Review Results

Overview

A widespread probe review was performed on the following procedure codes:

- *Radiologic examination, spine, lumbosacral; two or three views* (*CPT* code *72100*) – Revenue code: 0320
- *Radiologic examination, pelvis; one or two views* (*CPT* code *72170*) – Revenue code 0320
- *Radiologic examination, shoulder; complete, minimum of two views* (*CPT* code *73030*) – Revenue code 0320
- *Radiologic examination, hip, complete, minimum of two views* (*CPT* code *73510*) – Revenue code 0320

CPT codes *72100, 72170, 73030* and *73510* were chosen for a comprehensive data analysis for fiscal year 2004 based on July 1, 2002, to December 31, 2002, Medicare Part A data. Based on the conclusions of the findings and the continued growth rate of the number of services being performed, a recommendation was made to perform a widespread probe. Therefore, a widespread probe of 100 services from 20 providers for the time period from October 1, 2003, through May 31, 2004, was performed. The purpose of the review was to determine if the services billed to Medicare were documented as having been performed, appropriately coded, and determine the medical conditions for which the services were being performed. *The Physicians' Current Procedural Terminology (CPT 2001)*, American Medical Association, and American College of Radiology ACR Appropriateness Criteria were used in reviewing the services.

Summary

The summary of findings is as follows:

- Of the 100 claims reviewed, 25 of the services billed were for *CPT* code *72100* (*radiologic examination, spine, lumbosacral; two or three views*), 25 of the services billed were for *CPT* code *72170* (*radiologic examination, pelvis; one or two views*), 25 of the services billed were for CPT code *73030* (*radiologic examination, shoulder; complete, minimum of two views*), and 25 of the services billed were for *CPT* code *73510* (*radiologic examination, hip, complete, minimum of two views*).
- Eighty-nine services were documented as having been performed. The services were reasonable and necessary for the patients' conditions and documentation supported the need for these services. Therefore, these services were allowed as billed.
- Eleven services were denied. Six of these services were denied as the documentation submitted indicated that the services were not performed as billed. Four of these services were denied, as the medical records submitted did not support the need for the services as medical necessity/signs and symptoms were not noted in the documentation. One of these services was denied, as the documentation submitted did not include results of the X-ray to support that the service was performed as billed.
- Indications documented for *CPT* code *72100* (*radiologic examination, spine, lumbosacral; two or three views*) included: lower back pain, lower back pain after fall, lower back pain after surgery, radiculopathy and correlation with CT scan in relation to metastatic disease.
- Indications documented for *CPT* code *72170* (*radiologic examination, pelvis; one or two views*) included: pain after fall, follow-up examination status-post right total-hip arthroplasty, and correlation with CT Scan in relation to fracture status.
- Indications documented for *CPT* code *73030* (*radiologic examination, shoulder; complete, minimum of two views*) included: pain after fall, shoulder pain, and shoulder fracture.
- Indications documented for *CPT* code *73510* (*radiologic examination, hip, complete, minimum of two views*) included: hip pain, hip pain after fall, hip instability, and correlation with CT scan in relation to metastatic disease.

Education has been provided via widespread probe education letters to the providers that failed to sufficiently document services.

Inpatient Rehabilitation Facility—Widespread Probe Review Results

Overview

A widespread probe was performed on inpatient rehabilitation facilities to gain medical review experience, and knowledge relative to CMS coverage criteria for this provider type, determine if the services billed to Medicare were documented as having been performed, reasonable and necessary for the patient's condition, and reasonable and necessary to furnish the care on an inpatient setting rather than in a less intensive setting. The widespread probe consisted of 108 claims from 27 providers for the time period from June 1, 2003, to November 30, 2003.

Summary

The summary of findings is as follows:

- All 108 claims reviewed were for patients who required rehabilitation therapy to restore strength, increase range of motion (ROM), or upgrade the ability to function.
- All services billed to Medicare were documented as having been performed.
- Fifty-eight of the 108 claims reviewed required the patients to receive intensive rehabilitation therapy with a multidisciplinary coordinated team approach to upgrade their ability to function. These claims were allowed as billed.
- Fifty of the 108 claims reviewed indicated that the rehabilitation therapy could have been provided in a less intensive rehabilitation setting. These claims were denied as billed. This represents a 46 percent denial rate.
    - Twenty-seven of the 50 claims denied were for beneficiaries who had either a single joint replacement (total knee or total hip) or a laminectomy/fusion performed with the post-op courses being documented as essentially uneventful, and they had no other significant illnesses or comorbidities documented that required a hospital level of care. They only required rehabilitation to restore strength, ROM, or remobilization.
    - Eleven of the 50 claims denied were for beneficiaries with fractured hips with an open reduction internal fixation (ORIF) done. They had uneventful post-operative courses documented and were absent of other complicating medical problems. The patients required rehabilitation to restore strength and remobilization. (The Medicare Benefit Integrity Manual Chapter 110.3.2 – Specific Examples states "Absent other complicating medical problems, the type of rehabilitation program normally required by a patient with a fractured hip during or after the non-weight-bearing period or a patient with a healed ankle fracture does not require an inpatient hospital stay for rehabilitation care.")
    - Six of the 50 claims denied were for beneficiaries with a hip fracture who had a pinning (x1) performed, patella fracture with ORIF (x1), wrist fracture with surgical intervention done (x2) and non-displaced pelvic fracture (x2). Hospital stay and or post-op courses were essentially uneventful and they had no other significant illnesses or comorbidities documented that required a hospital level of care. They only required rehabilitation for either strengthening, increased ROM or remobilization.
    - Six of the 50 claims denied were for beneficiaries with medical conditions that caused deconditioning or debility during the hospital stay and the patients required rehabilitation for strength and ROM.

Based on these widespread probe findings, a local coverage determination (LCD) will be developed to further define the indications and limitations of coverage and/or medical necessity that would qualify an individual to receive rehabilitation therapy in an inpatient rehabilitation facility. Payments made for services deemed not medically necessary will be recovered.

ESRD SERVICES

Reimbursement for Automated Multi-Channel Chemistry Tests

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, suppliers, and ESRD facilities.

Provider Action Needed

Affected providers should note that this instruction begins the implementation of procedures to enforce compliance with the 50/50 payment policy for end stage renal disease (ESRD)-related laboratory services. The Centers for Medicare & Medicaid Services (CMS) is staggering the programming for this payment policy over multiple releases. Independent labs are not to revise their billing procedures at this time. CMS will release additional provider education in the future to educate providers regarding the effective date of revised billing procedures. Medicare carriers will have front-end edits to reject any line items containing modifiers CD, CE, or CF, as referenced in this article, until further notice.

Background

Medicare's composite rate payment to an ESRD facility or monthly capitation payment (MCP) to a physician includes reimbursement for certain routine clinical laboratory tests furnished to an ESRD beneficiary.

- Separate payment for AMCC tests (for an ESRD beneficiary) **is** permitted when **more** than 50 percent of all Medicare-covered AMCC tests furnished on a particular date of service are tests that are not included in the composite payment rate paid to the ESRD facility or capitation payment made to the MCP physician. In this event, all of the AMCC tests (composite payment rate tests and non-composite payment rate tests) furnished on that date are separately payable.
- Separate payment for AMCC tests (for an ESRD beneficiary) **is not** permitted if **less** than 50 percent of all Medicare-covered AMCC tests furnished on a particular date of service are tests that are not included in the composite payment rate paid to the ESRD facility or capitation payment made to the MCP physician. In this event, no AMCC test (including non-composite payment rate tests) furnished on that date is separately payable.

In other words, if 50 percent or more of the covered tests are included under composite payment rate tests, then all submitted claims are included within the composite payment. In this case, no separate payment in addition to the composite payment rate is made for any of the separately billable tests. However, if more than 50 percent of the covered tests are non-composite payment rate tests, then all AMCC tests submitted for that date of service are separately payable.

Defining Non-Composite Payment Rate Tests

A non-composite payment rate test is defined as any test separately reimbursable outside of the composite payment rate or beyond the normal frequency covered under the composite payment rate that is reasonable and necessary. Also, all chemistries ordered for beneficiaries with chronic dialysis for ESRD must be billed individually and must be rejected when billed as a panel.

The physician who orders the tests is responsible for identifying the appropriate modifier when ordering the test(s), and three pricing modifiers discreetly identify the different payment situations for ESRD AMCC services as follows:

- **CD –** AMCC test that has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable.
- **CE –** AMCC test that has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity.
- **CF –** AMCC that is not part of the composite rate and is a separately billable test that has been ordered by an ESRD facility or MCP physician.

In addition, the ESRD clinical laboratory test identified with modifiers "CD", "CE," or "CF" may not be billed as organ or disease panels. Upon the effective date of this requirement, all ESRD clinical laboratory tests must be billed individually.

Carrier Standard System Calculation

The Medicare carrier's standard system will calculate the number of AMCC services provided for any given date of service. For a date of service, it should add all AMCC tests that have a CD modifier and divide by the sum of all line items with a CD, CE or CF modifier for the same beneficiary and billing supplier/provider for any given date of service.

- If the result of the calculation for a date of service is 50 percent or greater, the carrier will not pay for the test.
- If the result of the calculation for a date of service is less than 50 percent, the carrier will pay for the entire test.

The carrier will adjust a previous claim when the incoming claim for a date of service is compared to a claim on history and the action is to pay a previously denied claim. The Medicare carrier will spread the payment amount over each line item on both claims (the claim on history and the incoming claim).

ESRD Facilities

ESRD facilities must specify for each test, when ordering an ESRD-related AMCC tests, whether the test is:

- Part of the composite rate and not separately payable;
- A composite rate test but is, on the date of the order, beyond the frequency covered under the composite rate and thus separately payable; or

Reimbursement for Automated Multi-Channel Chemistry Tests (continued)

- Not part of the ESRD composite rate and thus separately payable.

Laboratories

Laboratories must identify the following:

- Tests not included within the ESRD facility composite rate payment.
- Tests ordered for chronic dialysis for ESRD as follows:
  - Modifier CD: AMCC test that is part of the composite rate and is not separately billable and has been ordered by an ESRD facility or MCP physician.
  - Modifier CE: AMCC test that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity and has been ordered by an ESRD facility or MCP physician.
  - Modifier CF: AMCC test that is not part of the composite rate and is separately billable and has been ordered by an ESRD facility or MCP physician.
- Bill all tests ordered for a chronic dialysis ESRD beneficiary individually and not as a panel.

The laboratory tests subject to this rule are those tests included within AMCC tests and then only when furnished to an ESRD beneficiary, based upon an order by:

- A doctor rendering care in the dialysis facility; or
- An MCP physician for the diagnosis and treatment of the beneficiary's ESRD.

Implementation

The implementation date is January 3, 2005. The partial implementation on October 4, 2004, includes the calculation of payments at the lowest rate for these automated tests, application of the 50/50 rule, comparing claims to prior claims in history for the same date of service, and the rejection of any line items with modifiers CD, CE, and CF.

Related Instructions

The Medicare Claims Processing Manual, Chapter 16 (Laboratory Services from Independent Labs, Physicians, and Providers), Section 40 (Billing for Clinical Laboratory Tests), Subsection 6.1 (Billing for End Stage Renal Disease (ESRD) Related Laboratory Tests) was revised and can be found in Transmittal 79 of Pub 100-04, the original release of CR2813. This original CR may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R79CP.pdf*.

The official instruction issued to your contractor on these changes may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R198CP.pdf*.

This transmittal, which is Transmittal 198, also has some helpful examples of billing these tests as well as tables to show which tests are part of the composite rate and which are not.

If you have any questions regarding these changes, please contact your contractor at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 2813
Related CR Release Date: April 30, 2004
Related CR Transmittal Number: 198
Effective Date: October 4, 2004
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 198, CR 2813
CMS Pub 100-4 Transmittal 322, CR 3501

Clarification of Epoetin Alfa Billing Procedures and Codes in ESRD

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, suppliers, and renal dialysis facilities (RDFs) caring for patients with end stage renal disease (ESRD)

Provider Action Needed

Physicians, suppliers, and RDFs should note that this special edition provides an overview of the differences between Medicare's billing procedures and codes for end stage renal disease (ESRD) usage of EPO/DPA.

Background

Epoetin Alfa (EPO) Billing Procedures and Codes

The Centers for Medicare & Medicaid Services (CMS) has assigned a new Healthcare Common Procedure Coding System (HCPCS) code (Q4055) for epoetin alfa (EPO). HCPCS code Q4055 is provided for ESRD EPO usage only. Also, CMS has deleted all the current "Q" codes (Q9920 through Q9940) established for ESRD patients on EPO.

All other rules still apply for billing EPO for ESRD related anemia.

Intermediaries pay for EPO to ESRD facilities as a separately billable drug to the composite rate. No additional payment is made to administer EPO, whether in a facility or a home. Medicare beneficiaries dialyzing from home may choose between two methods of payment.

EPO payment is in addition to the composite rate and the following billing procedures are to be used for EPO administered in your facility. Identify EPO and the number of injections by:

- Revenue code 634: EPO administration of less than 10,000 units
- Revenue code 635: EPO administration of equal to or more than 10,000 units.

The following value codes should be used for reporting hemoglobin and hematocrit readings:

- Hemoglobin (Hgb) reading: value code 48
- Hematocrit (Hct) reading: value code 49.

In addition, use value code **68** for reporting the number of EPO units administered during the billing period.

Remember to include HCPCS code Q4055 on the claim.

Summarizing for EPO

For dates of service on and after January 1, 2004, claims include the following:

Bill Type	=	721 (Clinic ESRD First Service to Last Service) or other bill type as applicable
Revenue code	=	634 or 635 (according to units administered)
HCPCS codes	=	Q4055 (Required)
Units	=	Number of administrations (not to exceed 13 for a 30-day month or 14 for a 31-day month)
Value codes	=	48 (hemoglobin reading) or 49 (hematocrit reading)
Value code	=	68 (number of units of EPO administered)

Reimbursement remains the same at $10.00 per 1,000 units. (Reference: CMS Pub. 100-4, Chapter 8, Section 60.4)

Example 1: The following numbers of EPO units were administered during the billing period 2/1/04 – 2/28/04:

Date	EPO Units	Date	EPO Units
2/1	3000	2/15	2500
2/4	3000	2/18	2500
2/6	3000	2/10	2560
2/8	3000	2/22	2500
2/11	2500	2/25	2000
2/13	2500	2/27	2000

Total: 31,060 units

For value code 68, enter 31,060.

Your intermediary uses 31,100 to determine the rate payable. This is 31,060 rounded to the nearest 100 units. The rate payable is $311.00 (31.1 × $10).

Hgb = 10.2
Revenue code: 634 – 12
Value code: 68 – 31,060
HCPCS: Q4055
VC 48: 10.2

Example 2: The following number of EPO units was administered during the billing period 5/1/04 – 5/30/04:

Date	EPO Units	Date	EPO Units
5/10	20,000	5/24	9,500
5/12	9,000	5/26	10,000
5/14	11,000	5/28	10,000
5/19	8,000	5/30	10,000
5/22	15,000		

Total: 102,500 units

HCPCS code: Q4055
Revenue Code: 634, 3 (number of administration dates)
HCPCS code: Q4055
Revenue Code: 635, 6 (number of administration dates)
Value Code: 68, 102,500
Value Code: 49, 30.9 (Hct)
(See ESRD Manual Section 60.)

If an electronic submitter has additional documentation, which Medicare may require, they can indicate "DOCUMENTATION AVAILABLE UPON REQUEST" in the narrative (NTE02) segment. If the additional documentation you have is needed for Medicare to make its payment determination, a development letter will be sent requesting the information.

If the NTE02 segment does not indicate the availability of the additional documentation or the information is not returned in a timely manner, the claim will be returned as unprocessable.

Related Instructions

Change Request (CR) 2963, Transmittal 39, January 6, 2004 can be found at the following CMS website: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

CR 3037; Transmittal 36, December 24, 2003 can be found at the following CMS website: *http://cms.hhs.gov/manuals/pm_trans/R36OTN.pdf*.

CR 2984, Transmittal 118, March 5, 2004 can be found at the following CMS website: *http://www.cms.hhs.gov/manuals/transmittals/cr_num_asc.asp*.

Additional Information

The Medicare Renal Dialysis Facility Manual, Chapter II, Coverage of Services can be found at the following CMS website: *http://www.cms.hhs.gov/manuals/29_rdf/rd200.asp?#_1_17*.

Also, you can find the Medicare Benefit Policy Manual Chapter 11, regarding billing and payment details for EPO and DPA at the following CMS website: *http://www.cms.gov/manuals/102_policy/bp102c11.pdf*.

Lastly, see the Medicare Claims Process Manual, Pub. 100-04, Chapter 8, Section 60.4 at the following CMS website: *http://www.cms/manuals/104_claims/clm104c08.pdf*.

Related Change Request (CR) Number: N/A
Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Matters SE0406

Changes for Medicare Part B Drugs for End Stage Renal Disease Independent Dialysis Facilities

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Providers caring for ESRD patients and billing Medicare fiscal intermediaries (FIs) for drugs under Part B.

Provider Action Needed

STOP – Impact to You

Beginning on January 01, 2005, Medicare's Fiscal Intermediary Standard System (FISS) will carry at least two payment limits for ESRD-related HCPCS drug codes billed by differing types of facilities.

CAUTION – What You Need to Know

FIs will select the appropriate payment limits for HCPCS codes, based on type of facility. The ESRD price will apply only to independent dialysis facilities' claims and the non-ESRD price to all other providers' claims where payment is not based on cost or a PPS.

GO – What You Need to Do

When billing for PART B drugs for ESRD patients make sure that the correct TOB (type of bill) is used.

Background

Section 303 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides that the payment limits for ESRD-related drugs billed by differing types of facilities vary depending on the site of service.

For calendar year 2005, the payment limits for Medicare Part B drugs will be updated on a quarterly basis.

Therefore, Medicare shared systems (FISS) will have at least two payment limits, one for independent ESRD facilities and another for other facilities, for HCPCS drug codes, effective for dates of service on or after January 1, 2005.

Independent dialysis facilities should use **TOB 72x** for separately billable drugs to ESRD beneficiaries.

When Medicare receives a TOB 72x claim, it will pay based on the ESRD rate when the claim shows it is from an independent dialysis facility based on a provider number within the range of 2500-2899 (nonhospital renal facilities, or within the range of 2900-2999 (independent special purpose renal dialysis facilities).

Implementation

This change will be implemented by Medicare on January 3, 2005.

Additional Information

The Centers for Medicare & Medicaid Services' (CMS) website furnishes **current** drug-related information to Medicare providers, physicians and other suppliers at: *http://cms.hhs.gov/providers/drugs/asp.asp*.

These files will be updated effective January 1, 2005.

If you have any questions about this issue, please contact your FI at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3332
Related CR Release Date: July 30, 2004
Related CR Transmittal Number: 257
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 257, CR 3332

Line Item Dates of Service—October 1, 2004 Implementation

A Medlearn Matters article clarifying the Medicare need for specific line item dates of service (LIDOS) for each revenue code was published in the Fourth Quarter 2004 *Medicare A Bulletin* (page 78). Since then, the Centers for Medicare & Medicaid (CMS) has issued the following billing guidelines to assist providers submitting claims on a monthly basis.

Change request 3337, (issued under transmittal 199 to modify the Medicare Claim Processing Section of the Internet-Only Manual) states outpatient claims that do not contain a LIDOS for every revenue code line will be rejected by the fiscal intermediaries (FIs). This requirement is not really appropriate for dialysis, hospice, or home health claims for supplies. Dialysis and hospice claims are submitted on a monthly basis, and supplies used during a 60 day home health benefit period (under the prospective payment system, types of bills 32x and 33x) are far too numerous to enumerate individually. The LIDOS requirement is too cumbersome for these types of claims.

The policy for these three types of providers is to place any date between the "from" and the "through" date, inclusive of those dates (statement cover period), on the claim at the line level.

This is a workaround that these affected providers may use to avoid having claims rejected by their FIs. FIs will accept these workarounds for TOBs 72x, 81x, 82x, 32x, and 33x.

In response to inquiries, CMS has informed various dialysis, home health and hospice providers that it is acceptable to continue rolling up the services onto a single, dated line, as long as that line has a date that falls within the statement dates of the claim. Some providers have asked whether this meant that breaking out claims by individual dates of service was not allowed. CMS position on this issue is that either practice is allowable.

Source: CMS JSM 406, September 7, 2004

Payment Limits for J1000 (Depo-estradiol cypionate inj)—Drug Pricing Update

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, providers, and independent end stage renal disease (ESRD) facilities

Provider Action Needed

Providers should be aware that payment limits for Healthcare Common Procedure Coding System (HCPCS) drug code J1000 (Depo-estradiol cypionate inj) are changing for services furnished on or after January 1, 2004, and on or before December 31, 2004.

Background

This article advises providers that Medicare fiscal intermediaries (FIs) and carriers will update the payment limits for HCPCS drug code J1000 (Depo-estradiol cypionate inj) effective with dates of service on or after January 1, 2004, and on or before December 31, 2004.

From January 1, 2004 through December 31, 2004, the Medicare payment limits apply for the specific HCPCS drug codes listed below that are not paid on a cost or prospective payment basis. The payment limit listed for J1000 supersedes the payment limit published in Change Request (CR) 3105, dated January 30, 2004.

Note: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug.

	HCPCS	AWP %	2004 Payment Limit
Other than ESRD Drugs Separately Billed by Independent ESRD Facilities	J1000	85	$ 2.33
ESRD Drugs Separately Billed by Independent ESRD Facilities	J1000	95	$ 2.60

FIs and carriers will not search and adjust claims that have already been processed unless brought to their attention.

Implementation

The implementation date for this instruction is September 27, 2004.

Related Instructions

CR 105, Transmittal 75, dated January 30, 2004, can be found at the following Centers for Medicare & Medicaid Services (CMS) website: *http://www.cms.hhs.gov/manuals/pm_trans/R75CP.pdf*.

Additional Information

The official instruction issued to your carrier/intermediary regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that web page, look for CR 3418 in the CR NUM column on the right, and then click on the file for that CR.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3418
Related CR Release Date: August 27, 2004
Related CR Transmittal Number: 110
Effective Date: January 1, 2004
Implementation Date: September 27, 2004

Source: CMS Pub 100-20 Transmittal 110, CR 3418

SKILLED NURSING FACILITY SERVICES

Nursing Facility Visits (Codes 99301 – 99313)

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, non-physician practitioners (NPPs), skilled nursing facilities (SNFs).

Provider Action Needed

This article conveys revised payment policy so that NPPs may provide other covered, medically necessary visits prior to and after the initial visit by the physician in an SNF. This instruction states that Medicare policy requires a face-to-face visit with the resident for the SNF/nursing facility (NF) discharge day management service. The instruction also clarifies that a split/shared evaluation and management visit may not be reported in the SNF or NF setting.

Background

Section 483.40 (c)(4) at Title 42 of the Code of Federal Regulations (CFR) did not define what the law meant by "initial" physician visit and therefore left the meaning open to interpretation, which impacted access to medically necessary care by other providers.

Therefore, the Centers for Medicare & Medicaid Services (CMS) has increasingly been asked to clarify "initial" visit and to allow NPPs to provide medically necessary visits when needed prior to the initial visit by the physician.

To ensure that all residents of nursing facilities have appropriate access to medical care, CMS has defined "initial visit" (comprehensive assessment) according to Survey and Certification memorandum (S&C-04-08) released on November 13, 2003 to state survey agencies and Medicare Part A and B contractors. Prior to release of that memorandum, NPP visits could not be paid prior to the initial visit by the physician in an SNF per 42 CFR 483.40 (c)(4) and (e) and in an NF per requirements at 42 CFR 483.40(f).

The Medicare Claims Processing Manual is now being revised per the Survey and Certification memorandum (S&C-04-08, dated November 13, 2003) so that NPPs may provide other covered, medically necessary visits prior to and after the initial visit by the physician. This instruction states that Medicare policy requires a face-to-face visit with the resident for the SNF/NF discharge day management service.

The revision also states that a split/shared evaluation and management visit may not be reported in the SNF/NF setting.

This definition will now permit medically necessary visits to be provided by NPPs prior to and after the "initial (comprehensive assessment) by the physician. Medicare contractors are being instructed to implement this payment policy revision as soon as possible.

CMS reminds providers of the following:

- Payment requirements for NPPs may differ from federal survey and certification requirements.
- Medicare will pay only a physician for the initial/comprehensive evaluation and management visit in a SNF or NF.
- The Medicare carrier will pay the physician who reports the initial visit (comprehensive assessment) using one of the SNF/NF CPT codes in the 99301-99303 range, and generally 99303 is used for this purpose.
- Medicare will pay the NPP for covered, medically necessary evaluation and management visits prior to and after the initial/comprehensive visit reported by the physician and also for other required visits to comply with federal regulations at the option of the physician in the SNF setting and at the option of the state in the NF setting. Such visits should be reported with the appropriate CPT code in the 99301-99302 and 99311-99313 range.
- Medicare will pay for annual NF assessments (other than the initial comprehensive assessment performed and reported by the physician), readmissions to the facility, or a major change in status in the resident when such services are submitted by the physician/NPP using CPT code of 99301 or 99302.
- Payment for services rendered by nurse practitioners (NP) and clinical nurse specialists (CNS) employed at an NF may be reassigned to the NF by the NP or CNS. In such cases, the NF should bill the appropriate Medicare carrier for the professional service using the UPIN of the NP or CNS.
- When a NF employs a physician assistant (PA), the NF will always bill the Medicare carrier for the professional service using the PA's UPIN.
- Medicare will pay for the SNF/NF discharge day management day service when it is performed face-to face by the physician or NPP with the patient and is reported for the actual day of service. CPT codes 99315 and 99316 are used for this service.
- A split/shared service is not applicable in the SNF/NF setting.

Implementation

Medicare will implement these instructions on October 25, 2004.

Related Instructions

Survey and Certification memorandum (S&C-04-08), dated November 13, 2003, titled *Physician Delegation of Tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs,)* can be found at: *http://www.cms.hhs.gov/medicaid/survey-cert/sc0408.pdf*.

Nursing Facility Visits (Codes 99301 – 99313) (continued)

Additional Information

The Medicare Claims Processing Manual (Pub 100-4), Chapter 12 (Physician/Nonphysician Practitioners), Section 30 (Correct Coding Policy), Subsection 6.13 (Nursing Facility Visits – Codes 99301-99313) is being revised. The updated manual instructions are included in the official instruction issued to your contractor, and can be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3096 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3096
Related CR Release Date: September 24, 2004
Related CR Transmittal Number: 302
Effective Date: November 13, 2003
Implementation Date: October 25, 2004

Source: CMS Pub 100-4 Transmittal 302, CR 3096

Editing of Hospital and Skilled Nursing Facility Part B Inpatient Services

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals and skilled nursing facilities (SNFs).

Provider Action Needed

STOP – Impact to You

You can bill only the services noted in the bulleted text below as Part B inpatient services. Any bills that you submit for the revenue codes listed in the table below, under type of bills (TOB) 12x and 22x will be denied.

CAUTION – What You Need to Know

Medicare is requiring your fiscal intermediaries (FIs) to install an edit to assure payment is made on TOBs 12x and 22x only for those Part B inpatient services defined below. Payment for the revenue codes listed in the table will be prevented.

GO – What You Need to Do

Make sure that your billing staffs are aware that only the inpatient services noted in the text below can be billed under TOB 12x and 22x.

Background

Medicare will pay, under Part B, for certain physician and for certain non-physician medical and other health services that a participating hospital or SNF furnishes to their inpatients. This is done when these patients are not eligible or entitled to, or have exhausted, their Part A benefits.

However, CMS has identified that some FIs are paying for services under the TOBs 12x and 22x that do not meet the definition of these inpatient Part B services. Therefore, this CR requires the standard Medicare systems to include an edit to assure payment is made on TOBs 12x and 22x only for those services defined in the bulleted text below. These edits will prevent payment for the revenue codes listed in the table.

Payable services under inpatient Part B are:

- Diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians
- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations
- Prosthetic devices (other than dental), which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition
- Outpatient physical therapy, outpatient speech pathology services, and outpatient occupational therapy. (See Publication 100-02, Medicare Benefit Policy Manual, chapter 15, "Covered Medical and Other Health Services," section 220, which may be found at: *http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp*.)
- Screening mammography services
- Screening pap smears
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines
- Colorectal screening
- Bone mass measurements
- Diabetes self-management
- Prostate screening
- Ambulance services
- Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision
- Immunosuppressive drugs
- Oral anti-cancer drugs
- Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen
- Epoetin alfa (EPO).

Editing of Hospital and Skilled Nursing Facility Part B Inpatient Services (continued)

The following revenue codes will not be reimbursed under Part B inpatient services.

010x	022x	0269	045x	0546	0633	079x	096x
011x	023x	0270	0472	0547	0634	093x	097x
012x	024x	0273	0479	0548	0635	0940	098x
013x	0250	0277	049x	0549	0637	0941	099x
014x	0251	0279	050x	055x	064x	0943	100x
015x	0252	029x	051x	057x	065x	0944	210x
016x	0253	0339	052x	058x	066x	0945	310x
017x	0256	036x	053x	059x	067x	0946	
018x	0257	0370	0541	060x	068x	0947	
019x	0258	0374	0542	0630	072x	0948	
020x	0259	0379	0543	0631	0762	0949	
021x	0261	041x	0544	0632	078x	095x	

Should your intermediary deny a claim for services billed with one of the above revenue codes, your remittance advice will contain a reason code M28 to reflect that denial.

Additional Information

You can find more information about hospital and SNF Part B inpatient services at: *http://www.cms.hhs.gov/manuals/transmittals.comm_date_dsc.asp***.**

From that web page, look for CR 3366 in the CR NUM column on the right, and click on the file for that CR.

You might also want to look at the revised pages of the Medicare Claims Processing Manual, Chapter 4, sections 240/240.1 (Editing Hospital Part B Inpatient Services) and Chapter 7 sections 10/10.1/10.11 (Editing of Skilled Nursing Facilities Part B Inpatient Services). Those revised pages are attached to CR 3366.

Please note that the Centers for Medicare & Medicaid Services will be releasing another CR on this particular issue in the near future. As necessary, we will either update this article or issue another article as soon as that CR is issued.

If you have any questions, please contact your intermediary at their toll-free number at: *http://www.cms.hhs.gov/medlearn/tollnums.asp***.**

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3366
Related CR Release Date: September 17, 2004
Related CR Transmittal Number: 301
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-20 Transmittal 110, CR 3418

Additional Clarification on Bill Types 22x and 23x with Instruction for Involuntarily Moving a Beneficiary Out of the SNF and Ending a Benefit Period

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Skilled nursing facilities (SNFs)

Provider Action Needed

SNFs should note that this article provides clarification of the difference between bill types 22x, for SNF residents, and 23x, for nonresidents. It also provides instruction on when you can and cannot move a beneficiary involuntarily.

Note: This clarification replaces CR 2674. Instructions related to CR 2674 were published in the Fourth Quarter 2003 Medicare A Bulletin (page 49).

Background

Using the Correct Type of Bill

Section 313 of the Benefits Improvement and Protection Act of 2000, P.L 106-554 revised the "resident" definition to include only individuals who are actually placed in the Medicare-certified part of the SNF. For those residents, bill type 22x should be used. Individuals who are placed in the Medicare noncertified area of the institution will no longer be considered "residents," and bill type 23x should be used for those nonresidents.

When a SNF limits its Medicare participation to a distinct part unit (DPU) and moves a beneficiary who no

Additional Clarification on Bill Types 22x and 23x with Instruction for Involuntarily Moving... (continued)

longer meets Medicare skilled level of care (required for a cover Part A stay) from the Medicare-certified DPU to a noncertified part of the institution, the beneficiary has technically ceased to reside in the Medicare-certified SNF and, thus, is appropriately billed as a non-resident of the SNF using bill type 23x Incorrectly using bill type 22x could inappropriately trigger SNF consolidated billing edits for therapy services that the beneficiary receives in an outpatient setting. However, in the case in which the entire facility qualifies as a Medicare-certified SNF, all Part B therapies must continue to be billed by the SNF on a bill type 22x.

Involuntarily Moving a Resident Out of a Medicare-Certified SNF or DPU

The requirements for participation specify the limited circumstances under which a resident can be involuntarily moved out of a Medicare-certified SNF or DPU. These circumstances can include the resident's health improving to the point that he/she no longer requires SNF care. However, if a resident has exhausted his/her Part A benefits but continues to require SNF care, he/she cannot be moved out of the Medicare-certified SNF or DPU for reasons other than those stated in the regulations. (For example, the resident cannot be moved to avoid consolidated billing requirements, or to establish a new benefit period.) The determination to move a beneficiary out of the Medicare-certified SNF or DPU must not be made on the basis that the beneficiary has exhausted his/her benefits, but rather on the beneficiary's lack of need for further SNF care. If a resident of a Medicare-certified DPU ceases to require SNF care, he/she may be moved from the DPU to the Medicare non-certified area of the institution. Keep in mind that such a move would end the beneficiary's status as a SNF resident for consolidated billing purposes.

Ending a Benefit Period

A benefit period ends 60 days after the beneficiary ceased to be an inpatient of a hospital and has not received inpatient skilled care in a SNF during the same 60-day period.

If the SNF resident's health has improved to the point that he/she no longer needs or receives the level of skilled care required for Part A coverage, the SNF must bill one of the two following scenarios:

1. For residents who leave the Medicare-certified SNF or DPU:
   - Submit a final discharge bill.
   - Submit on a 23x any services rendered after the discharge and billed by the SNF.
2. For residents who remain in the Medicare-certified SNF or DPU after the skilled level of care ends:
   - Submit the last skilled care claim with an occurrence code 22 to indicate the date active care has ended.
   - Submit on a 22x any services rendered and billed by the SNF after the skilled care ended.
   - All therapies must be billed by the SNF on the 22x.

For additional instructions on ending a benefit period, go to the Medicare General Information, Eligibility and Entitlement manual, chapter 3, section 10.4.3.2.

The lack of a beneficiary's need for skilled care in a SNF triggers the start of the 60-day count toward ending a benefit period. However, it is physical location of the beneficiary within the certified part of the facility that confers resident status for the purposes of the SNF Part B consolidated billing rule for therapies.

It is possible for a beneficiary to no longer need or receive skilled care resulting in ending a benefit period, but still be a resident of the SNF or Medicare-certified DPU requiring the SNF to bill for all therapies rendered to the resident.

Additional Information

CR 3323 replaces CR 2674, which was issued as Transmittal A-03-040 on May 9, 2003. To view the full instruction and the revised Medicare manual changes that are attached to the instruction, visit: *http://www.cms.hhs.gov/manuals/pm_trans/R229CP.pdf.*

If you have questions, please contact your intermediary at their toll-free number, which may be found at: *http://www.cms.hhs/medlearn/tollnums.asp.*

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3323
Related CR Release Date: July 20, 2004
Related CR Transmittal Number: 229
Effective Date: August 19, 2004
Implementation Date: August 19, 2004

Source: CMS Pub 100-4 Transmittal 229, CR 3323

Skilled Nursing Facility Consolidated Billing

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All Medicare providers, suppliers, physicians, skilled nursing facilities (SNF), and rural swing bed hospitals

Provider Action Needed

This article is informational only and is intended to remind affected providers that SNFs must submit all Medicare claims for the services its residents receive, except for a short list of specifically excluded services as mentioned in the "Excluded Services" section below. This requirement was established initially as specified in the Balanced Budget Act of 1997 (BBA, P.L. 105-33) and is known as SNF consolidated billing (CB).

Background

Prior to the Balanced Budget Act of 1997 (BBA), a SNF could elect to furnish services to a resident in a covered Part A stay, either:

- Directly, using its own resources;
- Through the SNF's transfer agreement hospital; or
- Under arrangements with an independent therapist (for physical, occupational, and speech therapy services).

In each of these circumstances, the SNF billed Medicare Part A for the services.

However, the SNF also had the further option of "unbundling" a service altogether; that is, the SNF could permit an outside supplier to furnish the service directly to the resident, and the outside supplier would submit a bill to Medicare Part B, without any involvement of the SNF itself. This practice created several problems, including the following:

- A potential for duplicate (Parts A/B) billing if both the SNF and outside supplier billed.
- An increased out-of-pocket liability incurred by the beneficiary for the Part B deductible and coinsurance even if only the supplier billed; and A dispersal of responsibility for resident care among various outside suppliers, which adversely affected quality (coordination of care) and program integrity, as documented in several reports by the Office of the Inspector General (OIG) and the General Accounting Office (GAO).

Based on the above-mentioned problems, Congress enacted the Balanced Budget Act of 1997 (BBA), Public Law 105-33, Section 4432(b). This section of the law contains the SNF CB requirements. Under the CB requirement, **an SNF itself must submit all Medicare claims for the services that its residents receive** (except for specifically excluded services listed below).

Conceptually, SNF CB resembles the bundling requirement for inpatient hospital services that's been in effect since the early 1980s—assigning to the facility itself the Medicare billing responsibility for virtually the entire package of services that a facility resident receives, except for certain services that are specifically excluded.

CB eliminates the potential for duplicative billings for the same service to the Part A fiscal intermediary (FI) by the SNF and the Part B carrier by an outside supplier. It also enhances the SNF's capacity to meet its existing responsibility to oversee and coordinate the total package of care that each of its residents receives.

Effective Dates

CB became effective as each SNF transitioned to the prospective payment system (PPS) at the start of the SNF's first cost reporting period that began on or after July 1, 1998.

The original CB legislation in the BBA applied this provision for services furnished to every resident of an SNF, regardless of whether Part A covered the resident's stay. However, due to systems modification delays that arose in connection with achieving Year 2000 (Y2K) compliance, the Centers for Medicare & Medicaid Services (CMS) initially postponed implementing the Part B aspect of CB, i.e., its application to services furnished during noncovered SNF stays.

The aspect of CB related to services furnished during noncovered SNF stays has now essentially been repealed altogether by Section 313 of the Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554, Appendix F). Thus, with the exception of physical therapy, occupational therapy, and speech language pathology services (which remain subject to CB regardless of whether the resident who receives them is in a covered Part A stay), this provision now applies only to those services that an SNF resident receives during the course of a covered Part A stay.

Excluded Services

There are a number of services that are excluded from SNF CB. These services are outside the PPS bundle, and they remain separately billable to Part B when furnished to an SNF resident by an outside supplier. However, Section 4432(b)(4) of the BBA (as amended by Section 313(b)(2) of the BIPA) requires that bills for these excluded services, when furnished to SNF residents, must contain the SNF's Medicare provider number. Services that are categorically excluded from SNF CB are the following:

- Physicians' services furnished to SNF residents. These services are not subject to CB and, thus, are still billed separately to the Part B carrier.
- Certain diagnostic tests include both a professional component (representing the physician's interpretation of the test) and a technical component (representing the test itself), and the technical component is subject to CB. **The technical component of these services must be billed to and reimbursed by the SNF**. (See Medlearn Matters Special Edition Article SE0440 for a more detailed discussion of billing for these diagnostic tests.)
- Section 1888(e)(2)(A)(ii) of the Social Security Act specifies that **physical therapy, occupational therapy, and speech-language pathology services are subject to CB**, even when they are furnished by (or under the supervision of) a physician.
- Physician assistants working under a physician's supervision;

Skilled Nursing Facility Consolidated Billing (continued)

- Nurse practitioners and clinical nurse specialists working in collaboration with a physician;
- Certified nurse-midwives;
- Qualified psychologists;
- Certified registered nurse anesthetists;
- Services described in Section 1861(s)(2)(F) of the Social Security Act (i.e., Part B coverage of home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies);
- Services described in Section 1861(s)(2)(O) of the Social Security Act (i.e., Part B coverage of eoetin afa (EPO, trade name Epogen®) for certain dialysis patients. Note: drbepoetin afa (DPA, trade name Aranesp®) is now excluded on the same basis as EPO);
- Hospice care related to a resident's terminal condition;
- An ambulance trip that conveys a beneficiary to the SNF for the initial admission, or from the SNF following a final discharge.

Physician "Incident To" Services

While CB excludes the types of services described above and applies to the professional services that the practitioner performs personally, **the exclusion does not apply to physician "incident to" services** furnished by someone else as an "incident to" the practitioner's professional service. These "incident to" services furnished by others to SNF residents are subject to CB and, accordingly, must be billed to Medicare by the SNF itself.

Outpatient Hospital Services

In Program Memorandum (PM) Transmittal A-98-37 (November 1998, reissued as PM transmittal A-00-01, January 2000), CMS identified specific types of outpatient hospital services that are so exceptionally intensive or costly that they fall well outside the typical scope of SNF care plans. CMS has excluded these services from SNF CB as well (along with those medically necessary ambulance services that are furnished in conjunction with them). These excluded service categories are:

- Cardiac catheterization; computerized axial tomography (CT) scans;
- Magnetic resonance imaging services (MRIs);
- Ambulatory surgery that involves the use of an operating room;
- Emergency services;
- Radiation therapy services;
- Angiography; and
- Certain lymphatic and venous procedures.

Effective with services furnished on or after April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113, Appendix F) has identified certain additional exclusions from CB. The additional exclusions enacted in the BBRA apply only to certain specified, individual services ***within*** a number of broader service categories that otherwise remain subject to CB. Within the affected service categories the exclusion applies only to those individual services that are specifically identified by HCPCS code in the legislation itself, while all other services within those categories remain subject to CB. These service categories are:

- Chemotherapy items and their administration
- Radioisotope services
- Customized prosthetic devices.

In addition, effective April 1, 2000, this section of the BBRA has unbundled those ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services.

Finally, effective January 1, 2004, as provided in the August 4, 2003 final rule (68 *Federal Register* 46060), two radiopharmaceuticals, Zevalin™ and Bexxar®, were added to the list of chemotherapy drugs that are excluded from CB (and, thus, are separately billable to Part B when furnished to a SNF resident during a covered Part A stay).

Effects of CB

SNFs can no longer "unbundle" services that are subject to CB in order for an outside supplier to submit a separate bill directly to the Part B carrier. Instead, the SNF itself must furnish the services, either directly, or under an "arrangement" with an outside supplier in which the SNF itself (rather than the supplier) bills Medicare. The outside supplier must look to the SNF (rather than to Medicare Part B) for payment.

In addition, SNF CB:

- Provides an essential foundation for the SNF PPS, by bundling into a single facility package all of the services that the PPS payment is intended to capture.
- Spares beneficiaries who are in covered Part A stays from incurring out-of-pocket financial liability for Part B deductibles and coinsurance.
- Eliminates potential for duplicative billings for the same service to the Part A (FI) by the SNF and to the Part B carrier by an outside supplier.
- Enhances the SNF's capacity to meet its existing responsibility to oversee and coordinate each resident's overall package of care.

Additional Information

While this article presents an overview of the SNF CB process, CMS also has a number of articles that provide more specifics on how SNF CB applies to certain services and/or providers. These articles are as follows:

- Skilled Nursing Facility Consolidated Billing as It Relates to Certain Types of Exceptionally Intensive Outpatient Hospital Services *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0432.pdf*.
- Skilled Nursing Facility Consolidated Billing as It Relates to Ambulance Service *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0433.pdf*.
- Skilled Nursing Facility Consolidated Billing and Erythropoietin (EPO, Epoetin Alfa) and Darbepoetin Alfa (Aranesp) *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0434.pdf*.
- Skilled Nursing Facility Consolidated Billing as It Relates to Dialysis Coverage *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0435.pdf*.

Skilled Nursing Facility Consolidated Billing (continued)

- Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0436.pdf*.
- Skilled Nursing Facility Consolidated Billing as It Relates to Prosthetics and Orthotics *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0437.pdf*.
- Medicare Prescription Drug, Improvement, and Modernization Act – Skilled Nursing Facility Consolidated Billing and Services of Rural Health Clinics and Federally Qualified Health Centers *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0438.pdf*.
- Skilled Nursing Facility Consolidated Billing as It Relates to Clinical Social Workers *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0439.pdf*.
- Skilled Nursing Facility Consolidated Billing as It Relates to Certain Diagnostic Tests *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0440.pdf*.
- Skilled Nursing Facility Consolidated Billing and "Incident To" Services (Services That Are Furnished as an Incident to the Professional Services of a Physician or Other Practitioner) (coming soon) In addition, the CMS Medlearn Consolidated Billing Website can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

It includes the following relevant information:

- General SNF consolidated billing information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing)
- Therapy codes that must be consolidated in a non-covered stay
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Website can be found at: *http://www.cms.hhs.gov/providers/snfpps/cb*.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition Medlearn Matters SE0431

Skilled Nursing Facility Consolidated Billing as It Relates to Certain Types of Exceptionally Intensive Outpatient Hospital Services

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Skilled nursing facilities (SNFs), physicians, suppliers, providers, and imaging centers

Provider Action Needed

This special edition describes SNF consolidated billing (CB) as it relates to certain types of exceptionally intensive outpatient hospital services, such as magnetic resonance imaging (MRI) services, computerized axial tomography (CT) scans, and radiation therapy.

Background

When the SNF prospective payment system (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. For a detailed overview of SNF CB, including a section on services excluded from SNF CB. See Medlearn Matters Special Edition article SE0431 at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf***.**

The original CB legislation (Section 4432(b) of the Balanced Budget Act of 1997, P. L. 105-33 (BBA 1997)) specified a list of services at Section 1888(e)(2)(A)(ii) of the Social Security Act that were excluded from this provision. As with the inpatient hospital bundling requirement (Section 1862(a)(14) of the Social Security Act) on which it was modeled, the SNF CB provision excluded primarily the services of physicians and certain other practitioners.

Moreover, **these services were excluded categorically, without regard to the specific setting in which they were furnished**. This legislation did not authorize the Department of Health and Human Services (DHHS) to create additional categorical exclusions from CB administratively, thereby reserving this authority for the Congress itself. In fact, the Congress subsequently did enact a number of additional CB exclusions that applied uniformly to services furnished in both hospital and nonhospital settings, in

SNF CB as It Relates to Certain Types of Exceptionally Intensive Outpatient Hospital Services (continued)

Section 103 of the Balanced Budget Refinement Act of 1999 (BBRA 1999, P.L.106-113, Appendix F).

While the original CB legislation did not authorize DHHS to simply carve out entire categories of services from CB without regard to setting, it did define the SNF CB provision in terms of services furnished to a resident of a SNF, and provided a degree of administrative discretion in defining when a beneficiary is considered to be a SNF "resident" for this purpose.

Using this authority, the Centers for Medicare & Medicaid Services (CMS) identified several types of exceptionally intensive outpatient hospital services that were well beyond the general scope of SNF care plans. These services include:

- Emergency services
- Cardiac catheterizations
- Computerized axial tomography (CT) scans
- Magnetic Resonance Imaging (MRI) services
- Ambulatory surgery
- Radiation therapy
- Angiography
- Lymphatic and venous procedures.

CMS established that a beneficiary's receipt of such services in the outpatient hospital setting had the effect of temporarily suspending his/her status as a SNF resident for CB purposes, thus enabling the hospital to bill Part B separately for the services. (See Title 42 of the *Code of Federal Regulations* (42 CFR), Section 411.15(p)(3)(iii).) The underlying rationale for this exclusion was that these services were so far beyond the normal scope of SNF care as to require the intensity of the hospital setting in order to be furnished safely and effectively.

In the legislative history that accompanied the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), Congress explicitly recognized that this administrative exclusion is specifically limited to "…certain outpatient services **from a Medicare participating hospital or critical access hospital**…" (emphasis added). (See the House Ways and Means Committee Report (H. Rep. No. 108-178, Part 2 at 209), and the Conference Report (H. Conf. Rep. No. 108-391 at 641).) This means that the exclusion does not encompass services that are furnished in other, nonhospital settings (such as freestanding clinics).

As noted previously, in addition to the existing exclusion of certain types of intensive outpatient hospital services under the regulations at 42 CFR 411.15(p)(3)(iii), Congress has elected to exclude several categories of services from CB in the statute itself, at Sections 1888(e)(2)(A)(ii)-(iii) of the Social Security Act. Unlike the administrative exclusion discussed above, which applies solely to services furnished in the outpatient hospital setting, the statutorily excluded services are separately billable to Part B regardless of the setting (hospital versus freestanding) in which they are furnished. For example, as amended by Section 103 of BBRA 1999, Section 1888(e)(2)(A)(iii)(II) of the Social Security Act excludes certain types of intensive chemotherapy services, regardless of whether they are furnished in a hospital or freestanding setting. Additional legislation would be required to expand the exemption of CT scans, MRI services, and radiation therapy to apply to services furnished in non-hospital settings.

Chemotherapy and its administration and radioisotopes and their administration are identified in the statute by HCPCS code. These services are separately billable in all care settings, but the exclusion applies only to the codes specified in the Social Security Act and subsequent regulations. Therefore, other services given in conjunction with an excluded code (e.g., other pharmaceuticals, medical supplies, etc.) remain bundled and should be reimbursed by the SNF to the supplier.

Please note that the professional charge for the physician who performs/interprets the radiological procedure is NOT subject to CB. Since the physician service exclusion applies to the professional component of the diagnostic radiology service, **the physician bills his/her service directly to the Medicare Part B carrier for reimbursement**.

Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at**:** *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

The Centers for Medicare & Medicaid Services (CMS) Medlearn consolidated billing website can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

It includes the following relevant information:

- General SNF CB information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB)
- Therapy codes that must be consolidated in a non-covered stay
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS consolidated billing website can be found at: *http://www.cms.hhs.gov/providers/snfpps/cb*.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition Medlearn Matters SE0432

Skilled Nursing Facility Consolidated Billing as It Relates to Ambulance Services

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Skilled nursing facilities (SNFs), physicians, ambulance suppliers, and providers

Provider Action Needed

This special edition article describes SNF consolidated billing (CB) as it applies to ambulance services for SNF residents.

Background

When the SNF prospective payment system (PPS) was introduced in 1998, it changed not only the way SNFs are paid but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

Ambulance services have not been identified as a type of service that is categorically excluded from the CB provisions. However, certain types of ambulance transportation have been identified as being separately billable in specific situations, i.e., based on the reason the ambulance service is needed.

This policy is comparable to the one governing ambulance services furnished in the inpatient hospital setting, which has been subject to a similar comprehensive Medicare billing or "bundling" requirement since 1983.

Since the law describes CB in terms of services that are furnished to a "resident" of an SNF, the initial ambulance trip that brings a beneficiary to an SNF is not subject to CB, as the beneficiary has not yet been admitted to the SNF as a resident at that point.

Similarly, an ambulance trip that conveys a beneficiary from the SNF at the end of a stay is not subject to CB when it occurs in connection with one of the events specified in regulations at 42 CFR 411.15(p)(3)(i)-(iv) as ending the beneficiary's SNF "resident" status. The events are as follows:

- A trip for an inpatient admission to a Medicare-participating hospital or critical access hospital (CAH). (See discussion below regarding an ambulance trip made for the purpose of transferring a beneficiary from the discharging SNF to an inpatient admission at another SNF.)
- A trip to the beneficiary's home to receive services from a Medicare-participating home health agency under a plan of care.
- A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that are not included in the SNF's comprehensive care plan (see further explanation below).
- A formal discharge (or other departure) from the SNF that is not followed by readmission to that or another SNF by midnight of that same day.

Ambulance Trips to Receive Excluded Outpatient Hospital Services

The regulations specify the receipt of certain exceptionally intensive or emergency services furnished during an outpatient visit to a hospital as one circumstance that ends a beneficiary's status as an SNF resident for CB purposes. Such outpatient hospital services are, themselves, excluded from the CB requirement, on the basis that they are well beyond the typical scope of the SNF care plan.

Currently, only those categories of outpatient hospital services that are specifically identified in Program Memorandum (PM) No. A-98-37, November 1998 (reissued as PM No. A-00-01, January 2000) are excluded from CB on this basis. These services are the following:

- Cardiac catheterization
- Computerized axial tomography imaging (CT) scans
- Magnetic resonance imaging (MRI) services
- Ambulatory surgery involving the use of an operating room (the ambulatory surgical exclusion includes the insertion of percutaneous esophageal gastrostomy (PEG) tubes in a gastrointestinal or endoscopy suite)
- Emergency room services
- Radiation therapy
- Angiography
- Lymphatic and venous procedures.

Since the receipt of one of these excluded types of outpatient hospital services is considered to end a beneficiary's status as an SNF resident for CB purposes, any associated ambulance trips are, themselves, excluded from CB as well; thus, an ambulance trip furnished in connection with the receipt of such services should be billed separately to Part B by the outside supplier.

Other Ambulance Trips

By contrast, when a beneficiary leaves the SNF to receive offsite services **other than** the excluded types of outpatient hospital services described above and then returns to the SNF, he or she retains the status of a SNF resident with respect to the services furnished during the absence from the SNF. Accordingly, ambulance services furnished in connection with such an outpatient visit would remain subject to CB, even if the purpose of the trip is to receive a particular type of service (such as a physician service) that is, itself, categorically excluded from the CB requirement.

SNF CB as It Relates to Ambulance Services (continued)

However, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section 103) excluded from SNF CB those ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

Transfers Between Two SNFs

A beneficiary's departure from an SNF is not considered to be a "final" departure for CB purposes if he or she is readmitted to that or another SNF by midnight of the same day (see 42 CFR 411.15(p)(3)(iv)).

Thus, when a beneficiary travels directly from SNF 1 and is admitted to SNF 2 by midnight of the same day, that day is a covered Part A day for the beneficiary, to which CB applies. Accordingly, the ambulance trip that conveys the beneficiary would be bundled back to SNF 1 since, under section 411.15(p)(3), the beneficiary would continue to be considered a resident of SNF 1 (for CB purposes) up until the actual point of admission to SNF 2.

However, when an individual leaves an SNF via ambulance and does not return to that or another SNF by midnight, the day is not a covered Part A day and, accordingly, CB would not apply.

Roundtrip to a Physician's Office

If an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance (i.e., using any other means of transport would be medically contraindicated) (see 42 CFR 409.27(c)), then the ambulance roundtrip is the responsibility of the SNF and is included in the PPS rate.

The preamble to the July 30, 1999 final rule (64 *Federal Register* 41674-75) clarifies that the scope of the required service bundle furnished to Part A SNF residents under the PPS specifically encompasses coverage of transportation via ambulance under the conditions described above, rather than more general coverage of other forms of transportation.

Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

The Centers for Medicare & Medicaid Services (CMS) Medlearn Consolidated Billing website is at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

It includes the following relevant information:

- General SNF CB information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB)
- Therapy codes that must be consolidated in a non-covered stay
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Website can be found at: *http://www.cms.hhs.gov/providers/snfpps/cb*.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition Medlearn Matters SE0433

Skilled Nursing Facility Consolidated Billing and Erythropoietin (EPO, Epoetin Alfa) and Darbepoetin Alfa (Aranesp)

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Skilled nursing facilities (SNFs), physicians, suppliers, end-stage renal disease (ESRD) facilities, and hospitals

Provider Action Needed

This special edition is informational only and describes SNF consolidated billing (CB) as it applies to erythropoietin (EPO) alfa (Epoetin®) and darbepoetin alfa (Aranesp®) and related services.

Background

The original Balanced Budget Act of 1997 list of exclusions from the prospective payment system (PPS) and consolidated billing (CB) for SNF Part A residents specified the services described in section 1861(s)(2)(O) of the Social Security Act—the Part B erythropoietin (EPO) benefit. This benefit covers EPO and items related to its administration for those dialysis patients who can self-administer the drug, subject to methods and standards established by the Secretary for its safe and effective use (see 42 CFR 405.2163(g) and (h)). For an overview of SNF CB and a list of excluded services, see Medlearn Matters article SE0431 at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

Regulations at 42 CFR 414.335 describe payment for EPO and require that EPO be furnished by either a Medicare-approved ESRD facility or a supplier of home dialysis equipment and supplies. The amount that Medicare pays is established by law. Thus, the law and implementing

SNF CB and Erythropoietin (EPO, Epoetin Alfa) and Darbepoetin Alfa (Aranesp) (continued)

regulations permit an SNF to unbundle the cost of the Epogen drug when it is furnished by an ESRD facility or an outside supplier, which can then bill for it under Part B.

An SNF that elects to furnish EPO to a Part A resident itself cannot be separately reimbursed over and above the Part A SNF PPS per diem payment amount for the Epogen drug. As explained above, the exclusion of EPO from CB and the SNF PPS applies only to those services that meet the requirements for coverage under the separate Part B EPO benefit, i.e., those services that are furnished and billed by an approved ESRD facility or an outside dialysis supplier.

By contrast, if the SNF itself elects to furnish EPO services (including furnishing the Epogen drug) to a resident during a covered Part A stay (either directly with its own resources, or under an "arrangement" with an outside supplier in which the SNF itself does the billing), the services are no longer considered Part B EPO services, but rather, become Part A SNF services. Accordingly, they would no longer qualify for the exclusion of Part B EPO services from CB, and would instead be bundled into the PPS per diem payment that the SNF receives for its Part A services.

Note: The Part B coverage rules that apply to EPO are applied in the same manner to Aranesp. (See Medicare Claims Processing Manual, Pub. 100-04, Chapter 8 – Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, §60.7.2; see also Medicare Benefit Policy Manual, Pub. 100-02, Chapter 11 – End Stage Renal Disease [ESRD], Section90). Accordingly, Aranesp is now excluded on the same basis as EPO.

Note: EPO (epoetin alfa, trade name Epogen) and DPA (darbepoetin alfa, trade name Aranesp) are not separately billable when provided as treatment for any illness other than ESRD. In this case, the SNF is responsible for reimbursing the supplier. The SNF should include the charges on the Part A bill filed for that beneficiary.

Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

The Medicare Renal Dialysis Facility Manual, Chapter II, Coverage of Services can be found at the following CMS website: *http://www.cms.hhs.gov/manuals/29_rdf/rd200.asp?#_1_17*.

You can find the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 11, End Stage Renal Disease (ESRD), at the following CMS website: *http://www.cms.gov/manuals/102_policy/bp102index.asp*.

You can find the Medicare Claims Processing Manual, Pub. 100-04, Chapter 8, Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, at the following CMS website: *http://www.cms.gov/manuals/104_claims/clm104index.asp*.

The CMS Medlearn Consolidated Billing Website can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

It includes the following relevant information:

- General SNF consolidated billing information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing)
- Therapy codes that must be consolidated in a non-covered stay
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS consolidated billing website can be found at: *http://www.cms.hhs.gov/providers/snfpps/cb*.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition Medlearn Matters SE0434

Skilled Nursing Facility Consolidated Billing as It Relates to Dialysis Coverage

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Skilled nursing facilities (SNFs), physicians, end-stage renal disease (ESRD) facilities, and hospitals

Provider Action Needed

This special edition is an informational article that describes SNF consolidated billing (CB) as it applies to dialysis coverage for SNF residents. See Medlearn Matters article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

Background

Dialysis furnished to an SNF resident during a covered Part A stay falls within the scope of the SNF benefit under the Social Security Act, Section 1861(h)(7), as long as the SNF elects to provide the dialysis itself, either directly or under an "arrangement" with a qualified outside supplier in which the SNF itself assumes the Medicare billing responsibility. When covered in this manner, the dialysis would be included in the global Medicare Part A per diem payment that the SNF receives under the Prospective Payment System (PPS).

However, the SNF PPS legislation also gives SNFs the option of "unbundling" the dialysis and, thereby, allowing an outside supplier to furnish the dialysis services and submit a bill directly to its Medicare Part B carrier.

If the SNF elects this option, dialysis services that meet the requirements for separate coverage under the Part B dialysis benefit (as described in the Social Security Act, Section 1861(s)(2)(F)) are excluded from SNF CB. As such, these services can be furnished and billed directly to the Medicare Part B carrier by the outside dialysis supplier itself. In addition, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section 103) excluded from SNF CB those ambulance services that are necessary to transport an SNF resident offsite to receive the Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

As noted previously, if the SNF **elects** to provide the dialysis services under Part A, either directly or under an arrangement with an outside supplier, these services would be included in the SNF's PPS per diem payment (since dialysis services that SNFs furnished in this manner during the PPS base period would have been included on their cost reports and reflected in the PPS base).

Further, since the Social Security Act (Section 1833(d)) expressly prohibits payment under Part B for any service that is covered under Part A, such services would not be excluded from SNF CB, since they would no longer meet the statutory criteria (Section 1888(e)(2)(A)(ii)) of being items and services that meet the requirements for coverage under the separate Part B dialysis benefit of the Social Security Act (Section 1861(s)(2)(F)).

Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

The Centers for Medicare & Medicaid Services (CMS) Medlearn Consolidated Billing Website can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

It includes the following relevant information:

- General SNF CB information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB).
- Therapy codes that must be consolidated in a non-covered stay.
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Website can be found at: *http://www.cms.hhs.gov/providers/snfpps/cb*.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

Related Change Request (CR) Number: N/A Medlearn Matters Number: SE0435
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition Medlearn Matters SE0435

Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Skilled nursing facilities (SNFs), physicians, suppliers, and providers

Provider Action Needed

This special edition is an informational article that describes SNF consolidated billing (CB) as it applies to preventive and screening services provided to SNF residents.

Background

When the skilled nursing facility (SNF) prospective payment system (PPS) was introduced in the Balanced Budget Act of 1997 (BBA, P.L. 105-33, Section 4432), it changed the way SNFs are paid, and the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns to the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. See Medlearn Matters article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

The BBA identified a list of services that are excluded from SNF CB. These services are primarily those provided by physicians and certain other types of medical practitioners, and they can be separately billed to Medicare Part B carriers directly by the outside entity that furnishes them to the SNF's resident (Social Security Act, Section 1888(e)(2)(A)(ii)). Since the BBA did not list preventive and screening services among the services identified for exclusion, these services are included within the scope of the CB provision.

However, reimbursement for covered preventive and screening services, such as vaccines and mammographies, is subject to special billing procedures. As discussed in the May 12, 1998 *Federal Register* (63 FR 26296), since preventive services (such as vaccinations) and screening services (such as screening mammographies) do not appear on the exclusion list, they are subject to CB. Accordingly, if an SNF resident receives, for example, a flu vaccine during a covered Part A stay, the SNF itself is responsible for billing Medicare for the vaccine, even if it is furnished to the resident by an outside entity.

Nevertheless, even though the CB requirement makes the SNF itself responsible for billing Medicare for a preventive or screening service furnished to its Part A resident, the SNF would not include the service on its Part A bill, but would instead submit a separate bill for the service to Part B. This is because the Part A SNF benefit is limited to coverage of "diagnostic or therapeutic" services (i.e., services that are reasonable and necessary to diagnose or treat **a condition that has already manifested itself**). (See Sections 1861(h) following (7), 1861(b)(3), and 1862(a)(1) of the Social Security Act.)

Accordingly, the Part A SNF benefit does not encompass screening services (which serve to detect the presence of a condition while it is still in an early, asymptomatic stage) or preventive services (which serve to ward off the occurrence of a condition altogether). Such services are always covered under Part B, even when furnished to a beneficiary during the course of a covered Part A SNF stay. Under Section 1888(e)(9) of the Social Security Act, payment for an SNF's Part B services is made in accordance with the applicable fee schedule for the type of service being billed.

Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

The Centers for Medicare & Medicaid Services (CMS) Medlearn Consolidated Billing Website is at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

It includes the following relevant information:

- General SNF consolidated billing information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Website can be found at: *http://www.cms.hhs.gov/providers/snfpps/cb*.

It includes the following relevant information:

- Background;
- Historical questions and answers;
- Links to related articles; and
- Links to publications (including transmittals and *Federal Register* notices).

Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition Medlearn Matters SE0436

Skilled Nursing Facility Consolidated Billing as It Relates to Prosthetic and Orthotic Devices

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Skilled nursing facilities (SNFs), physicians, suppliers, and providers

Provider Action Needed

This special edition is an informational article that describes SNF consolidated billing (CB) as it applies to prosthetics and orthotics for SNF residents.

Background

The SNF CB provision of the Balanced Budget Act of 1997 (BBA, P.L. 105-33, Section 4432(b)) is a comprehensive billing requirement under which the SNF itself is responsible for billing Medicare for virtually all of the services that its residents receive. This billing requirement is similar to the billing requirement that has been in effect for inpatient hospital services since 1983.

The BBA identified a list of services that are excluded from SNF CB. These services are primarily those provided by physicians and certain other types of medical practitioners, and they can be separately billed to Medicare Part B carriers directly by the outside entity that furnishes them to the SNF's residents (Social Security Act, Section 1888(e)(2)(A)(ii)). Since the BBA did not list prosthetic devices among the services identified for exclusion, such items initially were categorically included within the scope of the CB provision.

However, effective with services furnished on or after April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113, Appendix F, Section 103) provided for the exclusion of certain additional types of services from SNF CB. These services are listed in a separate Medlearn Matters article, SE0431, which also provides an overview of SNF CB. This article can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

The original statutory exclusions enacted by the BBA consist of a number of broad service categories and encompass all of the individual services that fall within those categories. By contrast, the additional exclusions enacted in the BBRA are more narrowly targeted, and apply only to certain specified, individual services **within** a number of broader service categories that otherwise remain subject to CB.

For customized prosthetic devices, the exclusion applies only to those individual items that the legislation itself specifically identifies by Healthcare Common Procedure Coding System (HCPCS) code, while all other items within this category remain subject to CB. The individual HCPCS codes by which the excluded services are identified appear in annual and quarterly CB updates. These CB updates can be found at: *http://www.cms.hhs.gov/providers/snfpps/snfpps_pubs.asp*.

The BBRA Conference Committee report (H. Rep. 106-479) characterized the individual services that this legislation targeted for exclusion as "…high-cost, low-probability events that could have devastating financial impacts because their costs far exceed the payment [SNFs] receive under the prospective payment system…."

The BBRA also gives the Centers for Medicare & Medicaid Services (CMS) limited authority to identify additional prosthetic codes for exclusion, in response to developments such as major advances over time in the state of medical technology, or reconfigurations of the HCPCS codes themselves. When new HCPCS codes are established for excluded services, the new codes are communicated through the annual and quarterly CB updates.

Moreover, while Congress elected to exclude from CB certain specific customized prosthetic devices that meet the criteria discussed above regarding high cost and low probability, it declined to exclude other types of prosthetic devices, and also declined to exclude orthotics as a class. In contrast to prosthetics, those items in the orthotics category tend to be more standardized and lower in cost. Further, even those customized items that fall at the high end of the orthotics category generally are still significantly less expensive and more commonly furnished in SNFs than customized items that fall at the high end of the prosthetics category.

Accordingly, orthotics would not appear to meet the criteria of exceptionally high cost and low probability that served as the basis for the BBRA exclusions. Further, even if certain individual orthotic devices were to be identified as meeting these criteria, excluding them from the CB requirement could not be accomplished administratively, but would require further legislation by Congress to add this service category to the statutory exclusion list.

In addition, CMS notes that in contrast to prosthetics (where the needs of a patient with a missing limb can often be addressed only through the use of a single, particular type of customized device), it is often medically feasible to use a relatively inexpensive orthotic device in place of a more expensive one. Thus, CMS believes that the SNF PPS appropriately places the financial responsibility for such devices (along with the decision-making authority for selecting among them) with the SNF itself, because it may be possible to address a particular SNF resident's condition with equal efficacy by selecting among a broader range of orthotic devices.

Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

The Centers for Medicare & Medicaid Services (CMS) Medlearn consolidated billing website can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

It includes the following relevant information:

- General SNF consolidated billing information

SNF CB as It Relates to Prosthetic and Orthotic Devices (continued)

- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing).
- Therapy codes that must be consolidated in a non-covered stay.
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS consolidated billing website can be found at: *http://www.cms.hhs.gov/providers/snfpps/cb*.

It includes the following relevant information:

- Background
- Historical questions and answer
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition Medlearn Matters SE0437

Skilled Nursing Facility Consolidated Billing and Services of Rural Health Clinics and Federally Qualified Health Centers

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Skilled nursing facilities (SNFs), physicians, rural health clinics (RHCs), and federally qualified health centers (FQHCs).

Provider Action Needed

This special edition is an informational article that describes SNF consolidated billing (CB) as it applies to services provided by RHCs and FQHCs.

Background

When the SNF Prospective Payment System (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. CB places with the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay.

Payment for this full range of services is included in the SNF PPS global per diem rate. The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. For a detailed overview of SNF CB and a list of the services excluded from SNF CB, see Medlearn Matters Special Edition SE0431 at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

RHC and FQHC services currently do not appear on the list of services that are excluded from the SNF CB requirement. Consequently, when a SNF resident receives RHC or FQHC services during a covered Part A stay, the services are bundled into the SNF's comprehensive per diem payment for the covered stay itself, and are not separately billable as RHC or FQHC services to the Fiscal Intermediary (FI). This means that rather than submitting a separate bill to the FI for these services, the RHC or FQHC looks to the SNF for its payment.

However, Section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) has amended the law to specify that when a SNF's Part A resident receives the services of a physician (or another type of practitioner that the law identifies as being excluded from SNF consolidated billing) from an RHC or FQHC, those services would not become subject to CB merely by virtue of being furnished under the auspices of the RHC or FQHC.

In effect, the amendment enables such RHC and FQHC services to retain their separate identity as excluded "practitioner" services. As such, these RHC and FQHC services remain separately billable to the FI when furnished to an SNF resident during a covered Part A stay. The MMA specifies that this provision becomes effective with services furnished on or after January 1, 2005.

Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

Also, the Centers for Medicare & Medicaid Services (CMS) Medlearn consolidated billing website can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

It includes the following relevant information:

- General SNF consolidated billing information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing)
- Therapy codes that must be consolidated in a non-covered stay
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS consolidated billing website can be found at: *http://www.cms.hhs.gov/providers/snfpps/cb*.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

Related Change Request (CR) Number: N/A
Effective Date: January 1, 2005
Implementation Date: N/A

Source: CMS Special Edition Medlearn Matters SE0438

Skilled Nursing Facility Consolidated Billing as It Relates to Clinical Social Workers

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Skilled nursing facilities (SNFs), physicians, practitioners, and clinical social workers (CSW)

Provider Action Needed

This special edition is an informational article that describes SNF consolidated billing (CB) as it applies to CSW services furnished to SNF residents during a Part A covered stay.

Background

When the SNF prospective payment system (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns SNFs the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay.

Payment for this full range of services is included in the SNF PPS global per diem rate. The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. For a detailed overview of SNF

CB and a list of the services excluded from SNF CB, see Medlearn Matters Special Edition SE0431 at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

Since CSW services do not currently appear on this excluded list, they are included within the overall package of services that is subject to the SNF CB requirement. Although the inclusion of CSW services under the SNF CB requirement does not preclude Medicare coverage for these services, it makes the SNF responsible for including them in its Part A bill for the resident's covered stay.

In fact, bundling CSW services in the Part A payment rate is not a new concept. The corresponding Medicare comprehensive billing requirement for inpatient hospital services, which similarly includes CSW services while excluding the services of certain other types of mental health professionals, has been in effect since 1983, and served as a model for SNF CB.

Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

Also, the Centers for Medicare & Medicaid Services (CMS) Medlearn consolidated billing website can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

It includes the following relevant information:

- General SNF CB information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB)
- Therapy codes that must be consolidated in a non-covered stay
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS consolidated billing website can be found at: *http://www.cms.hhs.gov/providers/snfpps/cb*.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition Medlearn Matters SE0439

Skilled Nursing Facility Consolidated Billing as it Relates to Certain Diagnostic Tests

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Skilled nursing facilities (SNF), physicians, suppliers, providers, and radiology centers

Provider Action Needed

This special edition is an informational article that describes SNF consolidated billing (CB) as it applies to certain diagnostic tests that include both a technical component (representing the test itself) and a professional component (representing the physician's interpretation of the test). These tests commonly include diagnostic radiology procedures (such as X-rays) and laboratory tests, but can also include other types of diagnostic procedures (such as audiology services) as well.

Background

When the SNF prospective payment system (PPS) was introduced in 1998, it not only changed the way SNFs are paid, but changed the way SNFs must work with suppliers, physicians, and other practitioners.

CB assigns the SNF the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. See Medlearn Matters Special Edition SE0431 at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

It contains a detailed overview of SNF CB and a list of the services excluded from SNF CB.

However, one of the service categories that the law ***does*** exclude from the SNF CB provision is physician services, which are separately billable to the Medicare Part B carrier. (See Medlearn Matters Special Edition article SE0445 for a more detailed discussion of SNF CB as it relates to services that are furnished as "incident to" a physician's professional services. This article will be coming soon.) Since many diagnostic tests include both a technical component and a professional component, suppliers need to generate two bills. For example, with regard to diagnostic radiology services, such as X-rays, the physician service exclusion applies only to the professional component of the diagnostic radiology service (representing the physician's interpretation of the diagnostic test).

The physician service is billed directly to the Medicare Part B carrier.

Because the diagnostic radiology service's technical component is already included within the SNF's global per diem payment for its resident's covered Part A stay, the outside supplier that actually furnishes the technical component would look to the SNF (rather than to Medicare Part B) for payment.

As indicated in the preceding discussion, these policies are not new, and have been in effect since the implementation of the SNF PPS in 1998. What has changed, though, is that the Centers for Medicare & Medicaid Services (CMS) installed electronic edits in 2002 that enable the claims processing system to detect automatically any claims that are inappropriately submitted to Part B for those services that are already included within the SNF's global per diem payment for a resident's covered Part A stay (such as the technical component of diagnostic tests).

As discussed above, because these services are already included within the SNF's payment for its resident's Medicare-covered stay, an outside entity that furnishes the services must look to the SNF, rather than to Medicare Part B, for payment.

Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf*.

The CMS Medlearn consolidated billing website can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

It includes the following relevant information:

- General SNF consolidated billing information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing)
- Therapy codes that must be consolidated in a non-covered stay
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

Also, the SNF PPS consolidated billing website can be found at: *http://www.cms.hhs.gov/providers/snfpps/cb*.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

Related Change Request (CR) Number: N/A
Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Matters SE0440

CORF SERVICES

Medicare Comprehensive Outpatient Rehabilitation Facility Coverage

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Medicare comprehensive outpatient rehabilitation facilities (CORFs)

Provider Action Needed
STOP – Impact to You

The Medicare Benefit Policy Manual, Chapter 12 (Comprehensive Outpatient Rehabilitation Facility [CORF]), has been updated to clarify general requirements, covered and noncovered services, provisions of services, and specific CORF services.

CAUTION – What You Need to Know

Medicare defines a CORF as a facility that is primarily engaged in providing diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of the injured and disabled, or to patients recovering from illness.

Policy changes in the CORF manual touch on the following topics: Rules for Provision of Services; Place of Treatment; Personnel Qualification Requirements; and Services Furnished Under Arrangements (including Physicians, Physical Therapy, Occupational Therapy, Speech-Language Pathology, Respiratory Therapy, Social, Psychological, and Nursing Services). Policy changes were additionally made regarding: Referral for Treatment; Plan of Treatment; Prosthetic and Orthotic Devices and Supplies; Drugs and Biologicals; Home Environment Evaluation; and Outpatient Mental Health Treatment Limitation.

GO – What You Need to Do

The most pertinent changes are outlined below in the *Additional Information* section; however, to see all the changes, please refer to Chapter 12 of Publication 100-2, which is attached to CR 3315. (Instructions for accessing that CR are found later in this article.)

Background

A service may be covered as a CORF service only if it would be covered as an inpatient hospital service provided to a hospital patient. This does not mean that the beneficiary must require a hospital level of care or meet other requirements unique to hospital care. This provision merely requires that the service, if otherwise covered, would be covered if provided in a hospital.

Additional Information

Key policy changes made in the CORF manual include the following:

Physicians

CORF physician services are services such as a consultation, home, office, and institutional evaluation and management services rendered by a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he/she performs services. Examinations for the purpose of establishing and reviewing the plan of care that do not result in a billable service are also considered to be CORF physician services.

CORF facility physicians must have completed at least one year of training, subsequent to completion of a one-year hospital internship, in the medical management of patients requiring rehabilitative services or they must have completed at least one year of full-time or part-time experience in a rehabilitation setting, providing physician services similar to those required in a rehabilitation facility.

The facility physician must be present in the facility long enough to provide medical direction, medical care services, and consultation services within acceptable professional standards and practice.

Physicians are expected to work together with physical therapists, occupational therapists or speech language pathologists who will provide the actual therapy when establishing patient care plans, although the respiratory therapy plan of treatment is expected to be established entirely by the physician.

A physician specializing only in pulmonary rehabilitation is not considered to have the experience needed to medically manage patients who need skilled rehabilitation services.

Therapists/Social Services

Qualified physical or occupational therapists are required to evaluate and reevaluate the patient's level of function and to consult in the development of the plan of treatment. A qualified physical or occupational therapist assistant functioning under the general supervision of the qualified physical or occupational therapist may also carry out the implementation of the plan, in accordance with applicable state laws.

Social services are covered CORF services, if they are part of a coordinated, comprehensive skilled rehabilitation program and are included in the plan of treatment established and signed by the referring physician and contribute to the improvement of the individual's condition.

Coverage is limited to the services of one professional, i.e., either a physical or occupational therapist selected by the CORF (whose services are covered by the CORF benefit).

Respiratory Therapy

Respiratory therapy (respiratory care) services are services prescribed by a physician for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with respiratory deficiencies and abnormalities of function as part of a coordinated comprehensive skilled rehabilitation program. These services are covered CORF services if they are part of a coordinated, comprehensive, skilled rehabilitation program and included in the plan of treatment established and signed by the referring physician, and considered reasonable and necessary for the diagnosis or treatment of an illness or injury.

Respiratory services must be performed in conjunction with core CORF services by respiratory therapists, physical therapists, occupational therapists, or registered nurses, as recognized by applicable state law.

Medicare Comprehensive Outpatient Rehabilitation Facility Coverage (continued)

Prosthetics and Orthotics

Prosthetics and orthotics are considered covered CORF services if they are part of a comprehensive, coordinated, skilled rehabilitation program established and signed by the referring physician, and furnished in conjunction with a physician's service or on a physician's order. These devices are covered CORF services if they are part of a comprehensive, coordinated, skilled rehabilitation program.

Drugs and Biologicals

Drugs and biologicals are covered if they are part of a coordinated, comprehensive, skilled rehabilitation program and are included in the plan of treatment established and signed by the physician.

Home Visits

A single home environment evaluation visit is covered as a CORF service if it is a part of a coordinated, comprehensive, skilled rehabilitation program and is included in the plan of treatment established and signed by the referring physician. Coverage is limited to the services of one professional, i.e., either a physical or occupational therapist selected by the CORF (whose services are covered by the CORF benefit).

The official instruction issued to your intermediary regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3315 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions regarding these changes, please contact your fiscal intermediary at their toll free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The most pertinent changes are outlined in this *Additional Information* section; however, to see all the changes, please refer to the CORF manual, Chapter 12 of Pub 100-2, that is attached to CR 3315.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3315
Related CR Release Date: September 24, 2004
Related CR Transmittal Number: 21
Effective Date: June 30, 2004
Implementation Date: October 25, 2004

Source: CMS Pub 100-2 Transmittal 21, CR 3315

Change Regarding the Discontinued Use of Revenue Code 0910

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

1) Comprehensive outpatient rehabilitation facilities (CORFs), rural health clinics (RHCs), and federally qualified health centers (FQHCs); and
2) Hospital outpatient departments, community mental health centers (CMHCs), and critical access hospitals (CAHs) billing under the outpatient partial hospitalization program.

Provider Action Needed

Note that the effective date of the discontinuance of revenue code 0910, as mentioned in Medlearn Matters article MM3194 and related CR 3194, has been changed to October 16, 2003.

Background

This one-time notification contains changes to the effective date of the CR 3194 requirements pertaining to the discontinued use of revenue code 0910. The CR 3194 business requirements document made a revenue code change for claims for certain psychiatric/psychological treatment and services submitted on or after October 1, 2004. Specifically, it discontinued revenue code 0910 and replaced it with revenue code 0900.

This CR changes the effective date of that revenue code change. The revenue code change will now be effective for claims with "dates of service" on or after October 16, 2003.

To briefly review the revenue code change contained in CR 3194: CORFs, RHCs, and FQHCs must use revenue code 0900 to report psychiatric/ psychological treatment and services that are subject to the outpatient mental health treatment limitation, just as revenue code 0910 was used in the past.

Similarly, hospital outpatient departments, CMHCs, and CAHs that formerly reported psychiatric/psychological services under the outpatient partial hospitalization program using revenue code 0910 must now report such treatment under revenue code 0900.

Additional Information

You can find more information about revenue code 0900 by going to: *http://www.cms.hhs.gov/manuals/transmittals.comm_date_dsc.asp*.

From that Web page, look for CR 3343 in the CR NUM column on the right, and click on the file for that CR.

You can also find the original CR 3194 at that page, and the Medlearn Matters article MM3194 can be found at: *http://www.cms.hhs.gov/medleanr/matters/mmarticles/2004/MM3194.pdf*.

Finally, if you have any questions, please contact your intermediary at their toll-free number, which can be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3343
Related CR Release Date: July 23, 2004
Related CR Transmittal Number: 98
Effective Date: October 16, 2003
Implementation Date: October 4, 2004

Source: CMS Pub 100-20 Transmittal 98, CR 3343

PROVIDER AUDIT ISSUES

Inpatient Rehabilitation Facility Annual Update—Prospective Payment System PRICER Changes for Fiscal Year 2005

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

Regulations at 42 CFR section 412.624(e)(4) describe the criteria and procedures for determining whether an IRF subject to the IRF PPS qualifies for an additional payment for extraordinarily costly cases, known as high-cost outliers. A final rule, published on August 1, 2003 (68 FR 45674) revised the regulations at section 412.624(e)(4) for facilities subject to the IRF PPS. This change request (CR) provides instructions for implementing those revisions to the outlier policy for the IRF PPS.

Prospective Payment System PRICER Changes for Fiscal Year 2005

On August 1, 2003, CMS published a final rule in the *Federal Register* (68 FR 45674) that sets forth the prospective payment rates applicable for IRFs for fiscal year 2004. On July 30, 2004, CMS published a notice that sets forth the prospective payment rates applicable to for fiscal year 2005. A new IRF PRICER software package was released prior to October 1, 2004, containing the updated rates that are effective for claims with discharges that fall within October 1, 2004 through September 30, 2005. The new revised PRICER program was installed timely in the fiscal intermediaries shared systems to ensure accurate payments for the IRF PPS claims with discharges on or after October 1, 2004 through September 30, 2005.

Under the existing IRF PPS outlier methodology, the cost-to-charge ratio (CCR) from an IRF's latest settled cost report is used in determining whether a case qualifies for payment as an outlier and the amount of any such payment. Based on the final rule published in the *Federal Register* on August 1, 2003, this change request provides instructions for applying CCRs for IRFs, including:

- The use of an alternative CCR when directed by CMS or at the request of the facility.
- The use of a CCR based on the tentative settlement of the cost report for discharges on or after October 1, 2003.
- The use of the national averages.
- The criteria for identifying hospitals to be subject to reconciliation.
- Notification to hospitals about those updates.

Source: CMS Pub 100-4 Transmittal 263, CR 3378

Supplemental Security Income Medicare Beneficiary Data for Fiscal Year 2003 for Inpatient Prospective Payment System Hospitals

Section 9105 of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) provides additional payment amounts for hospitals with a disproportionate share of low-income patients. This is done by making adjustments to the prospective payment rate.

This instruction provides updated data for determining additional payment amounts for hospitals with a disproportionate share of low-income patients. The supplemental security income (SSI) Medicare beneficiary data for inpatient prospective payment system is available electronically and contains the name of the hospital, provider number, SSI days, covered Medicare days, and the ratio of Medicare Part A patient days attributable to SSI recipients. The file is located at the following CMS website address: *http://www.cms.hhs.gov/providers/hipps/dsh.asp*.

The data is used for settlement purposes for hospitals with cost reporting periods beginning during fiscal year 2003 (cost reporting periods beginning on or after October 1, 2002, and before October 1, 2003).

Source: CMS Pub 100-4 Transmittal 275, CR 3403

Skilled Nursing Facility Prospective Payment System PRICER Update for Fiscal Year 2005

Annual updates to the prospective payment system (PPS) rates are required by section 1888(e) of the Social Security Act, as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (the BBRA), and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), relating to Medicare payments and consolidated billing for skilled nursing facilities (SNFs).

On July 31, 2002, the Centers for Medicare & Medicaid Services published an update notice in the *Federal Register* (67 FR 49798) detailing the schedule of SNF PPS federal rates applicable for SNF payments in FY 2003,. CMS published the SNF payment rates for FY 2004 (October 1, 2003 through September 30, 2004), in the *Federal Register* on August 4, 2003 (68 FR 46036).

Medicare systems will apply the FY 2005 SNF PPS payment rates that are effective for discharges beginning October 1, 2004, through September 30, 2005. The new SNF PRICER module incorporates section 511 of the Medicare Modernization Act (MMA) of 2003, which specifies a separate add-on reimbursement for beneficiaries with AIDS (acquired immune deficiency syndrome), and will update all rates using the existing methodology.

- The update method is identical to that used in the previous year.
- The statute mandates an update to the federal rates using the latest SNF full market basket.

CMS developed the SNF PRICER system that calculates the Medicare payment rate, and determines the price upon which to base payment under prospective payment system. The PRICER is available electronically to the Shared Systems and is updated at least annually. The SNF PRICER system is updated at least annually and may be accessed at: *http://www.cms.hhs.gov/providers/pricer/default.asp*.

Source: CMS Pub 100-4 Transmittal 268, CR 3368

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

October 2004 Outpatient Code Editor Update Specifications Version 5.3

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All outpatient providers with the exception of hospitals not subject to outpatient prospective payment system (OPPS).

Provider Action Needed

Affected hospitals and providers should note that the related CR reflects the specifications that were issued for the July 2004 revision of the OPPS OCE (version 5.2), as well as changes for the October version, which is version 5.3.

Background

Full details of version 5.3 of the OPPS OCE are contained in CR 3395 and will not be repeated in this article, especially since many of the details are not changing and providers paid under the OPPS are likely familiar with these details. Key changes in version 5.3 include the following:

- Edit 67 is amended to reflect that the service was provided prior to FDA approval or prior to the date of a national coverage determination (NCD). Edit 67 is intended to line item reject any line that has a line item date of service that precedes the effective date of FDA approval (Medicare Modernization Act (MMA) Section 621 (a)(1)(15) OR the effective date of a NCD (MMA Section 731)). If the service is provided prior to the effective date of FDA approval or the effective date of the NCD, then the service is considered not covered by Medicare. Edit 67 was established to comply with MMA. (The italicized language has been added for reason 67.)
- Where submitted, if the charge for HCPCS surgical codes is less than $1.01 for any line with a packaging flag of zero, the packaging flag will be reset to three for that line when there are other surgical procedures on the claim with charges is greater than $1.00.

All the modifications are summarized in the following table.

Note: Readers should also read through the specifications and note the highlighted sections, which also indicate change from the prior release of the software. Some OCE/ambulatory payment classifications (APC) modifications in the release may also be retroactively added to prior releases. If so, the retroactive date will appear in the "Effective Date" column.

Effective Date	Description
January 1, 2003	Packaging Flag: 3 "Artificial charges for surgical procedure" Expand the logic as follows: • Apply to all lines with SI = T (or any lines with SI = S in HCPCS range 10000-69999) with charges less than $1.01 when there are other T procedures (or other S procedure in the same code range, 10000-69999) with charges greater than $1.00 on the claim. Applicable to all OPPS claims where the APC Return buffer is completed). • Change effective date for packaging flag 3 to 1/1/03 (previous effective date was July 1, 2004).
August 2000	Change the disposition for edit 27 from RTP to Claim rejection.
October 1, 2004	Make HCPCS/APC/SI and modifier changes, as specified by CMS. Implement version 10.2 of the NCCI file, removing all code pairs, which include anesthesia (00100-01999), E&M (92002-92014, 99201-99499), MH (90804-90911), CAD (76085, G0236) or G0168.
October 1, 2004	Update the valid diagnosis code list to add and delete ICD-9-CM diagnosis codes to reflect CMS updates effective October 1,2004, and set appropriate edit flags as indicated by CMS.
October 1, 2004	Update the valid revenue code list to add revenue codes 0343, 0344; and to delete revenue code 0910. Change description for edit 67 to read "Service provided prior to FDA approval or prior to date of national coverage determination (NCD)."

October 2004 Outpatient Code Editor Update Specifications Version 5.3 (continued)

Implementation

The implementation date for this instruction is October 4, 2004.

Additional Information

For complete details regarding the October version of the OPPS OCE (Version 5.3), please see the official instruction issued to your fiscal intermediary regarding this change. That instruction may be viewed by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR3395 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3395
Related CR Release Date: July 30, 2004
Related CR Transmittal Number: 254
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 254, CR 3395

October 2004 Update of the Hospital Outpatient Prospective Payment System

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hospitals and other providers paid under the OPPS

Provider Action Needed

This instruction provides changes to the OPPS for the October 2004 quarterly update. Unless otherwise noted, all changes in this article are effective for services furnished on or after October 1, 2004.

Background

This article describes changes to the hospital outpatient prospective payment system (OPPS) to be implemented in the October 2004 update. The October 2004 outpatient code editor (OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS) codes and ambulatory payment classification (APC) additions, changes, and deletions, identified in this article.

Details regarding OPPS changes for the October 2004 quarterly update, including Attachment A, Summary of Data Modifications, OCE/APC v5.3, effective October 1, 2004, are contained in the official instruction issued to your intermediary. That instruction may be viewed by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

On that website, look for CR 3420 in the CR NUM column on the right, and click on the file for that CR. A summary of key changes follows:

1. New Service

The following new service is assigned for payment under the OPPS OCE, effective October 1, 2004.

Table 1. Payment for New Service

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
C9717	10/01/04	T	0150	Stapled Hemorrhoidopexy	Hemorrhoidopexy, Complex or Extensive, by a Circular Stapler	$1,210.81	$242.16

2. Payment for Drugs and Biologicals Recently Approved by the FDA

Transmittal 188 (CR 3287) explains how hospitals may report new drugs and biologicals after Food and Drug Administration (FDA) approval but before assignment of product-specific HCPCS codes. Beginning in 2004, the Medicare Prescription Drug, Improvement and Modernization Act (MMA) requires that payment for new drugs and biologicals after FDA approval but before assignment of product-specific HCPCS codes be equal to 95 percent of AWP.

- For services furnished on or after the designated effective date in Table 2, through September 30, 2004, but prior to the effective date of pass-through status and assignment of a product-specific HCPCS code, payment for the drugs and biologicals in Table 2 will be made at 95 percent of AWP.
- For services furnished on or after the designated effective date in Table 2, through September 30, 2004, beneficiary copayment will equal 20 percent of the designated payment rate.

October 2004 Update of the Hospital Outpatient Prospective Payment System (continued)

- Effective October 1, 2004, the drugs and biologicals in Table 2 are approved for payment as passthrough drugs and biologicals (see section 3, below).
- Hospitals that used a code other than C9399 to bill for drugs and biologicals listed in Table 2 that were furnished prior to installation of the July 2004 release may submit adjustment bills.
- The "Effective Date of Payment Rate" listed in Table 2 reflects the date the drug or biological received FDA approval. Claims that are submitted using these HCPCS codes with dates of service prior to the specified "Effective Date of Payment Rate" found in Table 2 will receive OCE edit 67, "Service provided prior to FDA approval." OCE edits are addressed in the October 2004 OCE Specifications Recurring Update Notification, CR 3395.

Note: The Medlearn Matters article for CR 3395 may found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3395.pdf*.

Table 2. Payment for Drugs and Biologicals Recently Approved by the FDA

HCPCS	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment	Effective Date of Payment Rate
C9218	K	9218	Injection, azacitidine	Injection, azacitidine, per 1 mg	$4.52	$0.90	05/19/04
C9219	K	9219	Mycophenolic acid, oral	Mycophenolic acid, oral, per 180 mg	$2.67	$0.53	02/27/04

3. Drugs and Biologicals Newly Approved for Pass-Through Payment

- The drugs and biologicals listed in Table 3 have been designated as eligible for pass-through payment under the OPPS, effective October 1, 2004. The effective date of pass-through status for C9218 and C9219 coincides with the date of assignment of product-specific HCPCS codes for each of these drugs.
- Payment for the drugs and biologicals listed in Table 3 equals 95 percent of AWP. Effective October 1, 2004, beneficiary copayment for C9218 and C9219 is recalculated consistent with coinsurance rules that apply to drugs and biologicals with pass-through status.
- "Injection, azacitidine, per 1 mg" and "mycophenolic acid, oral, per 180 mg" were originally approved by the FDA effective 05/19/04 and 02/27/04, respectively (see Table 2). These drugs both received product-specific HCPCS codes and were assigned pass-through status effective 10/01/04. Therefore, for claims with dates of service from the effective date of FDA approval to September 30, 2004, these drugs may be appropriately billed using C9399. Effective October 1, 2004, these drugs are no longer billable using C9399 and must be billed using the appropriate HCPCS identified in this article.

Table 3. Drugs and Biologicals Newly Approved for Pass-Through Payment

HCPCS	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment	Effective Date of Pass-Through Status
C9218	G	9218	Injection, azacitidine	Injection, azacitidine, per 1 mg	$4.52	$0.68	10/01/04
C9219	G	9219	Mycophenolic acid, oral	Mycophenolic acid, oral, per 180 mg	$2.67	$0.40	10/01/04

4. Misclassified Drugs and Biologicals: Billing and Payment for "Ganciclovir Long Act Implant," "Bcg Live Intravesical Vac," and "Gallium ga 67"

In the January 6, 2004 interim final rule, the Centers for Medicare & Medicaid Services (CMS) inadvertently misclassified "Ganciclovir Long Act Implant," "Bcg Live Intravesical Vac," and "Gallium ga 67" as multiplesource products and, therefore, incorrectly established new HCPCS for brand name forms of these drugs.

These three drugs should not have been listed as multiple source drugs in CR 3144, "April 2004 Changes to the hospital outpatient prospective payment system (OPPS): Payment for Drugs, Biologicals, and Radiopharmaceuticals, Generic Versus Brand Name," in which CMS addresses coding and payment for innovator multiple-source (brand name) drugs and non-innovator multiple-source (generic) drugs, and in which CMS implements HCPCS codes and payment amounts for brand name drugs that CMS was not able to previously implement in the January 1, 2004 update.

October 2004 Update of the Hospital Outpatient Prospective Payment System (continued)

CMS is modifying the OCE and PRICER to reflect the reclassification of "Ganciclovir Long Act Implant," "Bcg Live Intravesical Vac," and "Gallium ga 67" as sole source products, effective January 1, 2004. As mandated by the MMA, the payment amounts for these products are between 88 and 95 percent of their May 1, 2003 AWP.

For claims that are submitted on or after implementation of the October 2004 update, for services furnished on or after January 1, 2004, hospitals should use the sole source codes identified in Table 4, below, for reporting "Ganciclovir Long Act Implant," "Bcg Live Intravesical Vac," and "Gallium ga 67."

HCPCS C9416 and C9434, representing "Bcg Live Intravesical, brand," and "Gallium ga 67, brand," are deleted from the OPPS OCE effective January 1, 2004. Because of release deadlines, CMS was unable to delete HCPCS C9412, representing "Ganciclovir Implant, brand," in the October update of the OCE.

Because PRICER was appropriately updated, however, hospitals should use the sole source code identified in Table 4, below, for reporting "Ganciclovir Long Act Implant." C9412 will be appropriately deleted in the January 1, 2005 OPPS update. **Separate instruction will be issued to address billing and payment for claims for "Ganciclovir Long Act Implant," "Bcg Live Intravesical Vac," and "Gallium ga 67" that were processed prior to implementation of the October 2004 update.**

Table 4. Reclassified Drugs and Biologicals

5. Billing for "FDG, per Dose (4-40 mCi/ml)," C9408 and APC 9408

HCPCS	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment	Effective Date
J7310	K	0913	Ganciclovir long act implant	Ganciclovir, 4.5 mg, long-acting implant	$4,400.00	$880.00	01/01/04
J9031	K	0809	Bcg live intravesical vac	BCG (intravesical) per instillation	$148.33	$29.67	01/01/04
Q3002	K	1619	Gallium ga 67	Supply of radiopharmaceutical diagnostic imaging agent, gallium GA 67, per mCi	$28.73	$5.75	01/01/04

In the October 2004 update of the OPPS OCE, CMS inadvertently deleted HCPCS code C9408 and its associated APC, 9408, effective January 1, 2004. For claims with dates of service on or after January 1, 2004, that are submitted after implementation of the October 2004 update, hospitals should bill for "FDG, per Dose (4-40 mCi/ml)" using HCPCS code C1775.

For claims submitted prior to implementation of the October 2004 update, hospitals may still use C9408 to bill for the brand name form of "FDG, per Dose (4-40 mCi/ml)."

6. October 2004 OCE Modifications

Attachment A of CR3420 is the OPPS OCE Summary of Data Modifications, effective October 1, 2004.

This document summarizes all of the modifications made to APCs, HCPCS and CPT procedure codes, APC assignments, status indicators, modifiers, revenue codes, and edits to update the OPPS OCE for the October 1, 2004 quarterly release. CR 3420 may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R290CP.pdf*.

Implementation

The implementation date for this instruction is October 4, 2004.

Additional Information

For further details, please see the official instruction issued to your intermediary. That instruction may be viewed by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R290CP.pdf*.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Related Change Request (CR) Number: 3420
Related CR Release Date: August 27, 2004
Related CR Transmittal Number: 290
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 290, CR 3420

The Health Insurance Portability and Accountability Act (HIPAA)

Update of Health Care Claim Status Codes and Health Care Claim Status Category Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All providers

Provider Action Needed

STOP – Impact to You

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all payers to use the applicable health care claim status category codes and health care claim status codes.

CAUTION – What You Need to Know

Medicare intermediaries (FIs) and carriers must periodically update their claim system with the most current health care claim status category codes and health care claim status codes for use with the Health Care Claim Status Request and Response ASC X12N 276/277.

GO – What You Need to Do

Providers will need to be aware of the new codes that may appear on their response to a claim status inquiry.

Background

Medicare FIs and carriers must periodically update their claim system with the most current health care claim status category codes and health care claim status codes for use with the Health Care Claim Status Request and Response ASC X12N 276/277. Under HIPAA, all payers must use health care claim status category codes and health care claim status codes approved by the Health Care Code Maintenance Committee.

At each X12 trimester meeting (generally held in the months of February, June and October) the Committee may update the claim status category codes and health care claim status codes. Included in the code list are specific details, such as the date a code was added, changed, or deleted.

Per HIPAA, health plans must be able to conduct the standard electronic transactions mentioned in the regulation. The named HIPAA transaction for claim status is the ASC X12N 276/277 4010A1 Health Care Claim Status Request and Response. The code sets for use with the 276/277 are the Health Care Claim Status Category Codes and Health Care Claim Status Codes.

Medicare contractors are already using these code sets because of prior instructions. However, recently some new codes and code changes were made with the designation "new as of 2/04." Medicare FIS and carriers will start using the "new as of 2/04" codes as of January 3, 2005.

Additional Information

Claim status codes are used in the Health Care Claim Status Notification (277) transaction in the STC01- 2, STC10-2 and STC11-2 composite elements. They indicate the detail about the general status communicated in the Claim Status Category Codes carried in STC01-1, STC10-1 and STC11-1.

Claim status codes communicate information about the status of a claim, i.e., whether it's been received, pended, or paid.

For users who are new to the Claim Status transaction, please review the *276/277 Implementation Guide* for using claim status codes.

The Claim Status transaction is not used as a financial transaction.

Claim status category codes are used in the Health Care Claim Status Notification (277) transaction in the STC01-1, STC10-1 and STC11-1 composite elements. They indicate the general category of the status (accepted, rejected, additional information requested, etc.), which is then further detailed in the claim status codes carried in STC01-2, STC10-2 and STC11-2.

The code sets for use with the 276/277 are the Health Care Claim Status Category Codes and Health Care Claim Status Codes found at: *http://www.wpc-edi.com/codes/codes.asp*.

By January 3, 2005, Medicare FIS and carriers must have all applicable code changes and new codes that are posted on the website with the "new as of 2/04" designation and prior dates available for use in production.

The official instruction issued to your contractor regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3361 in the CR NUM column on the right, and click on the file for that CR.

Related Change Request (CR) Number: 3361
Related CR Release Date: July 23, 2004
Related CR Transmittal Number: 230
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 230, CR 3361

Health Insurance Portability and Accountability Act X12N 837 Institutional Health Care Claim Implementation Guide Additional Updates

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All Medicare providers who bill Medicare fiscal intermediaries (FIs)

Provider Action Needed

STOP – Impact to You

On January 3, 2005, the Centers for Medicare & Medicaid Services (CMS) will implement additional edits for institutional claims submitted via direct data entry (DDE).

CAUTION – What You Need to Know

Please stay current with HIPAA edit instructions related to X12N 837 institutional claims as failure to comply may result in payment delays.

GO – What You Need to Do

Ensure that your billing practices comply with changes noted below to facilitate accurate and timely claim processing. Specific changes include requirements for a line item date of service for each revenue code on DDE outpatient claims (as defined in CR 3031) and that such claims may not contain covered days. Also, all DDE claims will be edited to ensure they do not contain a UPIN of NPP000.

Background

HIPAA institutional claim editing business requirements presented in CR 3031, CR3264, and CR 3337 are supplemented by additional claim edits contained in Change Request 3321.

Medicare claim processing systems used by FIs will be required to:

- Edit outpatient claims submitted via DDE to ensure that a line item date of service is included for each revenue code.
- Edit outpatient claims submitted via DDE to ensure that each does not contain covered days.
- Edit claims submitted via DDE to ensure each does not contain an invalid condition code.
- Edit X12N 837 claims to ensure each does not contain an invalid condition code.
- Edit all claims submitted via DDE to ensure that each does not contain an NPP000 UPIN.

All claims above submitted via DDE that do not meet the requirements noted will be subject to an appropriate online error message.

Additional Information

The official instruction issued to the intermediary regarding this change can be found online, referenced via CR 3321, at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

On the above online page, scroll down while referring to the CR NUM column on the right to find the link for CR 3321. Click on the link to open and view the file for the CR.

If you have questions regarding this issue, you may also contact your intermediary on their toll free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

For additional information on HIPAA, please refer to: *http://www.cms.hhs.gov/hipaa/hipaa2/links/default.asp*.

Related Change Request (CR) Number: 3321
Related CR Release Date: July 23, 2004
Related CR Transmittal Number: 238
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 138, CR 3321

ELECTRONIC DATA INTERCHANGE

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All providers

Provider Action Needed

STOP – Impact to You

The June 2004 updates have been posted for the X12N 835 Health Care Remittance Advice Remark Codes and the X12 N 835 Health Care Claim Adjustment Reason Codes.

CAUTION – What You Need to Know

The most current and complete list will be found online at: *http://www.wpc-edi.com/codes/Codes.asp*.

Please note that in case of a discrepancy, the code text included on the Washington Publishing Company (WPC) website will supersede any corresponding text in a CR.

In addition, with respect to health care claim adjustment reason codes, few temporary reason codes (D16-D20) were added for the cases where commercial payers do not make use of the available remark codes when the reason code used is too generic to help providers decide on the follow-up action. ***Medicare will not use these new temporary reason codes but rather will continue the current use of the combination of reason and appropriate remark codes.***

GO – What You Need to Do

The above noted codes are updated three times a year. Please advise billing staff to stay current with the latest approved and valid codes, in accordance with effective and implementation dates, to ensure accurate Medicare claims processing.

Background

The remittance advice remark code list is one of the code lists mentioned in the ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG). This list is maintained by the Centers for Medicare & Medicaid Services (CMS) and is updated three times a year.

The complete list of current codes is available online at the WPC website: *http://www.wpc-edi.com/codes/Codes.asp*.

The Claim Adjustment Reason Code and Status Code Maintenance Committee maintains the health care claim adjustment codes. The Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and decides on any additions, modifications, or retirement of reason codes. The updated list is posted three times a year and the complete list of current codes is available online at the WPC website: *http://www.wpc-di.com/codes/Codes.asp*.

Additional Information

The most recent changes approved for the remittance advice remark codes and the claim adjustment reason codes can be found in the official instruction issued to your fiscal intermediary or carrier, including durable medical equipment regional carriers (DMERCs). That official instruction is found in CR 3466, which is available at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

Once at that page, scroll down the CR NUM column on the right to find the link for CR 3466. Click on the link to open and view the file for the CR.

The CR attachments also include information on the process of decision-making that results in updates to the X12N 835 Health Care Remittance Advice Remark Codes and the X12 N 835 Health Care Claim Adjustment Reason Codes. It also includes a table of changes; however, please note that the most current and complete list is online at the WPC website. This CR includes changes made only from March through June of 2004.

If you have questions regarding this issue, you may also contact your fiscal intermediary or carrier at their toll free number at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

Related Change Request (CR) Number: 3466
Related CR Release Date: October 15, 2004
Related CR Transmittal Number: 313
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 313, CR 3466

Fiscal Intermediary 835 Flat File and Companion Document Change

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Providers who bill fiscal intermediaries (FIs)

Provider Action Needed

Be advised that a new field has been added to the FI Part A 835 flat file to accommodate the forced balancing amount in the standard paper remittance (SPR). In addition, the FI companion document has been changed to show that the total HCPCS reported charges amount in TS317 equals the sum of all reported charges with the HC qualifier.

Background

HIPAA transactions must comply with the implementation guides. The Centers for Medicare & Medicaid Services (CMS) policy is to make the standard paper remittance advice mimic the electronic remittance advice for those data elements contained in both the standard paper remittance (SPR) and the electronic remittance advice (ERA).

Changes in the Fiscal Intermediary Flat File to Accommodate the Forced Balancing Amount in the SPR

The forced balancing amount that is sometimes used to balance the SPR is reported in the ERA, and the SPR needs to expand to create the appropriate space for this information. Thus, the SPR report format will be modified to include a new field; the presumptive payment adjustment (PRE PAY ADJ) field will be added below the interest field in Part A and Part B claim detail sections.

FIs will place A7 (Presumptive Payment Adjustment) in the reason code field to reflect the forced balancing amount in the SPR.

Changes in the FI Companion Document

The FIs will ensure that the total HCPCS reported charge amount in TS317 is equal to the sum of reported charge amount(s) when the qualifier is HC.

Additional Information

The official instruction issued to the intermediary regarding this change can be found online at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

On the above online page, scroll down while referring to the CR NUM column on the right to find the link for CR 3344. Click on the link to open and view the file for the CR. A sample of the SPR is attached to the CR to illustrate these changes.

You may also refer to related CRs 1522, 1828, 1959, and 2233.

If you have questions regarding this issue, you may also contact your fiscal intermediary on their toll free number, which is available at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

Related Change Request (CR) Number: 3344
Related CR Release Date: July 23, 2004
Related CR Transmittal Number: 252
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 252, CR 3344

Guidance for Part A Providers Switching to Electronic Remittance Advices

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Providers who bill fiscal intermediaries (FIs).

Provider Action Needed

This Special Edition reminds providers that FIs are prohibited from sending providers standard paper remittance (SPR) advices if the providers have switched to receiving electronic remittance advices (ERAs). This is effective the 31st day after providers switch to the ERAs.

Background

The Centers for Medicare & Medicaid Services (CMS) issued the Medicare Part A Implementation Guide 4A.01 for the ANSI ASC X12 835 Version 003051 Electronic Remittance Advice as a tool to provide assistance in the development and execution of the electronic transfer of remittance advice data and/or payment. The purpose of implementing the electronic RA is to expedite the goal of achieving a totally paperless claims processing and payment system.

The *Medicare Claims Processing Manual, Publication 100-4, Chapter 22, Section 40.1*, states that FIs can allow providers to receive a hard copy remittance in addition to the ERAs during the first 30 days of receiving the ERAs and during other testing. After that time, FIs cannot send an SPR to providers in addition to the electronic transmission. This same requirement was included in the Medicare Intermediary Manual, the predecessor of the current manual, for more than five years.

CMS recently issued a memorandum to its FIs when it came to their attention that FIs were not adhering to these requirements. The memorandum states that by January 1, 2005, FIs must terminate the issuance of SPRs to those providers (or billing agents, clearinghouses, or other entities representing providers) currently receiving ERAs and begin enforcing the termination of SPRs effective with the 31st day after providers switch to the ERA.

Guidance for Part A Providers Switching to Electronic Remittance Advices (continued)

Additional Information

For more information on ERAs, refer to the Medicare Part A Implementation Guide 4A.01 for the ANSI ASC X12 835 Version 003051 Electronic Remittance Advice, which can be found at: *http://www.cms.hhs.gov/providers/edi/introset.pdf*.

You may also refer to Chapter 22 of the *Medicare Claims Processing Manual*, *Publication 100-4*, which can be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104c22.pdf*.

If you have any questions regarding this issue, you may also contact your FI at their toll free number, which is available at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

To speak to your FI's contact regarding a switch to ERAs, contact your FI's Electronic Data Interchange coordinator. Their phone number may be found at: *http://www.cms.hhs.gov/providers/edi/anum.asp*.

Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: January 1, 2005

Source: CMS Medlearn Matters Special Edition SE0447

Guidance Regarding Elimination of Standard Paper Remittance Advice Notices in the Old Format

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All Medicare physicians, providers, and suppliers.

Provider Action Needed

Be advised that only the most recent version of the standard paper remittance (SPR) advices will be used. The 835 version 4010A1 flat file is the appropriate format to produce SPRs. Also, no data may be included in paper remittance advices that are not included in an electronic remittance advice (ERA).

Background

The Centers for Medicare & Medicaid Services (CMS) prohibits the inclusion of data in paper remittance advice notices that is not included in the ERA transactions. The most recent version of the SPR advice and the ERA contain the same information in the comparable fields and date elements, including the same codes. The same flat file is supposed to be used to produce both the SPR and 835 version 4010A1 ERA.

CMS has issued a memorandum to all Medicare fiscal intermediaries and carriers, including durable medical equipment regional carriers, and regional home health and hospice intermediaries, stating that, effective January 1, 2005, only the 835 version 4010A1 flat file is to be used to produce the SPRs; no other format for SPRs will be used.

Additional Information

Refer to Chapter 22 of the Medicare Claims Processing Manual, Publication 100-4, which can be found online at: *http://www.cms.hhs.gov/manuals/104_claims/clm104c22.pdf*.

Additional information regarding the fiscal intermediary Part A 835 flat file, including a sample of the most recent SPR format, is available in CR 3344. You may view that CR at: *http://www.cms.hhs.gov/manuals/pm_trans/R252CP.pdf*.

If you have any questions regarding receipt of or conversion to ERAs, please contact your intermediary or carrier. If you bill an intermediary, their number may be found at: *http://www.cms.hhs.gov/providers/edi/anum.asp*.

If you bill a carrier, the number may be found at: *http://www.cms.hhs.gov/providers/edi/bnum.asp*.

Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: January 1, 2005

Source: CMS Medlearn Matters Special Edition SE0451

FRAUD AND ABUSE

CMS Program Integrity Initiative

August 30, 2004

The Centers for Medicare & Medicaid Services (CMS) today announced efforts to protect the nation's largest federal health programs through the use of enhanced tools that will help to better identify and reduce fraud and abuse and prevent improper payments.

CMS is building on its current program integrity efforts by increasing the use of claims data and further analyzing that information to more efficiently detect improper payments, vulnerabilities in all Medicare and Medicaid programs, and potential areas of fraud and abuse. CMS seeks to use its analysis to more effectively educate providers and beneficiaries in an effort to prevent and minimize waste, fraud, and abuse. CMS' program integrity efforts are being expanded beyond fee-for-service Medicare to also encompass oversight of the discount drug card program, Part D prescription drug benefit and the new Medicare Advantage plans. CMS will also continue to focus on program integrity efforts relating to the Medicaid program.

CMS is also taking a number of steps to enhance its program integrity efforts in response to the increased programmatic responsibilities assumed under the MMA and the demonstrated need for more coordinated efforts to identify and correct program vulnerabilities (as illustrated by the increase in power wheelchair spending and with hospital outliers).

Increased Oversight Role to Protect the Medicare Trust Funds

- The enhanced CMS Program Integrity oversight extends beyond fee-for-service Medicare and will now include the Medicare-Approved Drug Discount Card Program, the new Medicare prescription drug benefit and the Medicare Advantage plans.
- CMS has contracted with IntegriGuard, a program safeguard contractor (PSC), to monitor activities associated with drug cards. A critical task of this PSC is a weekly assessment of the sponsor's drug pricing information to identify any "bait and switch" activities. Additionally the PSC will be working to identify fraudulent activities surrounding the discount drug card program including counterfeit drug cards and identity theft schemes.
- CMS is also continuing to work with law enforcement agencies to aggressively pursue all cases where companies posing as drug card sponsors have compromised Medicare beneficiaries.

Increased Oversight of the Medicaid Program

CMS is expanding the Medicare-Medicaid (Medi-Medi) match program where claims data from both programs is analyzed together to detect patterns that may not be evident when billings for either program are viewed in isolation. As a result of combining the data, CMS can identify previously undetected patterns, such as "time bandits," providers who bill for a total of more than 24 hours in a day in both programs. This project allows CMS to identify vulnerabilities in both programs and work with the states, where appropriate, to take action to protect the federal share of Medicaid dollars. CMS' goal is to ultimately review this data in "real time."

- The Medi-Medi program began in 2001 with the State of California. After two years of data matching and expansion to six more states, this program has posted results of $75 million worth of cost avoidance, identification of program vulnerabilities, savings, and recoupments. More than 90 cases have been referred to federal and state law enforcement agencies that are in various stages of development and/or ongoing investigation. Given its success in the first seven states, CMS is expanding the Medicare and Medicaid data evaluation to the states of Ohio and Washington. Federal expenditures in these states exceed $28 billion.
- Expansion of the Medicare-Medicaid match project will also help in better oversight of prescription drug fraud since many Medicaid prescription drug beneficiaries will see their drug benefits through Medicare beginning in 2006.
- To support one of CMS' top priorities, combating fraud, waste, and abuse in the Medicare-Medicaid provider enrollment process, a workgroup has been established that explored the feasibility of coordinating the Medicare and Medicaid provider enrollment processes in ways that increase the overall effectiveness and efficiency of those systems. A pilot project involving three states began in fiscal year 2004. The intent of this project was to produce a "one-stop" or a combined provider enrollment form applicable to both programs. This effort has been very successful and has resulted in identifying efficiencies that have been beneficial to both programs.

CMS has issued a proposed regulation calling on states to report improper payments in Medicaid and State Children's Health Insurance programs to HHS. Under the proposed rule, which is open for public comment until September 27, CMS will require states to estimate these improper payments by reviewing a monthly sample of Medicaid and SCHIP claims. This information will be used to determine the accuracy of the payments based on whether the individual was eligible for the program, medical review and data processing. Once CMS receives this information from all 50 states and the District of Columbia the national error rate will be calculated. The regulation can be found at In addition to announcing its enhanced steps to analyze program data, CMS today issued a proposed regulation calling on states to report improper payments in Medicaid and State Children's Health Insurance programs to HHS.

CMS Program Integrity Initiative (continued)

Under the proposed rule, which is open for public comment until September 27, CMS will require states to estimate these improper payments by reviewing a monthly sample of Medicaid and SCHIP claims. This information will be used to determine the accuracy of the payments based on whether the individual was eligible for the program, medical review and data processing. Once CMS receives this information from all 50 states and the District of Columbia the national error rate will be calculated. (The proposed rule can be found at: *http://a257.g.akamaitech.net/7/257/2422/06jun20041800/edocket.access.gpo.gov/2004/04-19603.htm*.)

Greater Emphasis on Identifying, Responding to and Resolving Problems

- Building on its current data collection efforts, CMS will increase the use of electronic data to more efficiently detect improper payments, program vulnerabilities, and potential areas of fraud and abuse in both the Medicare and Medicaid programs.
- CMS is tracking and trending Medicare and Medicaid claims data on a national level so it can identify problems at the health care provider and service specific levels. This information can be used to proactively identify potential problematic utilization spikes so that their underlying cause can be determined.
- CMS is monitoring this information and work across the Agency to identify program vulnerabilities faster and more efficiently so problems can be addressed and possibly resolved through additional provider education and informational efforts.
- Through the collection and analysis of these data, CMS will be better able to effectively use provider and beneficiary education efforts to prevent and minimize waste, fraud, and abuse. CMS will continue to work closely with the Medicare contractors, the private companies that process and pay Medicare claims, to make sure appropriate education and guidance is given to the provider community on billing problems identified.

Expansion of Existing Successful Oversight Efforts

- A new CMS satellite office is being established in Los Angeles to reduce the unusually high rates of improper payments identified in the Medicare and Medicaid programs in California. Current CMS oversight efforts have identified many storefront operations set up to defraud the Medicare and Medicaid programs by billing for services never provided. CMS already has a satellite office in Miami that has been very successful in identifying fraudulent activities in that area.
- In addition to continuing the Comprehensive Error Rate Testing (CERT) program, which has successfully helped to reduce the Medicare national paid claims error rate from 14 percent in 1996 to 5.8 percent in 2003, CMS is implementing an initiative to determine the payment error rate for the Medicaid program and the State Children's Health Insurance Program. Combined, these programs will allow CMS to be able to identify and respond to improper payments quickly thereby stopping taxpayer dollars from going out the door. Through the work of the CERT program, CMS is able to better target problem areas and take the appropriate corrective action.

Source: CMS website, Headlines dated August 30, 2004

OIG Alert About Charging Extra for Covered Services

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed

Participating physicians, suppliers, and providers who consider charging Medicare patients additional fees should be mindful that they are subject to civil money penalties if they request any payment for already covered services from Medicare patients other than the applicable deductible and coinsurance.

Background

On March 31, 2004, the Office of the Inspector General (OIG) issued an alert that focused on physicians charging extra for services covered by Medicare. The alert noted that these extra contractual charges beyond Medicare's deductible and coinsurance constituted a potential assignment violation.

In the alert, the OIG reminded Medicare participating physicians of the potential liabilities posed by billing Medicare patients for services that are already covered by Medicare. Charging extra fees for already covered services abuses the trust of Medicare patients by making them pay again for services already paid for by Medicare.

Medicare participating providers can charge Medicare beneficiaries extra for items and services that are not covered by Medicare. In addition, participating providers may charge beneficiaries for any Medicare deductibles and coinsurance without violating the terms of their assignment agreements.

However, when participating providers request added payment for covered services from Medicare patients, they are liable for substantial penalties and exclusion from Medicare and other federal health care programs. The special services for added payment are known by various names and may include "concierge care," "boutique medicine," "retainer practice," or "platinum practice."

For example, the OIG recently alleged that a physician violated his assignment agreement when he offered his patients, including Medicare beneficiaries, a "Personal Health Care Medical Care Contract" that required payment of an annual $600 fee. The physician characterized the services to be provided under the contract as "not covered"

OIG Alert About Charging Extra for Covered Services (continued)

by Medicare, and the services offered under this contract included:

- Coordination of care with other providers;
- A comprehensive assessment and plan for optimum health; and
- Extra time spent on patient care.

The OIG alleged that based on the specific facts and circumstances of this case, at least some of these contracted services were already covered and reimbursable by Medicare. Therefore, OIG alleged that each contract presented to this physician's Medicare patients constituted a request for payment for already covered services, other than the coinsurance and deductible, and was therefore a violation of the physician's assignment agreement. To resolve these allegations, the physician agreed to pay a settlement amount to the OIG, and to stop offering these contracts to his patients.

Participating physicians, suppliers, and providers who consider charging Medicare patients additional fees are reminded that they are subject to civil money penalties if they request any payment for already covered services from Medicare patients other than the applicable deductible and coinsurance.

Note that a participating provider is a provider of Medicare covered items and services who agrees to accept the Medicare-approved charge for all covered services to Medicare patients. A participating provider "accepts assignment" for all Medicare-payable services.

Also note that non-participating providers may also be subject to penalties and exclusion for overcharging beneficiaries for covered services. This is true whether the provider accepts assignment for a given service or not, in which case the provider's charge is limited to the "limiting charge."

Related Instructions

The Physicians Information Resource for Medicare website is extensive and includes information about Medicare Participation, Participating Physician Directory, Policies and Regulations, including the CMS Quarterly Provider Update, Medicare Coverage Issues Manual, Medicare National Determination Manual, Physician Fee Schedule, Practicing Physician Advisory Council, Medicare Learning Network, and much more. This website can be found at: *http://www.cms.hhs.gov/physicians/*.

Additional Information

The OIG Alert, dated March 31, 2004 and titled "OIG Alerts Physicians About Added Charges for Covered Services," can be found at the following website: *http://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA033104AssignViolationI.pdf*.

Related Change Request (CR) Number: N/A
Release Date: N/A

Source: CMS Special Edition Medlearn Matters SE0421

EDUCATIONAL RESOURCES

Information and Education Resources for Medicare Providers, Suppliers, and Physicians

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All Medicare physicians, providers, and suppliers

Provider Action Needed

This article is informational only and is intended to notify Medicare physicians and other providers about the information and education resources that the Centers for Medicare & Medicaid Services (CMS) have developed to help meet their Medicare business needs.

Background

One of the goals of CMS is to give Medicare's 1.2 million physicians and other providers the information they need to understand the program, be aware of changes, and bill correctly. By making information and education resources easily accessible, understandable, and as timely as possible, physicians and other providers will be better able to submit bills correctly the first time, receive reimbursements more quickly, and spend less time dealing with paperwork. All of this can result in more time to spend on patient care.

We are committed to accomplishing this goal by offering Medicare physicians and other providers a variety of educational products and services and using various information delivery systems to reach the broadest and most appropriate audiences possible.

Three-Pronged Provider Information and Outreach Approach

CMS relies on the cooperative efforts of its Medicare contractors, regional offices, and central office provider communications staff to deliver a seamless information and outreach approach to Medicare physicians and other providers.

1) **Medicare Contractors**
Medicare contractors, also called fiscal intermediaries and carriers, serve as the primary point of contact for most Medicare physicians and other providers. These contractors provide toll-free telephone lines for inquiries, conduct outreach and education, and often interact with local professional associations. Their outreach and education activities include in-person seminars, bulletins and newsletters, speaker listservs (mailing lists).
If you have questions about the Medicare Program, you should first get in touch with your fiscal intermediary or carrier. To find fiscal intermediary and carrier contact information, please visit: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

   The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Centers is 1-877-602-8816.

2) **CMS Regional Offices**
Staff at CMS regional offices provide oversight of Medicare contractors and play a key role in resolving issues that physicians and other providers cannot get resolved. Our regional offices are active with the physician and other provider communities at state and local levels through their relationships with state and local associations and big billers, and through outreach activities such as hosting provider-oriented meetings, and furnishing speakers at professional conferences. CMS regional offices are located at various locations around the country. You can find their contact information at: *http://www.cms.hhs.gov/about/regions/professionals.asp*.

3) **CMS Central Office in Baltimore, Maryland**
The provider communication staff at the CMS central office works closely with both Medicare contractor and regional office staff to ensure that consistent and coordinated Medicare information and resources are available to all physicians and other providers. Education and outreach activities from the CMS central office are generally targeted to national associations with consistency and timeliness as our top priorities.

Given the hectic schedules of today's health care professionals, most of our current initiatives are aimed at fostering a "self-service" environment so that physicians and other providers can access information and education 24 hours a day, seven days a week. As a result, we have significantly increased the use of the Internet as a key tool for continuous-improvement customer service.

Our efforts have resulted in a variety of products and services, such as:

- **Medlearn Matters Articles –** One of the best sources for the latest Medicare information is "Medlearn Matters…Information for Medicare Providers" national articles, which are available at *http://www.cms.hhs.gov/medlearn/matters*. These articles are designed to give physicians and other providers and their staff easy to understand information related to new and recently changed Medicare rules and policies. The articles are written in consultation with clinicians and billing experts and focus on how these changes affect physician and other provider business functions. On the Medlearn Matters Web page, you'll find a searchable table for easy access to each article and its corresponding program instructions, if applicable. You can join the Medlearn Matters listserv to receive electronic notification when new articles are released. Medicare contractors also publish Medlearn Matters articles in their bulletins and on their websites. This CMS central office initiative serves to enhance and support contractors' local provider education efforts by promoting the availability of nationally consistent educational materials.

Information and Education Resources for Medicare Providers, Suppliers, and Physicians (continued)

- **Medicare Learning Network** – The Medlearn Matters articles are part of a broader inventory of physician and other provider educational products found under the Medicare Learning Network. The Medicare Learning Network is the brand name for official CMS physician and other provider educational products and is designed to promote national consistency of Medicare provider information developed for CMS initiatives. Products range from Web-based training courses, comprehensive training guides, brochures, and fact sheets to CD-ROMs and videos. All MLN products are free of charge and can be ordered or downloaded from the Medlearn Web page located at *http://www.cms.hhs.gov/medlearn*, which also gives easy access to other resources such as educational Web guides, electronic listservs, and provider-specific Web pages. Check back often for the latest products, resources, and provider-oriented links.
- **CMS Provider Web Pages** – CMS has designed provider-specific Web pages to assist individual physician and other provider types in obtaining information relevant to them more quickly. These Web pages are a customized, one-stop Web-based resource for the provider, supplier, and physician audience that also includes highlights on items such as new regulations and hot topics, links to general information on enrollment, billing, conditions of participation, publications, education, data, and statistics, and links to "specialty" information. For example, the Medicare Physician Web Page at *http://www.cms.hhs.gov/physicians* includes links to the Medicare Physician Fee Schedule Look-Up Tool, National Correct Coding Initiative edits, Practicing Physicians Advisory Council, Physicians Regulatory Issues Team, Medicare Coverage Database, and the CMS On-line Manual. We also have Specialty Physician Web Pages where we will continue to add links of special interest to physician specialties. The first Specialty Physician Web Page, "Medicare Information for Anesthesiologists," is available at *http://www.cms.hhs.gov/physicians/anesthesiologist/default.asp*.

From the CMS home page at *http://www.cms.hhs.gov*, you can access select physician and other provider pages from the "Professionals" drop-down menu. You can also see a complete listing of available provider and supplier Web pages by clicking on *http://www.cms.hhs.gov/providers* or *http://www.cms.hhs.gov/suppliers*. All pages have a comment section for you to electronically submit suggestions. We are always adding new pages, so check the site often.

- **Other Popular Provider Web Pages –** In addition to the pages mentioned above, other frequently visited pages include the CMS Online Manual System at *http://www.cms.hhs.gov/manuals*; the CMS Quarterly Provider Update at *http://www.cms.hhs.gov/providerupdate*, which gives a listing of regulations and major policies currently under development during the quarter, regulations and major policies completed or cancelled, and new or revised manual instructions; the Medicare Coverage home page at *http://www.cms.hhs.gov/coverage*, which contains complete coverage information including links to CMS coverage databases, frequently asked questions, and "What's New" lists.
- **Listserv Messages –** CMS has a number of listservs that transmit important Medicare notices and reminders to subscribers. For example, listservs have been established for most provider-specific Web pages as well as for updates on the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the Medicare Learning Network, and the Quarterly Provider Update. To view and subscribe to one or more listserv, please visit *http://www.cms.hhs.gov/mailinglists*.
- **Open Door Forums –** CMS is very interested in hearing from and interacting with the physicians and other providers who deliver quality health care to our nation's beneficiaries. We continue to emphasize our responsiveness through an ongoing series of Open Door Forums that provide an environment for interactive dialogue. Forums are chaired by senior-level agency officials and co-chaired by CMS regional office officials. For more information, please visit *http://www.cms.hhs.gov/opendoor*.
- **Exhibit Program –** CMS hosts exhibit booths at provider, supplier, and physician association meetings. The CMS Exhibit Program provides an excellent opportunity for CMS central and regional office staff to have direct contact with the Medicare provider, supplier, and physician community to listen to issues, concerns, and challenges and to share timely and relevant information. If you are interested in having a CMS exhibit at your national conference, please contact David Clark at dclark@cms.hhs.gov.

Physician and Other Provider Feedback

Although we try our best to be responsive to the Medicare physician and other provider community's education and information needs, we can't do it alone. Your feedback on the effectiveness and usefulness of our educational resources is very important to us as it helps ensure that we are "getting it right." Please submit your comments or suggestions at *http://www.cms.hhs.gov/providers* by selecting "Feedback" from the blue template located at the top of the page. There is also a feedback link on the Medlearn Web pages for your suggestions on new educational products at *http://www.cms.hhs.gov/medlearn/suggestform.asp*. We look forward to hearing from you.

Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Medlearn Matters Special Edition SE0454

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A

B

C

C (continued)

D

M (continued)

N

O

O (continued)

P

R

S

T

T (continued)

U

V

W

IMPORTANT ADDRESSES , TELEPHONE NUMBERS AND WEB SITES

Addresses

CLAIMS STATUS
Coverage Guidelines
Billing Issues Regarding
Outpatient Services, CORF, ORF, PHP
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

APPEAL RECONSIDERATIONS
Claim Denials (outpatient services only)
Medicare Fair Hearings (Part A)
P. O. Box 45203
Jacksonville, FL 32232-5203

MEDICARE SECONDARY PAYER (MSP)
Information on Hospital Protocols
Admission Questionnaires
Audits
Medicare Secondary Payer
Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

General MSP Information
Completion of UB-92 (MSP Related)
Conditional Payment
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Automobile Accident Cases
Settlements/Lawsuits
Other Liabilities
Medicare Secondary Payer Subrogation
P. O. Box 44179
Jacksonville, FL 32231-4179

PROVIDER EDUCATION
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Seminar Registration Hotline
1-904-791-8103

ELECTRONIC CLAIM FILING
"DDE Startup"
Direct Data Entry (DDE)
P. O. Box 44071
Jacksonville, FL 32231-4071

FRAUD AND ABUSE
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

REVIEW REQUEST
Denied claims that may have been payable under the Medicare Part A program
Medicare Part A Reconsiderations
P. O. Box 45053
Jacksonville, FL 32232-5053

OVERPAYMENT COLLECTIONS
Repayment Plans for Part A Participating Providers
Cost Reports (original and amended)
Receipts and Acceptances
Tentative Settlement Determinations
Provider Statistical and Reimbursement (PS&R) Reports
Cost Report Settlement (payments due to provider or Program)
Interim Rate Determinations
TEFRA Target Limit and Skilled Nursing Facility Routine Cost Limit Exceptions
Freedom of Information Act Requests (relative to cost reports and audits)
Provider Audit and Reimbursement Department (PARD)
P.O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

MEDICARE REGISTRATION
American Diabetes Association Certificates
Medicare Registration – ADA
P. O. Box 2078
Jacksonville, FL 32231-2078

Telephone Numbers

PROVIDERS
Customer Service Center Toll-Free
1-877-602-8816
Speech and Hearing Impaired
1-877-660-1759

BENEFICIARY
Customer Service Center Toll-Free
1-800-MEDICARE
1-800-633-4227
Speech and Hearing Impaired
1-800-754-7820

ELECTRONIC MEDIA CLAIMS
EMC Start-Up
1-904-791-8767, option 4

Electronic Eligibility
1-904-791-8131

Electronic Remittance Advice
1-904-791-6865

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

PC-ACE Support
1-904-355-0313

Testing
1-904-791-6865

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

Medicare Web Sites

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

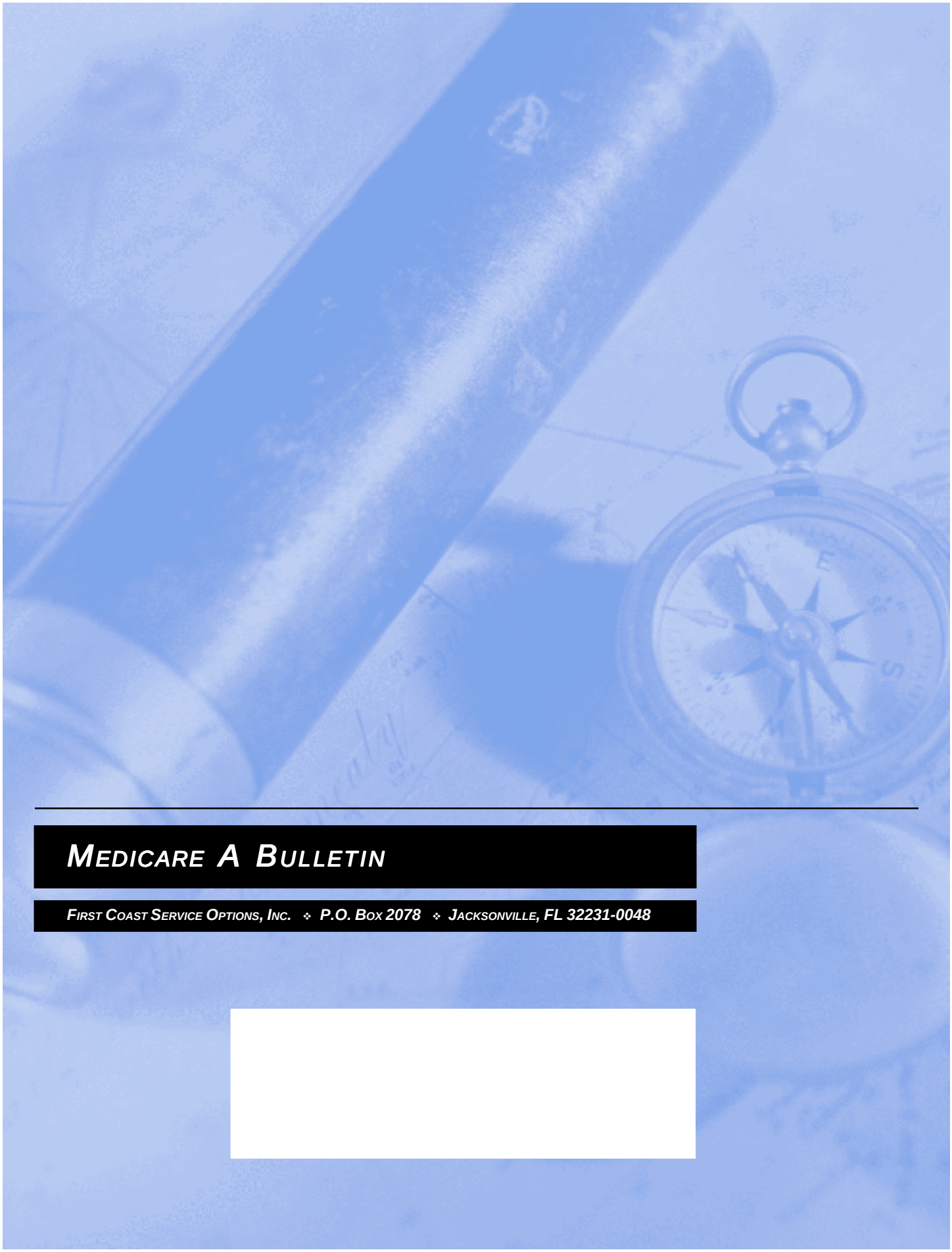
BENEFICIARIES
Centers for Medicare & Medicaid Services
www.medicare.gov

Other Important Addresses

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

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)
Durable Medical Equipment Claims
Orthotic and Prosthetic Device Claims
Take Home Supplies
Oral Anti-Cancer Drugs
Palmetto Goverment Benefit Administrators
P. O. Box 100141
Columbia, SC 29202-3141

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



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