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

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A Physician's Focus

Combating Fraud and Abuse in the Medicare Program—A Provider Responsibility Too

The complexity of our current health care system precludes one from overreacting to reports of health care fraud and abuse. The Medicare program alone has over 100,000 pages of regulations that make billing errors problematic. Most Medicare billing errors are mistakes and are not the result of physicians, providers, or suppliers trying to take advantage of the Medicare system. The limited resources of the Department of Justice should be directed at those who violate the simple definition of fraud and abuse – lying, stealing, and cheating. However, the demands of the health care delivery system and the Medicare claim administration can sometimes seem to overlap the legal, ethical, and business obligations of physicians, providers, and suppliers.

Recognizing the conflicting incentives, Congress has set up information gathering for the public and specific stakeholders. The Department of Health and Human Services (DHHS) Office of Inspector General (OIG) conducts audits and investigations of the Medicare program with the goal of working with decision makers to minimize fraud and abuse. The OIG fiscal year 2004 work plan includes aspects of many common episodes of care such as inpatient hospital DRG (diagnosis related group) coding, inpatient rehabilitation payments, diagnostic testing in the emergency room, coding of E/M (evaluation & management) services, and services and supplies incident to physicians' services such as injectable drugs, to name a few (*http://oig.hhs.gov*). The OIG also detects abusers of Medicare and other HHS programs so appropriate remedies, including criminal investigations may be initiated.

The Centers for Medicare & Medicaid Services (CMS) uses its authority under the Medicare Integrity Program to contract with organizations to specifically address issues of Medicare fraud and abuse. These program safeguard contractors (PSCs) focus on developing fraud cases for referral to the OIG, responding to requests for Medicare data and support from law enforcement entities, and identifying and reporting program vulnerabilities to CMS. PSCs also work with the traditional Medicare contractors (now known as affiliated contractors [ACs]).

As an affiliated contractor, First Coast Service Options, Inc. (FCSO) administers the day-to-day operation of claim payment for Medicare Part A and B in Florida, and Part B for Connecticut based in Florida. FCSO has the responsibility to pay the right amount for covered, medically necessary, and correctly coded services rendered to eligible beneficiaries by properly enrolled providers.

FCSO also has responsibilities of coordinating and communicating information with external partners, including PSCs and law enforcement agencies. Information on possible fraud and abuse cases comes from multiple sources including data analysis, provider or beneficiary complaints, and provider failure to respond to persistent education efforts on medical review.

The basics of fraud and abuse (lying, stealing and cheating) are not the purview of routine medical review. **Fraud** is defined as intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The term **abuse** describes incidents or practices of providers that are inconsistent with accepted sound medical practice. Abuse may directly or indirectly result in unnecessary costs to the program, improper reimbursement, or program reimbursement for services that fail to meet professionally recognized standards of care or which are medically unnecessary. The type of abuse to which Medicare is most vulnerable is overutilization of medical services.

An example of a FCSO referral to the PSC for fraud and abuse is the extraordinary utilization of Rho (D) immune globulin specific to certain providers in Florida. Despite investigations and interventions by the PSC, TriCenturion, Inc, excessive utilization persisted in 2003. In the second half of 2003, the Florida carrier/nation ratio was 14.44 for Rho (D) immune globulin (1400+% more $ per beneficiary compared to other states.). Florida was 97 percent of the allowed nation dollars (153 million dollars) and these dollars were limited to certain providers. Queries to clinical experts using the drug in similar episodes of care found no justification for the utilization patterns.

Whether this overpayment is ever recouped and future abuse curtailed depends not only on good case development by the appropriate authorities and proactive contractor interventions, but also on the support of the provider community. Health care professionals such as physicians, nurses, administrators, executives, and others must seek to clarify legal, ethical, and business obligations especially if the incentives are clearly conflicting. Improving health care is a serious and continuing responsibility, and profitability can never be the driver for a service that has uncertain or no value for a patient. Also, physicians as the drivers of the patient-physician relationship have a responsibility beyond health care industry standards in ensuring balance, coordination, comprehensiveness, safety, and openness when addressing patient care. FCSO salutes the vast majority of physicians and allied providers that *do the right things the right way*.

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About *The Medicare A Bulletin*

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

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

Important notifications that require communication in between these dates will be posted to the First Coast Service Options, Inc. (FCSO) Florida provider education Web site *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:

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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

Group Health Plan Payment System for Medicare Disease Management Demonstration Serving Medicare-Fee-for-Service Beneficiaries

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

Provider Types Affected

All Medicare providers

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) has begun a four-state Medicare Disease Management Demonstration to improve care for chronically ill Medicare fee-for-service beneficiaries who suffer from advanced stage heart disease or diabetes. The disease management programs that are currently enrolling beneficiaries are: CorSolutions in Lousiana; XLHealth in Texas; and HeartPartners in California and Arizona.

These disease management organizations are not HMOs, but are being paid, using the CMS group health system, a fixed monthly payment for disease management services as an "Option 1" cost plan. All fee-for-service claims will continue to be processed under traditional Medicare payment rules.

Beneficiaries enrolled in these demonstrations will be considered covered under the traditional Medicare fee-for-service program. Participants in the demonstration are not restricted in any way as to how they receive their other Medicare services.

> The Medicare beneficiaries participating in the Medicare Disease Management Demonstration are **NOT** enrolled in an HMO; they should be treated as traditional fee-for-service beneficiaries. No referrals for care are needed and all fee-for-service claims will be processed under traditional Medicare payment rules.

Background

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 mandated this demonstration to evaluate how disease management services, combined with a prescription drug benefit, can improve the health outcomes of Medicare beneficiaries diagnosed with advanced-stage illness from congestive heart failure, diabetes, or coronary heart disease.

Up to 30,000 eligible Medicare fee-for-service beneficiaries will be enrolled in the treatment arm of the study during the three-year project in California, Arizona, Louisiana, and Texas.

The project will help Medicare:

- Find better ways to improve the quality of life for people with diabetes and chronic heart disease;
- Determine the benefits of disease management programs for chronically ill persons; and
- Find ways to make these services available to people with Medicare.

Participants will be assigned to either a disease management group or a usual care group. The disease management group will receive disease management services and prescription drug benefits in addition to their usual Medicare benefits at no additional cost except for a modest co-payment for prescription drugs.

All participants remain in the traditional fee-for-service Medicare program under the care of their own doctor. The program is voluntary and the decision whether or not to participate does not affect Medicare benefits.

Demonstration Locations

Louisiana – CorSolutions will be providing services to 5,000 Medicare beneficiaries with congestive heart failure, diabetes, and/or coronary heart disease residing in the Shreveport – New Orleans corridor of Louisiana. (Questions? Call 1-800-917-2204).

Texas – XLHealth will be providing services to 10,000 Medicare beneficiaries with congestive heart failure (CHF), cardiovascular disease (CVD), or diabetes with co-morbidities of CHF, CVD or lower extremity complications in Texas. (Questions? Call 1-888-284-0001).

California and Arizona – HeartPartners℠ (collaboration among PacifiCare Health Systems, Qmed, and Alere Medical) will be providing services to 15,000 Medicare beneficiaries with congestive heart failure in California and Arizona. (Questions? Call 1-866-242-3432).

Medicare Common Working File Inquiry Screens

When confirming eligibility of a beneficiary participating in the Medicare Disease Management Demonstration, the common working file screens will display a line item indicating enrollment in an "Option 1" HMO Cost Plan. The definition of "Option 1" means that Medicare is still primary and fee-for- service benefits are covered; no referrals for care are needed. Claims continue to be processed by Medicare as primary under the traditional fee-for-service program. ❖

Related Change Request (CR) Number: N/A
Effective Date: N/A – Informational Only

Source: CMS Medlearn Matters Special Edition SE0425

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Reminder to Providers to Supply Information to Medicare's Comprehensive Error Rate Testing Program

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

Provider Types Affected

All Medicare providers.

Provider Action Needed

Providers are reminded that they must comply with requests from Medicare contractors for medical records needed for the comprehensive error rate-testing (CERT) program.

Background

The CERT program produces national, contractor-specific, and service-specific paid claim error rates, as well as a provider compliance error rate. The paid claim error rate is a measure of the extent to which the Medicare program is paying claims correctly. The provider compliance error rate is a measure of the extent to which providers are submitting claims correctly. The program uses independent reviewers to review representative random samples of Medicare claims (including both paid claims and denied claims) to ensure that the decision was appropriate.

The CERT process begins at the affiliated contractor (AC) – your Medicare carrier or intermediary processing site – where claims have entered the Medicare claim processing system. The CERT contractor randomly selects and extracts claims from the claim processing system each day. The CERT contractor obtains medical records from providers (or from the AC, if the AC had previously subjected the claim to manually medical review).

The CERT contractor requests medical records from providers in a written format, including a checklist of the types of documentation required. In addition, the CERT contractor follows up on written requests with phone calls to providers. Providers must submit documentation to the CERT Operations Center via fax or by mail at the number/address specified in the *Additional Information* section below.

Although providers are required to send documentation to support claims as part of the CERT process, many providers do not comply with this requirement. Providers may believe that it is a HIPAA violation to send patient records to CERT, they may not understand the CERT process, or they may not understand the importance of sending documentation in a timely fashion. It is, however, important to respond in a timely fashion to CERT requests and to provide the CERT contractor with all applicable medical records used to support a sampled claim.

If providers do not respond to initial CERT requests for medical records, they will receive up to four letters and three phone calls from the CERT contractor. Providers who fail to submit medical documentation to the CERT contractor should expect to receive overpayment demand letters from their AC, as services for which there is no documentation are interpreted as services not rendered.

Additional Information

The fax numbers for the CERT contractor are:

804-864-3268
804-864-9940
804-864-9979

You can also mail documentation to:

AdvanceMed
CERT Operations Center
1530 E. Parham Road
Richmond, VA 23228

If you have questions regarding this process, 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 representatives is 1-877-602-8816.

To learn more about the CERT program, you can view the manual instructions issued to your carrier/intermediary under CR 2976 by visiting: *http://www.cms.hhs.gov/manuals/pm_trans/R67PI.pdf*.

Recently, CMS issued additional clarifications (CR 3229) to your carrier/intermediary. To view these clarifications, visit: *http://www.cms.hhs.gov/manuals/pm_trans/R77PI.pdf*.

To find future CERT manual instructions issued to your carrier/intermediary, visit: *http://www.cms.hhs.gov/manuals/108_pim/pim83c12.pdf*. ❖

Related Change Request (CR) Number: 2976
Related CR Release Date: February 27, 2004
Related CR Transmittal Number: 67
Effective Date: March 12, 2004
Implementation Date: March 12, 2004

Source: CMS Pub 100-8 Transmittal 67, CR 2976

Sending Medical Records to CERT Contractors

The comprehensive error rate-testing (CERT) contractor reviews approximately 120,000 randomly selected claims and corresponding medical records (when available) each year. However, providers often fail to submit the requested medical records to the CERT contractor. These providers, known as nonresponders, contribute significantly to the Medicare fee-for-service (FFS) error rate. In an effort to reduce the error rate, fiscal intermediaries will contact billing providers under their jurisdiction who were selected for the November 2004 report and have failed to respond to the CERT contractor request for medical records and to encourage them to submit the needed record(s) to the CERT contractor.

Note: The November 2004 report contains error rates for claims submitted during calendar year 2003.

Provided Action Needed

Providers that have been selected for a CERT review should submit the requested medical records to the CERT contractor, Advancedmed, within 20 days from the initial request for medical records.

Providers may fax the requested medical records to 1-804-864-9980. Please include the barcode sheet with the medical record copy.

Providers may contact CERT contractor's customer service representatives at 1-804-864-9940. ❖

National 1-800-MEDICARE (1-800-633-4227) Implementation (Section 923(d) of MMA)

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 carriers (including DMERCs) and fiscal intermediaries will no longer maintain their own individual **beneficiary** toll-free telephone numbers. Instead, all beneficiary calls should be directed to 1-800-MEDICARE (1-800-633-4227).

CAUTION – What You Need to Know

Effective June 1, 2004, carriers and FIs will begin to transition to **1-800-MEDICARE (1-800-633-4227)** for all beneficiary questions that pertain to Medicare claims and services. The Centers for Medicare & Medicaid Services (CMS) will contact each carrier/FI on an individual basis to provide the specific migration/implementation date for that contractor (phase-in is planned for June – July 2004). As calls come in to the new centralized number, questions regarding specific claims will be routed to the appropriate Medicare carrier/FI for response.

GO – What You Need to Do

Medicare carriers/FIs will publish the new beneficiary toll-free telephone number on Medicare summary notices (MSNs), beneficiary correspondence, Medicare redetermination notices (formerly, appeals letters) and, if applicable, on Medicare beneficiary Web sites. On or after August 1, 2004, when you advise your patients to call Medicare with questions, direct them to 1-800-MEDICARE. However, for calls regarding eligibility status or claims status, and other provider-initiated inquiries, providers should continue to use the existing provider toll-free numbers.

Background

The change in policy, driven by the Medicare Modernization Act (MMA) of 2003 (section 923 (d)), requires all Medicare carriers/FIs to use one number—**1-800-MEDICARE (1-800-633-4227)**—for all Medicare questions from beneficiaries. By providing a single call-in number, Medicare aims to improve customer telephone service by connecting callers quickly with the correct Medicare contractor for their case and question, thereby reducing the number of calls and referrals overall.

Currently, an internal CMS workgroup is developing standard operating procedures for processes and exceptions to this new policy. All procedures will be communicated to contractors as soon as final decisions are made.

Additional Information

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 3195 in the CR NUM column on the right, and click on the file for that CR number.

Also, remember that 1-800-MEDICARE is for beneficiary-initiated calls. Providers calling Medicare should continue using the numbers currently in use. If you do not have that number, you may find it at: *http://www.cms.hhs.gov/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: 3195
Related CR Release Date: April 30, 2004
Related CR Transmittal Number: 159
Effective Date: June 1, 2004
Implementation Date: June 1, 2004 (Start date of phased implementation that should be completed on August 1, 2004.

Source: CMS Pub 100-04 Transmittal 159, CR 3195

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New Medicare-Approved Drug Discount Cards and Transitional Assistance Program: A Summary for 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

Understand the Medicare-Approved Drug Discount Cards and Transitional Assistance Program that begins in 2004 to help Medicare beneficiaries save on prescription drugs.

Background

As part of the Medicare Modernization Act of 2003 (MMA), the Medicare-Approved Drug Discount Cards and Transitional Assistance Program begins in 2004 to help Medicare beneficiaries save on prescription drugs. Medicare will contract with private companies to offer new drug discount cards until a Medicare prescription drug benefit starts in 2006. A discount card with Medicare's seal of approval can help Medicare beneficiaries save on prescription drug costs. This article is designed to give an overview of the new Medicare-Approved Drug Discount Cards and Transitional Assistance Program. It will also explain where you may refer Medicare patients for information on selecting and enrolling in the drug discount card that best suits their needs.

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

Medicare-Approved Drug Discount Cards

- Open enrollment started in May 2004.
- Available to qualified beneficiaries regardless of income.
- Represent a variety of discount and drug options from private companies.
- Available to beneficiaries eligible for or enrolled in Medicare Part A or enrolled in Medicare Part B, **unless** receiving outpatient prescription drug coverage through State Medicaid programs.
- May charge an annual enrollment fee of no more than $30, which may be paid by Medicare for some low-income beneficiaries.
- Do **not** require that beneficiaries purchase discount drugs through mail-order pharmacies.
- Provide beneficiaries the ability to use their discount cards in pharmacies near their homes.

Transitional Assistance Program

Beneficiaries with the greatest need will have the greatest help available to them. Individuals with an annual income in 2004 of no more than $12,569 if single or $16,862 if married, and individuals receiving help from their state in paying their Medicare premiums or cost sharing, may qualify for a $600 credit on their discount card to help pay for prescription drugs. These income limits change every year. 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.

"Different rules apply to the Medicare-approved drug discount card credit if the beneficiary lives in Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands. Each territory is enrolling qualified individuals into its own program to provide extra help to people with Medicare who have low income. For more information, see the questions and answers on *http://www.medicare.gov* or call 1-800-MEDICARE."

Where Do I 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. 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

This call center is available 24 hours per day and 7 days per week. It 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. Beneficiaries may request a copy of their individualized price comparison results. TTY users should call 1-877-486-2048.

The Prescription Drug and Other Assistance Programs Website at Medicare.gov *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 *http://www.medicare.gov*

This resource 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/Related/Ships.asp* on the Web.

Information Resources 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 Medicare-Approved Drug Discount Cards and Transitional Assistance Program – A Brochure for Physicians and Other Health Care Professionals at *http://www.cms.hhs.gov/medlearn*.
- 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.
- Contact your contractor for information by using the toll-free provider lines. Visit *http://www.cms.hhs.gov/medlearn/tollnums.asp* for your contractor's toll-free number. 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: N/A
Source: CMS Medlearn Matters Special Edition SE0422

Sending Payments to an Individual Bank Account

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

Provider Types Affected

Providers and suppliers.

Provider Action Needed

Become familiar with the revised policy regarding Medicare payments to be sent to a bank in the name of a provider/supplier.

STOP

There is a change in the policy allowing Medicare to send a payment to an individual provider or supplier's bank account for deposit.

CAUTION

If certain conditions are met, payments from Medicare to a provider or supplier may be sent to the provider's bank (or similar financial institution) for deposit into the provider's account. Please refer to the *Background* section for a review of these conditions.

GO

Follow these revised criteria if you want Medicare to deposit payments directly into your bank account.

Background

Medicare payments may be sent to a bank (or similar financial institution) to be deposited into a provider/supplier's account so long as the following requirements are met:

- The bank may provide financing to the provider/supplier as long as the bank states in writing, in the loan agreement, that it waives its right of offset. (This allows the bank to lend money to the provider as well as deposit money from Medicare into the provider/supplier's account.)
- The bank account is in the provider/supplier's name and only the provider/supplier may issue instructions on that account.
- The bank should only be bound by the provider/supplier's instructions.
- No other agreement that a provider/supplier has with a third party can have any influence on the account. In other words, if a bank is under a standing order from the provider/supplier to transfer funds from the provider/supplier's account to the account of a financing entity in the same or another bank and the provider/supplier rescinds that order, the bank honors this rescission notwithstanding the fact that it is a breach of the provider/supplier's agreement with the financing entity.

Irrespective of the language in any agreement a provider/supplier has with a third party that is providing financing, that third party cannot purchase the provider/supplier's Medicare receivables.

Additional Information

If you have questions, 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: 3079
Related CR Release Date: June 25, 2004
Effective Date: July 25, 2004
Implementation Date: July 25, 2004
Related CR Transmittal Number: 213

Source: CMS Pub 100-4 Transmittal 213, CR 3079

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Revised Criteria for Payment to Be Sent to a Bank

The Centers for Medicare & Medicaid Services (CMS) has revised the criteria for payment to be sent to a bank in the name of a provider/physician/supplier.

Medicare payments due a provider or supplier of services may be sent to a bank (or similar financial institution) for deposit in the provider/supplier's account so long as the following requirements are met:

- The bank may provide financing to the provider/supplier, as long as the bank states in writing, in the loan agreement, that it waives its right of offset. Therefore, the bank may have a lending relationship with the provider/supplier and may also be the depository for Medicare receivables; and
- The bank account is in the provider/supplier's name and only the provider/supplier may issue instructions on that account. The bank shall be bound by only the provider/supplier's instructions. No other agreement that the provider/supplier has with a third party shall have any influence on the account. In other words, if a bank is under a standing order from the provider/supplier to transfer funds from the provider/supplier's account to the account of a financing entity in the same or another bank and the provider/supplier rescinds that order, the bank honors this rescission notwithstanding the fact that it is a breach of the provider/supplier's agreement with the financing entity.

Irrespective of the language in any agreement a provider/supplier has with a third party that is providing financing, that third party cannot purchase the provider/supplier's Medicare receivables.

Criteria for payment to be sent to a bank in the name of a provider/physician/supplier may be found in CMS Pub. 100-04 – Medicare Claim Processing Manual, Chapter 1, Section 30.2.5 – Payment to Bank. ❖

Source: CMS Pub 100-4 Transmittal 213, CR 3079

Corrections Involving HCPCS Codes 0040T and A9603

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

Provider Types Affected

Physicians and providers

Provider Action Needed

STOP – Impact to You

Physicians and providers should note that this instruction includes Healthcare Common Procedure Coding System (HCPCS) corrections involving HCPCS codes 0040T and A9603.

CAUTION – What You Need to Know

This instruction places an end date on HCPCS code A9603 as of December 31, 2003. Also, HCPCS code A9603 is a duplicate of HCPCS code A9517, and HCPCS code A9517 is the correct HCPCS code that must be billed for this service. **HCPCS code 0049T was incorrectly categorized in the HCPCS database as a laboratory service and given a lab certification number. The lab certification number and category are being removed from the Medicare claim processing system so claims containing HCPCS code 0040T can be processed for payment, as of July 6, 2004.**

GO – What You Need to Do

In reference to HCPCS code 0040T, there is nothing you need to do. The error mentioned above is being corrected in the Medicare claim processing system.

However, when billing for "radiopharmaceutical therapeutic imaging agent, I-131 sodium iodide capsule, per mci," use HCPCS code **A9517** and not **A9603**. Refer to the *Background* and *Additional Information* sections of this instruction for further details regarding these changes.

Background

Each year in the United States, health care insurers process over five billion claims for payment. For Medicare and other health insurance programs to ensure that these claims are processed in an orderly and consistent manner, standardized coding systems are essential. The HCPCS was developed for this purpose, and it is used for identifying items and services.

The HCPCS is not a methodology or system for making coverage or payment determinations. The existence of a code does not, of itself, determine coverage or noncoverage for an item or service. While these codes are used for billing purposes, decisions regarding the addition, deletion, or modification of HCPCS codes are made independent of the process for making determinations regarding coverage and payment.

Implementation Date

This instruction has an implementation date of July 6, 2004.

Additional Information

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 3258 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 representatives is 1-877-602-8816.

In addition, a comprehensive overview of the HCPCS can be found at the following Centers for Medicare & Medicaid Services Web site: *http://www.cms.hhs.gov/medicare/hcpcs/codpayproc.asp*. ❖

Related Change Request (CR) Number: 3258
Related CR Release Date: May 7, 2004
Related CR Transmittal Number: 174
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 174, CR 3258

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Mammography Claims—MSN Messages

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 notice (MSN), which are sent to Medicare beneficiaries, and remittance advice messages and related situations where both film and digital screening mammography or film and digital diagnostic mammography are performed on the same day.

Background

Screening mammography tests can be performed by both film and digital technology. Because of this, some suppliers/providers have assumed the annual frequency rule did not apply in situations where both a film and digital screening is performed. That is not the case, however; Medicare will only pay for one screening test annually, whether performed by film or digital technology. Additionally, Medicare will pay only once for a screening test for a woman between the ages of 35 and 39. Further, Medicare will only pay for one mammography diagnostic test per day, not two.

Mammography Claims—MSN Messages (continued)

The revised manual instructions include Medicare Claims Processing Manual updates regarding which MSN message and ANSI X-12 835[1] adjustment reason code will be used on the remittance advice when Medicare denies a claim based on film and digital screening or film and digital diagnostic mammography services performed on the same day.

Currently, there are no established comparable MSN messages that can be used to explain why the claim is being denied. Without these new messages, beneficiaries would receive very general messages for denial of claims. The new MSN messages are to be used when both film and digital screening the mammography or film and digital diagnostic mammography has been performed on the same day. The Spanish translation for each new MSN messages 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:

- If the claim is denied because two screening mammographies were performed on the same day, the claim will be denied with reason code A1 *"Claim Denied Charges,"* along with remark code M90 *"Not covered more than once in a 12 month period."*
- If the claim is denied because two diagnostic mammographies were billed on the same day, the claim is denied with reason code A1 *"Claim Denied Charges,"* along with remark code M63 *"Service denied because payment already made for same/similar procedure within set timeframe."*
- 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 that were submitted with an invalid or missing FDA (Food & Drug Administration) 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 by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 2617 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 representatives 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 214, CR 2617

[1] American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X-12 transactions are part of the *Transactions and Code Sets Rule* selected by HIPAA.

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Unsolicited/Voluntary Refunds

All Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open accounts receivable). Intermediaries generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds. The Centers for Medicare & Medicaid Services reminds providers that:

> The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims. ❖

Source: CMS Pub 100-6 Transmittal 42, CR 3274

Elimination of Regulations for Written Statement of Intent

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

Provider Types Affected

All Medicare providers

Provider Action Needed

STOP – Impact to You

Effective with the claims filing period ending on December 31, 2004 and thereafter, Medicare will no longer accept statements of intent (SOIs) to extend the timely filing limit for filing initial claims.

CAUTION – What You Need to Know

Know the Medicare timely filing requirements for submitting claims. These requirements are in Chapter 1, Section 70 of the Medicare Claims Processing Manual, which may be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

GO – What You Need to Do

To ensure accurate claim processing, please submit filings in a timely manner and make certain that you will no longer utilize SOIs.

Background

Medicare regulations at 42 CFR Part 424.45 allowed for the submission of written SOIs to claim Medicare benefits. The purpose of an SOI was to extend the timely filing period for the submission of an initial claim.

An SOI, by itself, did not constitute a claim, but rather was used as a placeholder for filing a timely and proper claim.

A final rule published in the *Federal Register*, dated April 23, 2004, Volume 69, Number 79, pages 21963-21966, amended 42 CFR Part 424 by removing the SOI provision at 424.45, effective May 24, 2004.

Therefore, for the claim filing period ending on December 31, 2004, and all periods thereafter, Medicare carriers, intermediaries, and Medicare regional offices will no longer accept SOIs to extend the timely filing period for claims.

Additional Information

If you have questions regarding this issue, you may also contact your carrier or intermediary by their toll-free number. If you bill for Medicare Part A services, including outpatient hospital services, the toll-free number for your carrier/intermediary may be found online at: *http://www.cms.hhs.gov/providers/edi/anum.asp*.

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

If you bill for Medicare Part B services, the toll-free number may be found online at: *http://www.cms.hhs.gov/providers/bnum.asp*.

The official instruction issued to the carrier/intermediary regarding this change can be found online, referenced via CR 3310, 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 3310. Click on the link to open and view the file for the CR. ❖

Related Change Request (CR) Number: 3310
Related CR Release Date: June 18, 2004
Related CR Transmittal Number: 211
Effective Date: May 24, 2004
Implementation Date: July 19, 2004

Source: CMS Pub 100-4 Transmittal 211, CR 3310

Use of Group Health Plan Payment System for Demonstrations Serving Medicare Fee-for-Service Beneficiaries

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

Provider Types Affected

All Medicare providers.

Provider Action Needed

No action needed.

Background

The Centers for Medicare & Medicaid Services (CMS) is conducting several large coordinated care and disease management demonstrations under which private organizations will contract with CMS to provide disease management services to beneficiaries enrolled in the traditional Medicare fee-for-service program. In a previous Medlearn Matters article published on May 13, 2004 (SE0425), a summary of the Medicare Disease Management Demonstration was provided with an instruction to treat participants in the demonstration as traditional fee-for-service beneficiaries.

The Medicare beneficiaries participating in these demonstrations are **not** enrolled in an HMO. The Disease Management Organizations are being paid using the CMS Group Health Plan System as an "Option 1" cost plan. All fee-for-service claims will continue to be able to be processed under traditional Medicare payment rules and beneficiaries enrolled in these demonstrations will be considered covered under the traditional Medicare fee-for-service program.

Beneficiaries will only receive coordinated care/disease management services from these special demonstration plans. They are not restricted in any way as to how they receive their other Medicare services.

In order to avoid confusion about a beneficiary's access to services when providers or others check beneficiary eligibility on certain standard system screens, the related CR 3283 directs CWF to suppress any reference to HMO information on certain screens for beneficiaries enrolled in these demonstrations. ❖

Related Change Request (CR) Number: 3283
Related CR Release Date: May 14, 2004
Related CR Transmittal Number:4
Effective Date: October 4, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-19 Transmittal 4, CR 3283

Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

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

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed

STOP – Impact to You

Medicare will soon issue the annual update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) to Medicare contractors.

This update will apply for claims with service dates on or after October 1, 2004.

CAUTION – What You Need to Know

Remember that, as of October 1, 2004, Medicare no longer can provide a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes.

GO – What You Need to Do

Be ready to use the updated codes on October 1, 2004. Refer to the *Background* and *Additional Information* sections of this article for further details regarding this instruction.

Background

This instruction is a reminder that Medicare carriers and intermediaries will use the annual *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* coding update effective for:

- Dates of service on or after October 1, 2004; and
- Discharges on or after October 1, 2004 for institutional providers.

The Centers for Medicare & Medicaid Services (CMS) has been evolving the use of ICD-9-CM codes as follows:

- Beginning in 1979, ICD-9-CM codes became mandatory for reporting provider services on Form CMS- 1450.
- On April 1, 1989, the use of ICD-9-CM codes became mandatory for all physician services submitted on Form CMS-1500.
- Effective October 1, 2003, an ICD-9-CM code is required on all paper and electronic claims billed to Medicare carriers with the exception of ambulance claims (specialty type 59) (see Change Request (CR) 2725, dated June 6, 2003, at *http://www.cms.hhs.gov/manuals/pm_trans/B03045.pdf*.
- Effective for dates of service on and after October 1, 2004, CMS will no longer provide a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets be date-of-service compliant, and ICD-9-CM diagnosis codes are a medical code set. See CR 3094 dated February 6, 2004, at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3094.pdf*.

Updated ICD-9-CM codes are published in the *Federal Register* in April/May of each year as part of the proposed changes to the hospital inpatient prospective payment system and are effective each October first. Physicians, practitioners, and suppliers must use the current and valid diagnosis code that is in effect beginning October 1, 2004.

After the ICD-9-CM codes are published in the *Federal Register*, CMS places the new, revised, and discontinued codes on the following Web site: *http://www.cms.hhs.gov/medlearn/icd9code.asp*.

The update should be available at this site in June.

Implementation

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

Related Instructions

The Medicare Claims Processing Manual, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service) has been revised. 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 site, look for CR 3303 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 representatives is 1-877-602-8816.

Additional Information

The new, revised, and discontinued ICD-9-CM diagnosis codes are posted annually on the following CMS Web site: *http://www.cms.hhs.gov/medlearn/icd9code.asp*.

Providers can view the new updated codes at this Web site in June and providers are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

In addition, the National Center for Health Statistics (NCHS) also will place the new ICD-9-CM Addendum on their Web site *http://www.cdc.gov/nchs/icd9.htm* in June, which is also available for providers to visit. ❖

Related Change Request (CR) Number: 3303
Related CR Release Date: June 18, 2004
Related CR Transmittal Number: 210
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 210, CR 3333

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Payment Limits for J7308 (Levulan Kerastick) and J9395 (Faslodex®)—Drug Pricing Update

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

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed

STOP – Impact to You

New payment limits have been set for HCPCS drug codes J7308 (Levulan Kerastick) and J9395 (Faslodex) when these codes are not paid on a cost or prospective payment basis.

CAUTION – What You Need to Know

Medicare carriers are instructed to replace the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) payment limits for HCPCS drug codes J7308 (Levulan Kerastick) and J9395 (Faslodex) with the new rates listed in this instruction for dates of service on or after January 1, 2004.

GO – What You Need to Do

Be aware of the new payment limits for these two codes.

Background

This article informs providers that Medicare carriers will apply new payment limits for these HCPCS codes (J7308 (Levulan Kerastick) and J9395 (Faslodex)) for claims processed 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 for the specific HCPCS drug codes listed below (that are not paid on a cost or prospective payment basis) apply.

HCPCS	Short Description	Average Wholesale Price (AWP) %	2004 Payment Limit for Drugs (other than ESRD drugs separately billed by independent ESRD facilities and drugs infused through DME
J7308	Aminolevulinic acid hcl top	85	$111.47
J9395	Injection, Fulvestrant	85	$81.57

Note: The payment limits listed in the table above supercede the payment limits published in Change Request 3105 (Transmittal 75) dated January 30, 2004, only for these particular HCPCS drug codes for this time period. Also note that the absence or presence of an HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug.

Implementation

The implementation date for this instruction is July 25, 2004. The effective date of the change is January 1, 2004. However, Medicare contractors will not adjust any claims previously processed in order to apply these new payment limits unless the provider requests such an adjustment. ❖

Related Change Request (CR) Number: 3312
Related CR Release Date: June 25, 2004
Related CR Transmittal Number: 90
Effective Date: January 1, 2004
Implementation Date: July 25, 2004

Source: CMS Pub 100-20 Transmittal 90, CR 3312

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Provider Education Web Site Access Change

Due to recent improvements to our Internet server, users of our provider education Web site will be required to change their settings in order to access *www.floridamedicare.com.*

In the past, users were not required to type the "www" at the beginning of this address. This has now changed. Users must now type the full address. For those users who have saved this site within their browser's "Favorites", the link will need to be changed to include "www" in the URL. For example, *http://floridamedicare.com* needs to be changed to *http://www.floridamedicare.com.* ❖

New Condition Code for ESRD Facilities and Patient Status Code Changes

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

Provider Types Affected

Hospitals and end stage renal disease (ESRD) facilities.

Provider Action Needed

ESRD facilities should note that new condition code 59 must be used when an ESRD beneficiary receives non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility.

In addition, patient status codes 8, 61, and 65 are being clarified, and the Medicare Claims Processing Manual (Pub. 100-4), Chapter 25 (Completing and Processing UB92 Data Set), Section 60 (Instructions for Completing CMS-1450), is being updated to include these changes.

Background

Effective October 1, 2004, the National Uniform Billing Committee (NUBC) has approved the use of the following new condition code:

- **Condition Code 59 –** Non-primary ESRD facility.

This new condition code must be used when an ESRD beneficiary receives non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility.

In addition, patient status codes 8, 61, and 65 are being clarified as follows (***changes bolded and*** **italicized):**

- **Status code 8 –** Discharged/transferred to home under care of a home IV drug therapy provider. (***This is not a certified Medicare provider***.)
- **Status code 61 –** ***Discharged/transferred to a hospital-based, Medicare-approved swing bed***.
- **Status code 65 –** Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital ***(for future use). Providers shall continue to use patient status code 05 until further notice***.

Also in this instruction, Medicare fiscal intermediaries (FIs) are advised to continue to accept patient status code 05 for discharges/transfers to inpatient psychiatric hospitals and units until further notice.

Implementation

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

Related Instructions

The *Medicare Claims Processing Manual (Pub 100-04), Chapter 25 (Completing and Processing UB92 Data Set), Section 60*, is modified by this CR. The revised portions of the manual are included with the official instruction released by the Centers for Medicare & Medicaid Services (CMS).

That instruction, which was issued to all Fis, can be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***.**

From that Web page, look for CR 3183 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 representatives is 1-877-602-8816. ❖

Related Change Request (CR) Number: 3183
Related CR Release Date: April 23, 2004
Related CR Transmittal Number: 149
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 149, CR 3183

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Reminder of the Elimination of the 90-day Grace Period for HCPCS Codes

Effective January 1, 2005, Medicare providers will no longer have a 90-day grace period for billing discontinued Healthcare Common Procedure Coding System (HCPCS) codes for services furnished in the first 90 days of the year. HCPCS codes are updated annually every January 1, and a grace period for billing services furnished under discontinued codes was granted from January 1, through March 31 of each year. The Health Insurance Portability and Accountability Act (HIPAA) transaction and code set rule requires providers to **use the medical code set that is valid at the time the service is provided**. Therefore, the Centers for Medicare & Medicaid Services (CMS) is eliminating the 90-day grace period for billing discontinued HCPCS codes effective for services furnished **on or after January 1, 2005.**

Effective January 1, 2005, fiscal intermediaries will return to the provider any claim containing services reported under discontinued HCPCS codes for the current year.

Providers are encouraged to access the CMS Web site to view the new, revised, and discontinued alpha-numeric codes for the upcoming year. The CMS Web site to view the annual HCPCS update is *http://www.cms.hhs.gov/providers/pufdownload/anhcpcdl.asp.*

In addition, providers may obtain the American Medical Association's *Current Procedural Terminology (cpt®),* Fourth Edition coding book that is published each October from the AMA Web site at: *www.ama-assn.org/catalog*.

For additional information on the elimination of the 90-day grace period for HCPCS codes see the article published in the Third Quarter 2004 *Medicare A Bulletin* (pages 9-10).

You may also view a "Medlearn Matters…Information for Medicare Providers" article on the CMS Web site at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3093.pdf.* ❖

Source: CMS Pub 100-4 Transmittal 89, CR 3093

Procedures for Reissuance and Stale Dating of Medicare Checks

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

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed
STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is clarifying the policy for reissuing, stale dating, and reporting outstanding Medicare checks.

CAUTION – What You Need to Know

This instruction updates the Medicare Financial Management Manual (Pub. 100-06) and incorporates Change Request (CR) 1364 (Transmittal AB-01-122, September 10, 2001) regarding CMS procedures for reissuance and stale dating of Medicare checks.

GO – What You Need to Do

Be aware of these instructions in the event you have a problem in the future regarding lost, stolen, defaced, mutilated, destroyed, forged, or uncashed checks from your Medicare carrier/intermediary.

Background

This instruction updates the *Medicare Financial Management Manual (Pub. 100-06)* and incorporates Change Request (CR) 1364 (Transmittal AB-01-122, September 10, 2001) regarding the CMS procedures for reissuance and stale dating of Medicare checks, which expired in September 2002. Legal authority for the CMS reissuance and stale dated check policy is contained in Medicare regulations published at 42 CFR 424.352.

Introduction

As part of the CMS effort to improve financial reporting, CMS is clarifying the policy for reissuing, stale dating, and reporting outstanding Medicare checks.

Reissuing Medicare Checks

In December 1993, CMS issued 42 *Code of Federal Regulations* (CFR) Subpart M – Replacement and Reclamation of Medicare Payments 424.352: Intermediary and carrier checks that are lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsements. All Medicare contractors must re-issue checks in accordance with 42 CFR 424.352.

The provisions of this regulation require that a Medicare contractor (fiscal intermediary or carrier) perform certain tasks upon notification by a payee that a check has been lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsements. These tasks are as follows:

A. The Medicare contractor must contact the financial institution on which the check was drawn to determine whether the check has been negotiated.

B. If the check **has** been negotiated:

   1. The Medicare contractor will provide the payee with a copy of the check and other pertinent information (such as a claim form, affidavit, or questionnaire to be completed by the payee) required to pursue the claim in accordance with state law and commercial banking regulations.
   2. To pursue the claim, the payee must examine the check and certify (by completing the claim form, affidavit, or questionnaire) that the endorsement is not the payee's.
   3. The claim form and other pertinent information are sent to the Medicare contractor for review and processing of the claim.
   4. The Medicare contractor reviews the payee's claim. If the Medicare contractor determines that the claim appears to be valid, it forwards the claim and a copy of the check to the issuing bank. The Medicare contractor takes further action to recover the proceeds of the check in accordance with state law and regulations.
   5. Once the Medicare contractor recovers the proceeds of the initial check, the Medicare contractor issues a replacement check to the payee.
   6. If the bank of first deposit refuses to settle on the check for good cause, the payee must pursue the claim on his or her own, and the Medicare contractor will not reissue the check to the payee.

C. If the check has not been negotiated:

   1. The Medicare contractor arranges with the bank to stop payment on the check; and
   2. Except as provided in paragraph (D) of 42 CFR 424.352, the Medicare contractor reissues the check to the payee.

D. No check may be reissued under (C)(2) unless the claim for a replacement check is received by the contractor no later than one year from the date of issuance of the original check, unless state law (including any applicable federal banking laws or regulations that may affect the relevant state proceeding) provides a longer period, in which case that state law will apply.
Medicare contractors may receive requests for reissuance of Medicare checks that are older than one year. Based on 42 CFR 424.352 (summarized above), Medicare contractors should inform beneficiaries and providers/physicians/suppliers regarding the possibility that state law may provide a more favorable time frame for re-issuance. Medicare contractors should forward requests for reissuance to their regional office based on state law. The regional office will work with the General Counsel regional office to resolve these requests on a case-by-case basis.
Medicare contractors regularly receive requests for reissuance of Medicare checks that are older than one year. Under 42 CFR 424.352 many of these requests must be denied. However, 42 CFR 424.352 applies **only** to checks that have been lost, stolen, defaced, mutilated, destroyed, or paid on a forged endorsement. Accordingly, Medicare checks that are in the physical possession of the payee, have not been defaced or mutilated, and have not been negotiated are not subject to the one-year time limit for reissuance required by 42 CFR 424.352 (d). Therefore, if the below criteria below

Procedures for Reissuance and Stale Dating of Medicare Checks (continued)

are met, such checks may be reissued by the Medicare contractor even if they are older than one year. The criteria are:

1. The payee (beneficiary, physician, supplier, provider, etc.) and/or authorized representative can present the physical check;
2. The Medicare contractor can confirm that the check was not previously reissued; and
3. Reissuance is not barred by a federal and/or state statute of limitations.

Any questions that the Medicare contractors have regarding application of the above criteria should be forwarded to their regional office. The regional office will work with the General Counsel regional office to resolve the questions.

Stale Dating of Checks

Medicare contractors are expected to continuously review all outstanding checks, take the appropriate action to stale date checks in conformance with federal and/or state/local banking regulations, and adjust financial reporting for these actions. Medicare contractors must advise their financial institution of the change in the status of a check.

Outstanding checks are checks that have been issued as payment for Medicare benefits and have not been presented for payment to a financial institution and subsequently drawn from the Medicare trust funds. Checks are "voided" by rendering them nonnegotiable either physically or by placing a stop payment on them.

Stale dated checks are checks that have reached a specific age from date of issue (e.g., one year from the date of issuance) and have not been presented for payment to a financial institution and subsequently drawn from the Medicare trust funds. Additionally, once a check has been stale-dated and is no longer negotiable, the financial institution must be notified in writing.

Undeliverable Checks

Medicare providers, physicians, suppliers, and beneficiaries are responsible for providing their Medicare contractor with their current and accurate mailing address.

The Medicare contractors must comply with the policy established by the "Do Not Forward (DNF) Initiative."

This policy requires Medicare contractors to re-issue the check based on the receipt of updated verified address information per Form CMS-855; and if no updated address information has been submitted, then Medicare contractors must void any returned checks. Checks voided due to DNF may be reissued in accordance with the instructions in the preceding section titled "Reissuing Medicare Checks."

Implementation

The implementation date for this instruction is August 16, 2004.

Related Instructions

The Medicare Financial Management Manual, Pub. 100-06, Chapter 5 (Financial Reporting/Section 420 – Procedures for Reissuance and Stale Dating of Medicare Checks) is new. These updated manual instructions will be incorporated into the new Internet-only Office of Financial Management Manual, but are available now as part of the official instruction issued to your carrier/intermediary. This instruction (CR 2951) can be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 2951 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 representatives is 1-877-602-8816. ❖

Related Change Request (CR) Number: 2951
Related CR Release Date: July 16, 2004
Related CR Transmittal Number: 49
Effective Date: August 16, 2004
Implementation Date: August 16, 2004

Source: CMS Pub 100-6 Transmittal 49, CR 2951

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New Rural Health Fact Sheets

The Centers for Medicare & Medicaid Services (CMS) has issued four new rural health fact sheets that contain rural health information, definitions, helpful rural health resources, and enhancements from Medicare Prescription Drug, Improvement and Modernization Act of 2003 (if applicable). These new fact sheets are now available on the Medicare Learning Network Web site at *http://www.cms.hhs.gov/medlearn/pubs.asp*.

The new fact sheets are entitled:

- Rural Health Clinic
- Sole Community Hospital
- Federally Qualified Health Center
- Critical Access Hospital Program. ❖

Source: CMS JSM 337, July 16, 2004

Discontinued Use of Revenue Code 0910

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

Provider Types Affected

Comprehensive outpatient rehabilitation facilities (CORF), rural health clinics (RHC), and federally qualified health centers (FQHC) that bill for services subject to the outpatient mental health treatment limitation; hospital outpatient departments, community mental health centers (CMHC), and critical access hospitals (CAH) billing under the outpatient partial hospitalization program.

Provider Action Needed

STOP – Impact to You

Effective October 1, 2004, your reimbursement may be impacted if you don't use revenue code 0900 in place of revenue code 0910 on your claims for certain psychiatric/psychological treatment and services.

CAUTION – What You Need to Know

Revenue code 0910 will not be accepted after September 30, 2004. You must use revenue code 0900 in its place when billing for certain psychiatric/psychological treatment and services.

GO – What You Need to Do

Make sure that your billing staffs are aware that they must substitute revenue code 0900 in place of revenue code 0910 when billing for certain psychiatric/psychological treatment and services.

Background

Historically, comprehensive outpatient rehabilitation facilities (CORFs), rural heath clinics (RHCs), and federally qualified health centers (FQHCs) have been required to use revenue code 0910 as the basis for applying the outpatient mental health treatment limitation to their claims when billing for psychiatric/psychological services. Likewise, hospital outpatient departments, community mental health centers (CMHCs), and critical access hospitals (CAHs), billing under the outpatient partial hospitalization program, have also been required to use this revenue code.

However, the National Uniform Billing Committee (NUBC) has approved the restructuring/renaming of the 090X and 091X revenue code series for psychiatric and psychological services; as part of this restructuring, it has designated revenue code 0910 as "Reserved for National Use." Thus, the code is unavailable for use. You can no longer use revenue code 0910 and must use 0900 in its place effective on October 1, 2004. This includes provider-initiated adjustments.

Specifically, 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 formally reported psychiatric/psychological services under the outpatient partial hospitalization program using revenue code 0910 must now report such treatment under revenue code 0900. Please be aware that the October release of the outpatient code editor will be changed to no longer accept revenue code 0910.

Note: Revenue code 0900 description is as follows:

090x – Behavioral Health Treatments/Services (also see 091x, an extension of 090x)

Subcategory
0 – General Classification.

Additional Information

You can find additional ***material*** *related to this CR on the CMS Web site at: http://www.cms.hhs.gov/manuals/transmittals/cr_num_dsc.asp*.

From that Web page, look for CR 3194 in the CR NUM column on the right, and click on the file for this CR.

You can find more detail about revenue code 0900 in various chapters of the *Medicare Claim Processing Manual (Publication 100-4):*

- Chapter 1, Section 50.22 – Frequency of Billing to FIs for Outpatient Services
- Chapter 4, Section 20.5 – HCPCS/Revenue Code Chart
- Chapter 4, Section 170 – Hospital and CMHC Reporting Requirements for Services Performed on the Same Day
- Chapter 4, Section 260.1 – Special Partial Hospitalization Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals
- Chapter 4, Section 260.7 – Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHCs)
- Chapter 9, Section 60.2 – Application of Limit
- Chapter 9, Section 100 – General Billing Requirements
- Chapter 25, Section 60 – General Instructions for Completion of Form CMS-1450 for Billing
- Chapter 25, Section 100 – Form CMS-1450, UB-92, ANSI X12n 837A 4010 and 3051 3A.01 Crosswalk of Data Elements.

This manual can be found on the CMS Web site at: *http://www.cms.hhs.gov/manuals/cmsindex.asp*. ❖

Related Change Request (CR) Number: 3194
Related CR Release Date: April 30, 2004
Related CR Transmittal Number: 167
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 167, CR 3194

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Medicare Secondary Payer Policy for Hospital Reference Lab Services and Independent Reference Lab Services

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

Clarification for CR 3064 – MMA

The Medlearn Matters article related to Change Request 3064 was published in the Third Quarter 2004 Medicare A Bulletin (page 22).

Provider Types Affected

Hospitals, critical access hospitals (CAH), and independent reference laboratories

Provider Action Needed

STOP – Impact to You

Hospitals are no longer required to collect Medicare secondary payer (MSP) information where there is no face-to-face encounter with a beneficiary because independent reference laboratories no longer need the information to bill Medicare for reference laboratory services.

CAUTION – What You Need to Know

This clarification of CR 3064 and Medlearn Matters article MM3064 provides additional information regarding preparation of the claim Form CMS-1500.

Compliance with this instruction will help assure prompt and correct processing of reference laboratory claims.

GO – What You Need to Do

Affected providers should ensure that billing staff enters "None" in block 11 of the Form CMS-1500 when filing claims to Medicare for reference laboratory services when there is not a face-to-face encounter with the Medicare beneficiary.

Background

Section 943 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates that:

"The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to Medicare secondary payer provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory."

Prior to the enactment of MMA, hospitals were required to collect MSP information every 90 days in order to bill Medicare for reference lab services.

Further, those providers billing carriers are reminded to enter "None" in Block 11 of the claim Form CMS-1500 for reference laboratory services in order to bill Medicare for the reference laboratory services, as described in Section 943(b).

Additional Information

Because of these policy changes, Medicare intermediaries have been instructed to not include claims for reference laboratory services, as described in Section 943(b) of MMA, in the sample of claims that are reviewed during MSP hospital audits. This is effective for reference laboratory service claims with dates of service of December 8, 2003 and later.

To view the actual instruction issued to your carrier/intermediary, go to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

Once at that site, scroll down the right hand CR NUM column to find CR 3267 and click on the link for that CR. ❖

Related Change Request (CR) Number: 3267
Related CR Release Date: July 16, 2004
Related CR Transmittal Number: 17
Effective Date: December 8, 2003
Implementation Date: August 16, 2004

Source: CMS Pub 100-4 Transmittal 228, CR 3267

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Centers for Medicare & Medicaid Services Working to Improve Provider Enrollment Process

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

Provider Types Affected

All Medicare physicians and providers.

Provider Action Needed

This article is primarily for informational purposes, but providers want to be sure they understand the processes available to assist them when enrolling for Medicare or when updating their information with Medicare. This article deals mostly with problems carriers are having in processing new provider enrollment applications, changes in provider enrollment information, and applications for reassignment of payments by providers.

Background

For some time, providers have expressed concerns about the length of time it takes to enroll in Medicare and about the processes they must go through to accomplish that enrollment. CMS also has been concerned about ways to improve the process, while assuring it has the information needed to process claims correctly and the data needed to safeguard Medicare trust funds.

As a way to improve the overall infrastructure for the systems supporting the provider enrollment function, CMS launched a new national enrollment system, the Provider Enrollment and Chain/Ownership System, also referred to as PECOS. This system was implemented in July 2002 for

Centers for Medicare & Medicaid Services Working to Improve Provider Enrollment Process (continued)

Medicare fiscal intermediaries (FIs) and the process began rather smoothly for providers who deal with FIs.

On November 3, 2003, CMS implemented PECOS for carriers, extending the new process to physicians and other providers who interact with carriers. Unfortunately, the extension of PECOS to the carriers was considerably more problematic than the implementation for FIs. Some of the problems with the carrier implementation phase included the following:

- Some carriers were already facing backlogs of work in the enrollment area and the introduction of PECOS initially increased that backlog.
- The PECOS system and its supporting infrastructure was not as stable on the carrier side as on the FI side, mostly due to the much larger provider population on the carrier side, and a correspondingly higher volume of data and transactions.
- The interaction between PECOS and carrier systems was more problematic than the interaction between PECOS and FI systems.
- CMS may have underestimated the amount of time that carrier staff needed to train on the system and the carrier staff actually needed more training on the enrollment process itself in order to use PECOS effectively.

To compound these problems, CMS was operating under a continuing budget resolution in November 2003, which meant it had no budgetary authority to enable the carriers to hire temporary staff or to work significant amounts of overtime to handle the increased and problematic workloads. The result was that many providers trying to enroll with carriers or change their enrollment information encountered undue delays in processing their requests and this caused a significant problem for many providers. CMS regrets these problems and has been working aggressively with the carrier community to eliminate the bottlenecks.

Additional Information

As soon as CMS became aware of the problems, it took measures to resolve the issues. CMS' actions included the following:

- An emergency team, led by a senior CMS manager, was formed to identify the specific problems, visit the carriers with the more significant backlogs, and to formulate solutions.
- In February 2004, CMS was able to provide fiscal year 2004 budget authority to the carriers and, more recently, CMS directed the carriers to identify funding needs and to hire temporary staff to reduce the backlogs and expedite processing of enrollment actions.
- Special work teams, consisting of CMS staff and staff from the CMS contractor that developed PECOS, have been formed to communicate with the carriers daily to resolve known problems and to surface new problems for resolution.
- CMS has directed the carriers to make some basic changes to their enrollment processes so initial screenings of enrollment actions are made early and missing information can be identified and obtained from providers more quickly than was previously done.
- CMS has directed the carriers to make other changes to streamline the overall enrollment process, while preserving the integrity and accuracy of those processes.

CMS and the carriers believe these initial steps will result in significant improvements, but CMS is also aware that it will take some time to reduce the backlogs and bring stability to these processes. If any provider is facing a severe problem as a result of this situation, CMS encourages them to contact their carrier at the toll-free enrollment help line. These toll-free numbers may be found at: *http://www.cms.hhs.gov/providers/enrollment/contacts*.

In addition, CMS outlines some steps that providers can take to speed up the processes for their own transactions, such as the following:

- Providers are encouraged to be sure to submit complete and correct applications, including all necessary information.
- If your carrier contacts you for additional information, be ready to provide it promptly.
- When the carrier contacts you by letter for more information, be sure to reply by letter to the specific address listed in the communication to you.
- When contacted by phone, ask the carrier how best to get the information back to them, i.e., by phone, mail, e-mail, or fax.
- Use the PDF version of the enrollment application. This PDF form has built-in edits that help eliminate basic errors. This form can also be found at: *http://www.cms.hhs.gov/providers/enrollment/forms*.

Remember that you need not complete an entire form to change an address. Complete only the portions required to effect the change.

CMS regrets the inconvenience and burden these problems have caused providers. It is not unusual to experience growing pains when new and improved computer systems are installed. Nonetheless, CMS appreciates that providers should expect prompt and correct processing of their transactions. CMS and the carriers are working aggressively to make that happen.

Eventually, providers will benefit from PECOS because the new system will make it much easier for providers to establish additional offices with Medicare or to enroll for multiple sites with Medicare. ❖

Related Change Request (CR) Number: N/A
Effective Date: N/A – Informational Only

Source: CMS Medlearn Matters Special Edition SE0417

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Correction of Minor Errors and Omissions Without Appeals—MMA Section 937

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

Provider Types Affected

All Medicare physicians, providers, and suppliers

Provider Action Needed

Understand the Medicare rules that enable you to correct minor errors and omissions on Medicare claims without having to go through the appeals process. This article will provide information needed to make such minor corrections to Medicare claims within existing procedures.

Background

Section 937 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108-73, requires the Secretary of the Department of Health and Human Services to establish a process for physicians, providers, and suppliers to correct minor errors and omissions in claims without pursuing the formal appeals process. The Centers for Medicare & Medicaid Services (CMS) currently provides the following ways to make such corrections:

1. Correcting Incomplete or Invalid Claim Submission

Medicare instructions currently provide an opportunity for physicians, suppliers, and providers to correct errors or omissions in a submitted claim without the need to initiate a formal appeal, such as a review or, reconsideration. These processes are outlined in the *Medicare Claims Processing Manual, Pub. 100-4, Chapter 1 – General Billing Requirements, section 80.3.2 – Handling Incomplete or Invalid Claims* and *Section 70.2.3.1 – Incomplete or Invalid Submissions*.

The instructions provide the rationale for determining whether a claim (Forms CMS-1450, CMS-1500 or their electronic equivalent) is considered complete for processing purposes and outlines the actions to be taken by contractors upon receipt of incomplete or invalid claim submissions.

Basically, the instructions identify incomplete claims as ones submitted with required information missing, such as the provider's name. Invalid submissions also are claims that contain complete and required information, but the information is illogical or incorrect (e.g., incorrect HIC number or invalid procedure code) or the information does not conform to required claim formats.

The following definitions may be applied to determine whether data on submitted claims are incomplete or invalid:

- **Required** – Any data element that is needed in order to process the submission, such as provider name.
- **Not Required** – Any data element that is optional or is not needed to process the submission, such as the patient's marital status.
- **Conditional** – Any data element that must be completed if other conditions exist (e.g., if there is insurance primary to Medicare, then the primary insurer's group name and number must be entered on a claim). If these conditions exist, the data element becomes required.

Based on these instructions, if a claim is submitted with missing or incorrect information for certain specified items, it is considered to be unprocessable and is to be "returned" to the provider. Returning a claim as unprocessable does not mean that every claim is physically returned to the provider. The terms "return as unprocessable" or "return to provider" refer to the many processes utilized for notifying the provider or supplier of service that their claim cannot be processed, and that it must be corrected or resubmitted.

Different contractors use various techniques for returning claims as unprocessable. Following are just two examples:

- If incomplete or invalid information is detected at the front-end of claims processing, the claim may be returned to the provider identifying the error(s) and explaining how to correct the errors prior to resubmission.
- If incomplete or invalid information is detected at the front-end of the claims processing system, the claim may be suspended and developed; requested corrections and/or medical documentation must be submitted within a 45-day period. After the requested information is received, the claim is processed. Otherwise, the suspended portion is returned and the supplier or provider of service is notified by means of the remittance advice.

Under these instructions, carriers and fiscal intermediaries (FIs) typically either suspend claims with defective data for development and correction by the provider or send the claim back to the provider, noting the missing or incorrect items, for correction and resubmission. Claims submissions that are returned to the provider are not considered claims under Medicare regulations. Therefore, neither of these processes allows for the initiation of an appeal.

For more details on these sections, you may view *Chapter 1*, *Sections 70.2.3.1* and *80.3.2*, of the *Medicare Claims Processing Manual, Pub. 100-04*, at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

Once at that site, scroll down to Chapter 1 and click on the file type you wish to download.

2. Correcting Mistakes in Previously-Processed Claims

Another process a provider can use is the adjustment request process. Adjustment requests are the most common mechanism for FIs to change a previously accepted bill. The adjustment payment process is outlined in the *Medicare Claims Processing Manual, Pub. 100-4, Chapter 3 – Inpatient Hospital Billing, section 50, Adjustment Bills*. **Adjustments are required when bills have been accepted and posted in error to a particular record.**

You may also view this section of the manual to obtain further details on adjustments by going to: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

Once at that page, scroll down to Chapter 3 and click on the type of file you wish to download.

3. Reopening Claims

A third process that providers can use is the reopening process. Section 1869(b) (1) (G) of the Act provides for the reopening and revision of any initial determination according to guidelines prescribed by the Secretary. The *Medicare*

Correction of Minor Errors and Omissions Without Appeals—MMA Section 937 (continued)

Claims Processing Manual, Pub. 100-4, Chapter 29 – Appeals of Claims Decisions, section 60.27 – Reopening and Revision of Claims Determinations and Decisions, distinguishes the reopening process from the appeals process.

The purpose for a reopening should be to change the determinations or decisions that result in either overpayments or underpayments. Reopenings have been misconstrued as a level of the appeals process.

A reopening is not an appeal right; it is a discretionary action as defined under 42 CFR 405.841.

Requests for adjustments to claims resulting from clerical errors must be handled through the reopening process. The request must be made within one year from the date of the notice of the initial determination.

A provider has a four-year timeframe to initiate a reopening after the date of the initial determination if good cause exists.

4. Correcting HIPAA Compliance Issues

The fourth process relates to CMS's existing process for evaluating a claim's HIPAA compliance. This process can be found in the *Medicare Claims Processing Manual, Pub. 100-4, Chapter 24 - EDI Support Requirements, sections 30.6 - Translators; 70.1 - FI Requirements*; and *70.2 - Carrier/DMERC Requirements.*

Currently, Medicare contractor translators validate the syntax compliance of the X12N 837 standard. The entire file will be rejected when the file is syntactically incorrect. The contractor will send to the provider the X12N 997 functional acknowledgment to report the syntax errors. If the file is syntactically correct, HIPAA implementation guide-compliance validation of the X12N 837 is performed. Compliance validation edits check for required loops and segments, appropriate segments within a loop, valid calendar dates, qualifiers, and so on. Individual claims are rejected to the provider when they contain errors. The errors are then reported on contractor specific error reports.

To view the manual sections on reopening information or for the HIPAA information, use the same Web address as provided above and scroll to Chapters 29 and 24, respectively. Once at each chapter, select the version of the file you wish to review.

Additional Information

If you encounter problems or have any questions, please contact your carrier or FI on their toll-free number. If you do not have that number, you may find it 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: N/A
Effective Date: N/A – Informational Only

Source: CMS Medlearn Matters Special Edition SE0420

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Medicare Replacement Drug Demonstration

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

Provider Types Affected

All Medicare physicians and providers

Provider Action Needed
STOP – Impact to You

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

CAUTION – What You Need to Know

A physician certification will need to be filled out for any of your patients who are interested in 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.

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 your patients know. If they have any questions about the demonstration, they can call a toll-free number: 1-866-563-5386 (TTY number: 1-866-563-5387) or visit our Web site (*http://www.medicare.gov*) for more information or an application package. In addition, if any of your patients contact you about the demonstration and the required physician certification form, please complete the form in a timely manner. Enrollment in the demonstration is limited and all applications must be received by September 30, 2004 to be considered. Those who have submitted completed applications by August 16, 2004 may be eligible for coverage by September 1, 2004. An application is not considered complete without the physician certification form, so your prompt attention is appreciated.

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. Section 641 of the Medicare Modernization Act authorized this demonstration. 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

Medicare Replacement Drug Demonstration (continued)

outreach efforts to beneficiary advocacy groups, physicians, and others interested in this demonstration. TrailBlazer has subcontracted with AdvancePCS, a Caremark company, 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:

- The beneficiary must have Medicare Part A and Part B.
- Medicare must be the beneficiary's primary health insurance.
- The beneficiary must reside in one of the 50 states or the District of Columbia.
- The beneficiary must have a signed certification form from his or her doctor stating that he or 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 the Medicare Replacement Drug Demonstration

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-2b (PEG-Intron)
CMV Retinitis	Valcyte (Valganciclovir)
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)
• 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)

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

Source: CMS Medlearn Matters Special Edition SE0443

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July Quarterly Update for 2004 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, suppliers, and providers

Provider Action Needed

STOP – Impact to You

This instruction provides details regarding the July 2004 quarterly update for the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedules.

CAUTION – What You Need to Know

The 2004 fee schedule amounts for selected Healthcare Common Procedure Coding System (HCPCS) codes are being revised to correct calculation errors.

GO – What You Need to Do

Refer to the *Background* and *Additional Information* sections of this instruction for further details regarding these changes.

Background

The DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error.

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Section 1834(a), (h), and (i)), and payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in the Code of Federal Regulations (42 CFR 414.102).

This instruction provides specific details regarding the July quarterly update for the 2004 DMEPOS fee schedule.

Codes **K0630 through K0649** were added to the HCPCS effective April 1, 2004. The fee schedule amounts for these codes were not computed in time to be implemented as part of the April quarterly update and will be implemented as part of the July quarterly update. The durable medical equipment regional carriers (DMERCs) have calculated local fee schedule amounts for purposes of paying claims for codes K0630 through K0649 received prior to July 1, 2004.

Codes **K0650 through K0669** are being added to the HCPCS effective July 1, 2004. The fee schedule amounts for these codes will not be computed in time to be implemented as part of the July quarterly update because the products that fall under these codes have not yet been identified. DMERCs and regional home health intermediaries (RHHIs) will determine the payment amounts for K0650 through K0669 when such claims are received for services on or after July 1, 2004 through September 30, 2004.

The fee schedule amounts for codes K0650 through K0669 will be implemented as part of the October quarterly update.

Codes **A4216, A4217, A4217AU, L5782, and L8511 through L8514** have been paid on an individual consideration basis by the DMERCs and fiscal intermediaries (FIs). Fee schedule amounts are being established for these codes as part of the July quarterly update. For service in 2004, FIs will use the fee schedule amount for A4217 without the AU modifier.

Code **A4290** was added to the fee schedule under the prosthetic device category. It does not qualify, however, for separate payment under the prosthetic device benefit. This code is being removed from the DMEPOS fee schedule file as part of the July quarterly update.

Also, please note that codes **E0973, E0990, E1225, and E1226** have been added to the list of codes requiring a certificate of medical necessity, while code E0300 has been removed from that list.

Implementation

The implementation date for this instruction is July 6, 2004.

Related Instructions

The quarterly updates process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 60 (Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule), which can be reviewed at the following CMS Web site: *http://www.cms.hhs.gov/manuals/104_claims/clm104c23.pdf*.

Additional Information

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 CR3253 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 representatives is 1-877-602-8816.

In addition, a comprehensive overview of the HCPCS can be found at the following CMS Web site: *http://www.cms.hhs.gov/medicare/hcpcs/codpayproc.asp*. ❖

Related Change Request (CR) Number: 3253
Related CR Release Date: May 7, 2004
Related CR Transmittal Number: 171
Effective Date: January 1, 2004 for revised 2004 fee schedule amounts and April 1, 2004 for fee schedule amounts for codes K0630 through K0649
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 171, CR 3253

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Second Update to the 2004 Medicare Physician Fee Schedule

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

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed

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

Background

This instruction corrects errors in payment files issued to carriers based upon the November 7, 2003, and January 7, 2004, final rules for the 2004 Medicare physician fee schedule database. Details of the changes in this second update of the year may be found in the *Additional Information* section below.

Also, unless otherwise stated, these changes are retroactive to January 1, 2004. However, carriers and fiscal intermediaries will not search their files to either retract payment for claims already paid or to retroactively pay claims based on the corrected rates. Carriers will adjust claims brought to their attention by the provider.

Implementation

The implementation date for this instruction is July 6, 2004.

Additional Information

The official instruction issued to your contractor regarding this change may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R173CP.pdf*.

Changes included in this instruction to the second update to the 2004 Medicare physician fee schedule database are shown in the following table.

Should you have any questions regarding these changes, 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 representatives is 1-877-602-8816. ❖

Related Change Request (CR) Number: 3286
Related CR Release Date: May 7, 2004
Related CR Transmittal Number: 173
Effective Date: January 1, 2004
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 173, CR 3286

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July 2004 Update to Medicare Outpatient Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) has issued the July 2004 update to the 2004 Medicare outpatient fee schedules. The 2004 outpatient fee schedules were published in the Second Quarter 2004 *Medicare A Bulletin* (pages 65-85).

Medical/Surgical Supplies

Effective for services furnished **on or after January 1, 2004**

Code/Mod	Fee
A4216	$0.43
A4217	$3.13

Orthotic/Prosthetic Devices

Effective for services furnished **on or after January 1, 2004**

Code/Mod	Fee
L5782	$3,420.91
L8511	$58.99
L8512	$1.77
L8513	$4.22
L8514	$76.49

Skilled Nursing Facility Services

Effective for services furnished **on or after July 1, 2004**

Code/Mod	Loc. 01/02	Loc. 03	Loc. 04
G0329	$8.72	$9.37	$9.85

Durable Medical Equipment

Effective for services furnished **on or after April 1, 2004**

Code/Mod	Fee
K0630	$27.91
K0632	$58.94
K0634	$57.26
K0635	$68.07
K0636	$366.23
K0637	$64.47
K0639	$141.73
K0640	$717.67
K0642	$224.42
K0646	$432.52
K0647	$1,067.55
K0648	$649.00
K0649	$846.98

Medicare Secondary Payer Fact Sheets

The Centers for Medicare & Medicaid Services (CMS) has issued four new fact sheets on the subject of Medicare secondary payer. These fact sheets are available on the ***Medlearn*** Web page at: *http://www.cms.hhs.gov/medlearn/pubs.asp*.

These fact sheets should prove to be very useful in explaining provider/billing clerk responsibilities. The fact sheets are titled as follows:

- Collecting, Submitting, and Updating Beneficiary Insurance Information for Clinical Laboratories
- Complying with Medicare Secondary Payer Requirements
- Collecting, Submitting, and Updating Beneficiary Insurance Information to Medicare
- When Medicare Is the Primary Payer. ❖

Source: CMS JSM 235, May 6, 2004

Ambulance Services—Implementation of Section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

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

Note: This is a re-release of this article to reflect the changes made in the re-release of the CR 3099. The changes in this article are shown italicized.

Providers Affected

All ambulance services including volunteer, municipal, private, independent, and institutional providers such as hospitals, critical access hospitals and skilled nursing facilities.

Provider Action Needed
STOP – Impact to You

The new Medicare Prescription Drug, Improvements, and Modernization Act of 2003 (MMA) makes a number of important changes to Medicare payment for ambulance services rendered on or after July 1, 2004.

CAUTION – What You Need to Know

During the five-year period, July 1, 2004 – December 31, 2009, the fee schedule will include certain temporary increases in payment.

GO – What You Need to Do

Make sure your billing staff understands the new changes and bill according to those changes to assure receipt of accurate payment.

Background

The MMA provides several changes to the payment for ground ambulance services under Section 414 of the Act. Specifically, this section establishes a floor amount for the fee schedule portion of the payment, provides increased payments for urban and rural services, adds an increased payment for ambulance transports originating in certain low density population areas, and provides a 25 percent bonus on the mileage rate for ground transports of 51 miles or greater. These payment changes apply to ground transports only and the air ambulance base and mileage rates remain unchanged. *All increases are percentage increases and are cumulative.*

More details on these changes are as follows:

Regional Ambulance FS Payment Rate Floor for Ground Ambulance Transports

To discuss these changes further, we begin with the provision regarding the regional ambulance fee schedule (FS) payment rate floor for ground transport services. For services furnished during the period of July 1, 2004, through December 31, 2009, the base rate portion of the payment under the ambulance FS for ground transports is subject to a minimum amount. This minimum depends upon the area of the country in which the service is furnished.

Basically, the country is divided into nine census divisions and each of those divisions has a regional FS that is constructed using the same methodology as the national FS. Where the regional FS is greater than the national FS, the base rates for ground ambulance transports are determined by a blend of the national FS rate and the regional rate in accordance with the following schedule:

Year	National FS Percentage	Regional FS Percentage
July 1, 2004 – December 31, 2004	20%	80%
Calendar year 2005	40%	60%
Calendar year 2006	60%	40%
Calendar year 2007 – 2009	80%	20%
Calendar year 2010 and thereafter	100%	0%

Where the regional rate is not greater than the national rate, there is no blending and only the national FS amount applies.

Adjustment to the Ground Mileage Payment Amount for Miles Greater than 50

For services furnished during the period July 1, 2004, through December 31, 2008, a 25 percent increase is applied to the appropriate ambulance FS mileage rate for each mile of a transport (both urban and rural points of pickup (POP) that exceeds 50 miles (i.e., 51 miles or greater) when the beneficiary is onboard the ambulance.

The 50 percent increase applied to the rural ambulance FS mileage rate for the first 17 miles of a rural Point of Pickup (POP) continues to apply as it always has under the FS.

For services furnished during the period January 1, 2004, through June 30, 2004, for all ground miles greater than 17 miles, the FS rate equals the urban mileage rate per mile.

Adjustments for FS Payment Rate for Certain Rural Ground Ambulance Transports

For services furnished during the period July 1, 2004, through December 31, 2009, *there is a 22.6 percent increase in the FS portion of the base payment for ground ambulance services in low population density rural areas. This increase applies where the POP is in a rural county (or Goldsmith area) that is comprised by the lowest quartile by population of all such rural areas arrayed by population density. These rural areas are identified by a ZIP code with a "B" indicator on the national ZIP code file.*

Adjustments for FS Payment Rates for Ground Ambulance Transports

The payment rates under the FS for ground ambulance transports (both the FS base rates and the mileage amounts) are increased for services furnished during the period of July 1, 2004, through December 31, 2006. For services furnished where the POP is urban, the rates are increased by one percent and for services furnished where the POP is rural, the rates are increased by two percent. The following chart summarizes the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 payment changes for ground ambulance services that becomes effective on July 1, 2004:

Ambulance Services—Implementation of Section 414 of the MMA of 2003 (continued)

This chart will give you the increase percentage on miles, along with the effective dates of service.

Miles	Effective Dates	Payment Increase*
All rural miles	7/1/04 – 12/31/06	2%
Rural miles 51+	7/1/04 – 12/31/08	25% **
All urban miles	7/1/04 – 12/31/06	1%
Urban miles 51+	7/1/04 – 12/31/08	25% **
All rural base rates	7/1/04 – 12/31/06	2%
Rural base rates (lowest quartile)	7/1/04 – 12/31/09	*22.6%***
All urban base rates	7/1/04 – 12/31/06	1%
All base rates (regional fee schedule blend)	7/1/04 – 12/31/09	Floor

Note: * All payments are percentage increases and all are cumulative.

***Carrier/intermediary systems perform this calculation. All other increases are incorporated into the Medicare Ambulance FS file. However, carriers and intermediaries will continue to apply the applicable FS and reasonable charge/cost blended percentages to determine the payment rates through December 31, 2005, in accordance with the rules of the transition period.*

Additional Information

Reimbursement for ambulance services will be based on *two blended amounts. First, the FS portion of the payment is based on a blend of the national and regional FS amounts. Second, the FS portion is then blended with the reasonable charge/reasonable cost portion during the transition period.*

For further information, you may wish to view the actual re-released instruction issued to your Medicare contractor. That instruction can be seen at: *http://www.cms.hhs.gov/manuals/pm_trans/R220CP.pdf*.

Important Dates

These changes will sunset on different dates but all apply beginning with services furnished on July 1, 2004. ❖

Related Change Request (CR) Number: 3099
Related CR Release Date: *June 25, 2004 re-release date*
Related CR Transmittal Number: 88
Effective Date: July 1, 2004
Implementation Date: July 5, 2004

Source: CMS Pub 100-4 Transmittal 220, CR 3099

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July 2004 Update to the Ambulance Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) has issued the July 2004 update to the 2004 Medicare physician fee schedules.

Ambulance Fee Schedule Rates

Effective for services furnished **on or after July 1, 2004**

HCPCS Code	Urban Area 60%	Rural Area 62%
A0425	$5.71	$5.76
A0426	$205.30	$207.33
A0427	$325.05	$328.27
A0428	$171.08	$172.77
A0429	$273.73	$276.44
A0430	$2,324.60	$3,486.91
A0431	$2,702.69	$4,054.04
A0432	$299.39	$302.35
A0433	$470.47	$475.13
A0434	$556.01	$561.51
A0435	$6.78	$10.17
A0436	$18.07	$27.11
Q3019	$273.73	$276.44
Q3020	$171.08	$172.77

Customer Service Toll-Free Telephone Number—Reminder

First Coast Service Options, Inc. customer service representative telephone number for Medicare Part A providers was changed three years ago to a toll-free number. There are a few Part A providers still dialing the old telephone number. The telephone company has recently assigned this old number to a local private line in the Duval county area.

Action Required by Providers

Please ensure that the staff in your office has the correct toll-free telephone number. **The toll-free number for First Coast Service Options, Inc. Medicare Part A customer service representatives is 1-877-602-8816.**

Please continue to use your current FCSO personnel contacts and telephone numbers for issues related to EDI and PARD questions and concerns. ❖

GENERAL COVERAGE

Changes to the Laboratory National Coverage Determination Edit Software for October 2004

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

Provider Types Affected

Clinical diagnostic laboratories

Provider Action Needed
STOP – Impact to You

Laboratories must be aware of changes being made to the ICD-9-CM codes as part of the national coverage determination (NCD) edit software update in October 2004.

CAUTION – What You Need to Know

These changes are necessary so that the lab edit module will appropriately process claims using the most current ICD-9-CM codes effective October 1, 2004. They also implement changes to the list of covered codes developed through the coding analysis public process.

GO – What You Need to Do

Adopt the new codes in your billing process effective October 2004 and begin using them for services on or after that time to assure prompt and accurate payment of your claim.

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 and incorporated in the Medicare's claims processing systems so that laboratory claims subject to one of the 23 NCDs are processed uniformly throughout the nation effective January 1, 2003.

The laboratory edit module for the NCDs is being updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. (See Pub. 100-4, Chapter 16, section 120.2.)

Implementation

This article describes upcoming changes to the list of codes associated with the 23 negotiated laboratory NCDs. Most of the changes are a result of new ICD-9-CM codes that become effective on October 1, 2004. A few changes are the result of coding analysis that were conducted through the public process announced in the December 24, 2003 *Federal Register*.

In accordance with the coding analysis the following laboratory services will have coding changes:

1. **Deleting** the following diagnosis codes from the list of "ICD-9-CM Codes Covered by Medicare" for the urine culture NCD:
   - 584.5 Acute renal failure with lesion of tubular necrosis
   - 584.9 Acute renal failure, unspecified
   - 586 Unspecified renal failure.

   Coverage for these codes will terminate for services furnished **on or after October 1, 2004.**

2. **Adding** diagnosis code *729.81 – Swelling of limb*, to the list of "ICD-9-CM Codes Covered by Medicare" for the prothrombin time (PT) and partial thromboplastin time (PTT) NCDs. Coverage for this code will begin for services furnished **on or after October 1, 2004.**

3. **Adding** diagnosis code *600.01 – Benign prostate hypertrophy with urinary obstruction*, to the list of "ICD-9-CM Codes Covered by Medicare" for the prostate specific antigen (PSA) test NCD. Coverage for this code will begin for services furnished **on or after October 1, 2004.**

In order to accommodate the new ICD-9-CM coding changes that become effective **on October 1, 2004,** the Centers for Medicare & Medicaid Services (CMS) is making the following changes to the edit module.

These changes become effective for services furnished **on or after October 1, 2004.**

- CMS is **adding** new ICD-9-CM code 788.38 to the list of ICD-9-CM codes covered by Medicare for urine culture NCD.
- CMS is **adding** new ICD-9-CM codes 070.70, 070.71, 588.81, 588.89, V01.71, and V01.79 to the list of ICD-9-CM codes covered by Medicare for HIV testing (diagnosis). CMS is terminating coverage of ICD-9-CM codes V01.7 and 588.8 with services furnished on or after October 1, 2004.
- CMS is **adding** the following new ICD-9-CM codes to the list of ICD-9-CM codes that do not support medical necessity for the blood counts NCD:

521.06	521.07	521.08
521.10-521.15	521.20-521.25	521.30-521.35
521.40-521.42	521.49	524.07
524.20-524.37	524.39	524.50-524.57
524.59	524.64	524.75
524.76	524.81	524.82
524.89	525.20-525.26	618.00-618.05
618.09	618.81- 618.83	618.89
692.84	V72.40	V72.41.

  CMS is **removing** the following ICD-9-CM codes that are no longer valid from that list: 521.1, 521.2, 521.3, 521.4, 524.2, 524.3, 524.5, 524.8, 525.2, 618.0, 618.8, and V72.4.

- CMS is **adding** the following new ICD-9-CM codes to the list of ICD-9-CM codes covered by Medicare for the partial thromboplastin time NCD: 070.70, 070.71, 453.40-453.42.

Changes to the Laboratory National Coverage Determination Edit Software for October 2004 (continued)

- CMS is **adding** the following new ICD-9-CM codes to the list of covered diagnoses for the prothrombin time NCD: 070.70, 070.71, 453.40-453.42, 530.86, and 530.87.
- CMS is **adding** the following new ICD-9-CM codes to the list of covered diagnoses for the serum iron studies NCD: 070.70 and 070.71.
- CMS is **adding** the following new ICD-9-CM codes to the list of covered diagnoses for the collagen crosslinks NCD: 252.00-252.02, and 252.08.
  CMS is **removing** ICD-9-CM code 252.0, which is no longer a valid code, from that list.
- CMS is **adding** the following new ICD-9-CM codes to the list of covered diagnoses for the blood glucose testing NCD: 491.22, 707.00-707.07, 707.09, and V58.67.
  CMS is **removing** ICD-9-CM code 707.0, which is no longer a valid code, from that list.
- CMS is **adding** new ICD-9-CM code V58.67 to the list of covered diagnoses for glycated hemoglobin.
- CMS is **adding** new ICD-9-CM codes to the list of covered diagnoses for the lipid testing NCD: 588.81, and 588.89. CMS is **removing** ICD-9-CM code 588.8, which is no longer a valid code, from that list.
- CMS is **adding** new ICD-9-CM codes to the list of covered diagnoses for the digoxin therapeutic drug assay NCD: 588.81, and 588.89. CMS is **removing** ICD-9-CM code 588.8, which is no longer a valid code, from that list.
- CMS is **adding** new ICD-9-CM code 273.4 to the list of covered diagnoses for alpha-fetoprotein.
- CMS is **adding** the following new ICD-9-CM codes to the list of covered diagnoses for the gamma glutamyl transferase NCD: 070.70, 070.71, 252.00-252.02, 252.08, 273.4, 453.40-453.42, 588.81, and 588.89.
  CMS is **removing** ICD-9-CM code 252.0 and 588.8, which are no longer valid codes, from that list.
- CMS is **adding** the following new ICD-9-CM codes to the list of covered diagnoses for the hepatitis panel NCD: 070.70 and 070.71.
- CMS is **adding** new ICD-9-CM code V58.66 to the list of covered diagnoses for the fecal occult blood test.

Related Instructions

The official instruction issued to your 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 3358 in the CR NUM column on the right, and click on the file for that CR.

Additional Information

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date-of-service compliant. Since ICD-9-CM is a medical code set, effective for dates of service on and after October 1, 2004, CMS will no longer provide a 90-day grace period for providers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims.

The updated ICD-9-CM codes are published in the *Federal Register* in April/May of each year as part of the proposed changes to the hospital inpatient prospective payment systems in Table 6 and effective each October 1.

Carriers and DMERCs must eliminate the ICD-9-CM diagnosis code grace period from their system effective with the October 1, 2004 update. Carriers and DMERCs will no longer accept discontinued diagnosis codes for dates of service October 1 through December 31 of the current year. Claims containing a discontinued ICD-9-CM diagnosis code will be returned as unprocessable.

Physicians, practitioners, and suppliers must use the current and valid diagnosis code that is in effect beginning October 1, 2004. After the ICD-9-CM codes are published in the *Federal Register*, CMS places the new, revised, and discontinued codes on the following Web site: *http://www.cms.hhs.gov/medlearn/icd9code.asp*. ❖

Related Change Request (CR) Number: 3358
Related CR Release Date: July 9, 2004
Related CR Transmittal Number: 225
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 225, CR 3358

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Diabetes Self-Management Training Services

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

Provider Types Affected

Physicians, suppliers, and providers.

Provider Action Needed

STOP – Impact to You

Physicians, suppliers, and providers should note that the definition for diabetes mellitus has been changed.

CAUTION – What You Need to Know

This instruction revises the current *Internet Only Manual* (IOM) for diabetes self-management training (DSMT), and changes the definition for diabetes mellitus. Also, material that was not originally included from previous instructions has been added to the IOM.

GO – What You Need to Do

Refer to the Background and Additional Information sections of this instruction for additional information regarding these changes.

Background

This instruction, recently issued by the Centers for Medicare & Medicaid Services (CMS), revises the current *Internet Only Manual* (IOM) for DSMT (Section 300 through 300.5), and the definition for diabetes mellitus has been changed per Volume 68, Number 216, November 7, 2003, page 63261 of the *Federal Register*.

Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of DSMT services when a certified provider who meets certain quality standards furnishes these services. This program is intended to educate beneficiaries in the successful self-management of diabetes. The program includes instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin dependent; and motivation for patients to use the skills for self-management. Diabetes self-management training services may be covered by Medicare only if the treating physician or treating qualified nonphysician practitioner who is managing the beneficiary's diabetic condition certifies that such services are needed. The referring physician or qualified nonphysician practitioner must maintain the plan of care in the beneficiary's medical record and documentation substantiating the need for training on an individual basis when group training is typically covered, if so ordered. The order must also include a statement signed by the physician that the service is needed as well as the following:

- The number of initial or follow-up hours ordered (the physician can order less than 10 hours of training).
- The topics to be covered in training (initial training hours can be used for the full initial training program or specific areas such as nutrition or insulin training).
- A determination that the beneficiary should receive individual or group training.

The provider of the service must maintain documentation in file that includes the original order from the physician and any special conditions noted by the physician.

Beneficiaries Eligible for Coverage and Definition of Diabetes

Medicare Part B covers (not to exceed) ten hours of initial training for a beneficiary who has been diagnosed with diabetes. Diabetes is defined as diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria:

- A fasting blood sugar greater than or equal to 126 mg/dL on two different occasions;
- A two-hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions; ***or***
- A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Related Instructions

The following sections of the Medicare Benefit Policy Manual (Pub 100-2), Chapter 15 (Covered Medical and Other Health Services) have been revised:

- Section 300 (Diabetes Outpatient Self-Management Training Services)
  - Subsections 300.1 (Coverage Requirements)
  - 300.2 (Certified Providers)
  - 300.3 (Frequency of Training)
  - 300.4 (Outpatient Diabetes Self-Management Training).

The Medicare Benefit Policy Manual, Chapter 15 can be found at the following CMS Web site: *http://www.cms.hhs.gov/manuals/102_policy/bp102c15.pdf*

Additional Information

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 3185 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 representatives is 1-877-602-8816. ❖

Related Change Request (CR) Number: 3185
Related CR Release Date: May 28, 2004
Related CR Transmittal Number: 13
Effective Date: January 1, 2004
Implementation Date: June 28, 2004

Source: CMS Pub 100-2 Transmittal 13, CR 3185

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Arthroscopic Lavage and Arthroscopic Debridement for Osteoarthritic Knee

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

Provider Types Affected

All Medicare physicians and providers

Provider Action Needed

STOP – Impact to You

Medicare has issued a national coverage determination (NCD) related to the arthroscopic lavage and arthroscopic debridement for the osteoarthritic knee.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) has issued an NCD stating that (1) arthroscopic lavage alone for treatment of osteoarthritis of the knee, (2) arthropscopic debridement for presentation of knee pain only, or (3) arthroscopic debridement and lavage with or without debridement, for patients with severe osteoarthritis of the knee are now nationally **noncovered.** All other indications of debridement for patients without severe osteoarthritis of the knee who present with symptoms other than pain alone are at the discretion of the Medicare contractor (carrier or intermediary).

GO – What You Need to Do

Be aware of this NCD and its impact on the services you provide.

Background

Arthroscopy is a surgical procedure that allows the direct visualization of the interior joint space. In addition to providing visualization, arthroscopy enables the process of joint cleansing through the use of lavage or irrigation. Lavage alone may involve either large or small volume saline irrigation of the knee by arthroscopy. Although generally performed to reduce pain and improve function, current practice does not recognize the benefit of lavage alone for the reduction of mechanical symptoms.

Arthroscopy also permits the removal of any loose bodies from the interior joint space, a procedure termed debridement. Debridement, when used alone or not otherwise specified, may include low-volume lavage or the College of Rheumatology defines a patient diagnosis of osteoarthritis of the knee as presenting with pain, and meeting **at least five** of the following criteria:

- Over 50 year of age
- Less than 30 minutes of morning stiffness
- Crepitus (noisy, grating sound) on active motion
- Bony tenderness
- Bony enlargement
- No palpable warmth of synovium
- ESR <40mm/hr
- Rheumatoid Factor <1:40
- Synovial fluid signs

Because the clinical effectiveness of arthroscopic lavage and arthropscopic debridement for the severe arthritic knee has not been verified by scientifically controlled studies and after thorough discussions with clinical investigators, the orthopedic community, and other interested parties, CMS issued this NCD.

In this NCD, CMS determines that the following procedures are not considered reasonable or necessary in treatment of the osteoarthritic knee and are **not** covered by the Medicare program:

- Arthroscopic lavage used alone for the osteoarthritic knee;
- Arthroscopic debridement for osteoarthritic patient presenting with knee pain only; or
- Arthroscopic debridement and lavage, with or without debridement, for patients presenting with severe osteoarthritis. Severe osteoarthritis is defined in the Outerbridge classification scale, grades III and IV. Outerbridge is the most commonly used clinical scale that classifies the severity of joint degeneration of the knee by compartments and grade. Grade I is defined as softening or blistering of joint cartilage. Grade II is defined as fragmentation or fissuring in an area <1 cm. Grade III presents clinically with cartilage fragmentation or fissuring in an area >1 cm. Grade IV refers to cartilage erosion down to the bone. Grade III and IV are characteristic of severe osteoarthritis.

Other than the above non-covered indications for arthroscopic lavage and/or arthroscopic debridement of the osteoarthritic knee, all other indications of debridement for patients without severe osteoarthritis of the knee who present with symptoms other than pain alone, remain at the discretion of the local carrier or intermediary. In order to determine coverage in such cases, the carrier or intermediary may require submission of **one or all** of the following documents:

- Operative notes
- Reports of standing X-rays
- Arthroscopy results

Additional Information

This is a revision of Chapter 1 section 150.9 of Pub. 100-03, the Medicare National Coverage Determination Manual. The NCDs are binding on all Medicare carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans.

Under 42 CFR 422.256(b), an NCD that expands coverage is also binding on a Medicare+Choice (Medicare Advantage) organization. In addition, an administrative law judge may not review an NCD. (See 1869(f) (1) (A) (i) of the Social Security Act). To view the actual NCD issued by CMS, go to: *http://www.cms.hhs.gov/manuals/pm_trans/R14NCD.pdf*. ❖

Related Change Request (CR) Number: 3281
Related CR Release Date: June 10, 2004
Related CR Transmittal Number: 14
Effective Date: June 11, 2004
Implementation Date: July 11, 2004

Source: CMS Pub 100-3 Transmittal 14, CR 3281

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Billing Requirements for Hyperbaric Oxygen Therapy for the Treatment of Diabetic Wounds of the Lower Extremities

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

Provider Types Affected

Providers who submit claims to Medicare fiscal intermediaries/carriers for hyperbaric oxygen (HBO) therapy.

Provider Action Needed

This instruction manualizes the billing requirements from two prior Program Memoranda, issued by the Centers for Medicare & Medicaid Services (CMS) regarding hyberbaric oxygen (HBO) therapy for the treatment of wounds of the lower extremities. Providers should not submit claims for HBO therapy with bill type 22x (skilled nursing facility, inpatient, Part B).

Background

Two prior Program Memoranda (Transmittals AB-02-183 [CR 2388, December 27, 2002] and AB-03-102 [CR 2388 and CR 2769]) were issued by CMS regarding HBO therapy for the treatment of wounds of the lower extremities.

HBO therapy exposes the entire body to oxygen under increased atmospheric pressure. Effective April 1, 2003, a national coverage decision expanded the use of HBO therapy to include coverage for the treatment of diabetic wounds of the lower extremities. For specific coverage criteria for HBO therapy, refer to the National Coverage Determinations Manual, Chapter 1, Section 20.29.

This latest instruction also contains one revision regarding bill type 22x (skilled nursing facility inpatient Part B claim). Transmittal AB-03-102 instructed fiscal intermediaries to include bill type 22x for this benefit. However, this is **incorrect**. Bill type 22x is **not** acceptable for HBO therapy.

Providers: do not submit such claims with bill type 22x.

Also, please note that topical application of oxygen does not meet the definition of HBO therapy as stated above. Also, its clinical efficacy has not been established. Therefore, no Medicare reimbursement may be made for the topical application of oxygen.

The Coverage Issues Manual Section 35-10 contains the specific expanded coverage criteria of HBO therapy for the treatment of diabetic wounds of the lower extremities in patients including the specific diagnosis codes. This coverage information will soon appear in the National Coverage Determinations Manual, Chapter 1, Section 20.29. Revised instructions have also been issued for Chapter 32, Section 30 of the Medicare Claims Processing Manual. These instructions are attached to CR 3172, which may be accessed by following the instructions below.

Implementation

The implementation date for this instruction is June 28, 2004.

Additional Information

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 CR3172 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 representatives is 1-877-602-8816.

Transmittal AB-02-183, CR2388, "Coverage of Hyperbaric Oxygen (HBO) Therapy for the Treatment of Diabetic Wounds of the Lower Extremities" can be found at: *http://www.cms.hhs.gov/manuals/pm_trans/ab02183.pdf*.

Also, Transmittal AB-03-102, CR2769, "Clarification Regarding Coverage of Hyperbaric Oxygen (HBO) Therapy for the Treatment of Diabetic Wounds of the Lower Extremities," can be found at: *http://www.cms.hhs.gov/manuals/pm_trans/AB03102.pdf*. ❖

Related Change Request (CR) Number 3172
Related CR Release Date: May 28, 2004
Related CR Transmittal Number: 187
Effective Date: April 1, 2003
Implementation Date: June 28, 2004

Source: CMS Pub 100-4 Transmittal 187, CR 3172

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Sensory Nerve Conduction Threshold Test

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

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed

This instruction reaffirms the existing Medicare noncoverage policy on any type of sensory nerve conduction threshold test (sNCT), and the device(s) used to perform the test, to diagnose sensory neuropathies or radiculopathies. This instruction constitutes a technical correction to previously issued Change Request (CR) 2988, and CR 2988 should be discarded and replaced with this instruction. CR2988 was issued on March 19, 2004.

Background

As a result of reconsideration, this instruction reaffirms the existing Medicare noncoverage policy on any type of sensory nerve conduction threshold test (sNCT), and the device(s) used to perform the test, to diagnose sensory neuropathies or radiculopathies.

The revision to Section 160.23 of Pub. 100-03 is a national coverage determination (NCD), and NCDs are binding on all Medicare carriers, fiscal intermediaries,

Sensory Nerve Conduction Threshold Test (continued)

quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans. Under 42 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 the Social Security Act, Section 1869(f)(1)(A)(i))

Note: This instruction constitutes a technical correction to previously issued Change Request (CR) 2988. CR2988 should be discarded and replaced with this instruction. (Instructions addressing CR 2988 were published in the Third Quarter 2004 Medicare A Bulletin, page 28.)

Implementation

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

Related Instructions

The updated manual instructions are also 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 site, look for CR 3339 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 representatives is 1-877-602-8816.

Additional Information

The following is the revision to the Medicare National Coverage Determinations Manual, Pub. 100-03, Chapter 1 (Coverage Determinations), Section 160 (Nervous System), Subsection 160.23 (Sensory Nerve Conduction Threshold Tests (sNCTs). Revised sections are ***bolded and italicized***.

Medicare National Coverage Determinations Manual
Chapter 1 - Coverage Determinations
160 – Nervous System
160.23 – Sensory Nerve Conduction Threshold Tests (sNCTs)
160.23 – Sensory Nerve Conduction Threshold Tests (sNCTs)

A. General

Sensory nerve conduction threshold tests (sNCT) is a psychophysical assessment of both central and peripheral nerve functions. It measures the detection threshold of accurately calibrated sensory stimuli. This procedure is intended to evaluate and quantify function in both large and small caliber fibers for the purpose of detecting neurologic disease. Sensory perception and threshold detection are dependent on the integrity of both the peripheral sensory apparatus and peripheral-central sensory pathways. In theory, an abnormality detected by this procedure may signal dysfunction anywhere in the sensory pathway from the receptors, the sensory tracts, the primary sensory cortex, to the association cortex.

This procedure is different and distinct from assessment of nerve conduction velocity, amplitude and latency. It is also different from short-latency somatosensory evoked potentials.

Effective October 1, 2002, CMS initially concluded that there was insufficient scientific or clinical evidence to consider the sNCT test and the device used in performing this test reasonable and necessary within the meaning of section 1862(a)(1)(A) of the law.

Therefore, sNCT was noncovered.

Effective April 1, 2004, based on a reconsideration of current Medicare policy for sNCT, CMS concludes that **the use of any type of sNCT device (e.g. "current output" type device used to perform current perception threshold (CPT), pain perception threshold (PPT), or pain tolerance threshold (PTT) testing or "voltage input" type device used for voltagenerve conduction threshold (v-NCT) testing) to diagnose sensory neuropathies or radiculopathies in Medicare beneficiaries is not reasonable and necessary.**

B. Nationally Covered Indications

Not applicable.

C. Nationally Noncovered Indications

All uses of sNCT to diagnose sensory neuropathies or radiculopathies are noncovered.

(This NCD last reviewed ***June*** 2004.) ❖

Related Change Request (CR) Number: 3339
Related CR Release Date: June 18, 2004
Related CR Transmittal Number: 15
Effective Date: April 1, 2004
Implementation Date: April 1, 2004

Source: CMS Pub 100-3 Transmittal 15, CR 3339

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Acupuncture for Fibromyalgia/Osteoarthritis—Manualization NCD

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

Provider Types Affected

Physicians, suppliers, and providers.

Provider Action Needed

STOP – Impact to You

Physicians, suppliers, and providers should note that this instruction relates to acupuncture for the treatment of fibromyalgia and osteoarthritis.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) concludes that acupuncture is not reasonable and necessary for the treatment of fibromyalgia and osteoarthritis within the meaning of Section 1862(a)(1) of the Social Security Act. Therefore, CMS continues its national **noncoverage** determination for acupuncture.

GO – What You Need to Do

Refer to the *Background* and *Additional Information* sections of this instruction for further details regarding these changes.

Background

After reconsideration of the national noncoverage determination for acupuncture, CMS concludes that acupuncture is not reasonable and necessary for the treatment of fibromyalgia and osteoarthritis within the meaning of Section 1862(a)(1) of the Social Security Act.

Therefore, CMS continues its national **noncoverage** determination for acupuncture.

This revision 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. Under 42 Code of Federal Regulations (CFR) 422.256(b), an NCD that expands coverage is also binding on Medicare+Choice organizations.

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 instruction is April 16, 2004.

Related Instructions

The following Internet Only Medicare Manual (IOM) has been edited with revised and new sections to reflect changes implemented with this instruction.

The Medicare National Coverage Determinations Manual (Pub. 100-3), Chapter 1 (Coverage Determinations)

- Table of Contents – revised
- Section 30.3.1 (Acupuncture for Fibromyalgia) – revised
- Section 30.3.2 (Acupuncture for Osteoarthritis) – revised.

Changes to sections of the Medicare National Coverage Determinations Manual are included in CR 3250 referenced below in the *Additional Information* section. These revised instructions briefly explain the process CMS used in reaching this decision.

Additional Information

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 3250 in the CR NUM column on the right, and click on the file for that CR. ❖

Related Change Request (CR) Number: 3250
Related CR Release Date: April 16, 2004
Related CR Transmittal Number: 11
Effective Date: April 16, 2004
Implementation Date: April 16, 2004

Source: CMS Pub 100-3 Transmittal 11, CR 3250

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HOSPITAL SERVICES

CMS to Increase Payments to Hospitals Reclassified Under Medicare Reform Law

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

Provider Types Affected

Hospitals

Provider Action Needed

STOP – Impact to You

This Special Edition concerns the increase of payments to hospitals reclassified geographically under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) announced that 121 hospitals in 25 states have been geographically reclassified, and each will begin receiving higher payments retroactive to April 1, 2004, for patients who were discharged on or after April 1, 2004.

GO – What You Need to Do

Refer to the *Background* and *Additional Information* sections of this instruction for further details regarding these changes.

Background

Medicare pays hospitals for inpatient services provided to Medicare beneficiaries according to the inpatient prospective payment system (IPPS), and payment under the IPPS is based on the average cost of treating patients with a similar diagnosis. However, the actual amount received by a hospital for a particular case depends on a number of factors, including the geographic area in which the hospital is located. As a general rule, hospitals in urban areas, as defined by the Census Bureau's Metropolitan Statistical Areas (MSAs), are paid at a higher rate than those in rural areas.

Under Section 508 of the MMA, Congress directed CMS to create a one-time-only appeals procedure for certain hospitals that were deemed to be in need of financial relief, but fell just outside Medicare's existing criteria for reclassification from their current geographic areas into an adjoining area with higher payment rates.

The MMA was signed by President Bush on December 8, 2003, and CMS published a notice in the January 6, 2004, *Federal Register* (Vol. 69, No. 3) defining the criteria hospitals must meet to be eligible for the appeals process authorized by the MMA. In a notice issued in the February 13, 2004, *Federal Register* (Vol. 69, No. 30), CMS further clarified the criteria hospitals must meet and made technical corrections to the January notice.

Nearly 550 hospitals appealed for geographic reclassification by the February 15 deadline based on one or more of the eight criteria established by CMS, and the decision regarding their reclassification was made by the Medicare Geographic Classification Review Board. Within CMS, this independent panel is responsible for geographic classification appeals under the general criteria in the regulations.

On April 20, 2004, CMS announced that 121 of these hospitals (covering 25 states) were geographically reclassified, and each hospital will begin receiving higher payments under the special one-time-only provision in the MMA. The higher payments will be retroactive to April 1, 2004 for patients who were discharged on or after April 1, 2004, and before April 1, 2007.

The list of the hospitals that have been geographically reclassified can be found at the following CMS Web site: *http://www.cms.hhs.gov/media/press/files/041904_NationalAppendix.asp*.

Additional Information

The CMS press release, "CMS to Increase Payments to Hospitals Reclassified Under Medicare Reform Law," can be found at the following Web site: *http://www.cms.hhs.gov/media/press/release.asp?Counter=1015*.

Federal Register, Vol. 69, No. 3, CMS Notice "One-Time Appeal Process for Hospital Wage Index Classification," issued Tuesday, January 6, 2004, can be found at: *http://www.cms.hhs.gov/providerupdate/regs/cms1373n.pdf*.

In addition, *Federal Register,* Vol. 69, No. 30, CMS Notice "Medicare Program; Revisions to the One-Time Appeal Process for Hospital Wage Index Classification," issued February 13, 2004, can be found at: *http://www.cms.hhs.gov/providerupdate/regs/cms1373n2.pdf*. ❖

Related Change Request (CR) Number: N/A
Effective Date: April 1, 2004
Implementation Date: N/A

Source: CMS Special Edition Medlearn Matters SE0419

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Policy Expansion for Medicare Advantage Organization Beneficiaries

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

Summary of Changes: Expansion of policy where the patient is a member of a Medicare Advantage organization for only a portion of the billing period, to include inpatient rehabilitation facilities (IRFs) and long-term care hospitals (LTCHs) per the Medicare Modernization Act of 2003 (MMA section 211(e)).

Provider Types Affected

Hospitals (specifically inpatient rehabilitation facilities and long term care hospitals)

Provider Action Needed

STOP – Impact to You

This instruction reflects new policy that applies to coverage of Medicare beneficiaries in an inpatient rehabilitation facility (IRF) or long-term care hospital (LTCH) who are in a Medicare Advantage organization for a portion of their stay per the Medicare Modernization Act of 2003 (MMA section 211(e)).

CAUTION – What You Need to Know

Per the MMA, the terminology "Medicare Advantage" organization will now be used instead of "Medicare + Choice" organization. In addition, the policy regarding coverage when a patient is a member of a Medicare Advantage organization for only a portion of the billing period will now include IRFs and LTCHs.

GO – What You Need to Do

Refer to the *Background* and *Additional Information* sections of this instruction for further details regarding this instruction.

Background

For hospitals paid under the prospective payment system (PPS), the Code of Federal Regulation (42 CFR 422.264) outlined a policy for coverage in a Medicare Advantage (MA) organization that begins or ends during an inpatient stay.

The rule states that **the patient's status at admission determines liability**. For example, a patient is admitted to a hospital on January 28 and is discharged on February 5. On February 1 the patient enrolls in a MA organization. Medicare fee-for-service (FFS) is liable for this inpatient stay because the patient had Medicare FFS at admission.

A similar scenario would be true if the patient disenrolled in the MA organization on February 1. In this case the MA organization would be responsible for this inpatient stay that started on January 25. There are no Medicare claims processing system changes needed for this CR because the system was set up to process claims correctly in this fashion since the inception of IRF and LTCH prospective payment.

This instruction notifies Medicare fiscal intermediaries (FIs) and providers that the Medicare Modernization Act of 2003 (MMA – Section 211(e)) expanded this policy to include IRFs and LTCHs. Also per MMA, the terminology "Medicare Advantage" organization will be used instead of "Medicare + Choice" organization.

Additional Information

Following is an excerpt of the revised Chapter 1, Section 90 of the Medicare Claims Processing Manual, which reflects these changes. The italicized print shows the changes.

"Where a patient either enrolls or disenrolls in an *MA organization* (See the General Information, Eligibility, and Entitlement Manual (Pub. 100-01), Chapter 5, section 80 for definition) during a period of services, two factors determine whether the *MA organization* is liable for the payment.

Hospital Services

If the provider is an inpatient acute care hospital, *inpatient rehabilitation facility, or a long term care hospital*, and the patient changes *MA* status during an inpatient stay for an inpatient institution, the patient's status at admission or start of care determines liability.

If the hospital *in*patient was not a *MA* enrollee upon admission but enrolls before discharge, the *MA organization* is not responsible for payment.

For hospitals exempt from PPS (children's hospitals, cancer hospitals, and psychiatric hospitals/units) and Maryland waiver hospitals, if the MA organization has processing jurisdiction for the MA involved portion of the bill, it will direct the provider to split the bill and send the appropriate portions to the appropriate FI or MA organization. When forwarding a bill to a MA organization, the provider must also submit the necessary supporting documents.

If the provider is not a PPS provider, the *MA organization* is responsible for payment for services on and after the day of enrollment up through the day that disenrollment is effective.

Related Instructions

The actual instructions issued to your intermediary can be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Website, look for CR3309 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 representatives is 1-877-602-8816. ❖

Related Change Request (CR) Number: 3309
Related CR Release Date: June 18, 2004
Related CR Transmittal Number: 207
Effective Date: January 1, 2004
Implementation Date: July 19, 2004

Source: CMS Pub 100-2 Transmittal 13, CR 3185

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Long Term Care Hospital Prospective Payment System Annual Update

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

Provider Types Affected

Long term care hospitals paid under Medicare long term care prospective payment system (PPS)

Provider Action Needed

This article provides the annual LTCH PPS updates and also conveys some Medicare policy changes for the LTCH PPS based on the final rule published on May 7, 2004 for the LTCH PPS (69 FR 25674).

Background

Long term care hospitals (LTCHs) are certified under Medicare as short-term, acute care hospitals that have been excluded from the inpatient acute care hospital prospective payment system (IPPS) under section 1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average length of stay of greater than 25 days. The LTCH PPS replaces the reasonable cost-based payment system under which the LTCHs were paid.

The Balanced Budget Refinement Act (BBRA) of 1999 and the Benefits Improvement and Protection Act (BIPA) of 2000, which mandated the development of a PPS for LTCHs, conferred extremely broad authority on the Secretary in designing the LTCH PPS, specifying only that a budget neutral, per discharge PPS for LTCHs based on diagnosis-related groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002.

Payment rates under the LTCH PPS are updated on a July 1 through June 30 cycle, a LTCH rate year. The relative weights for the LTC-DRG patient classification system remain linked to the October 1 through September 30 schedule of the acute inpatient PPS, and are therefore published in the annual IPPS final rule by August 1. The Centers for Medicare & Medicaid Services (CMS) is required to update the payments made under this PPS annually, and for the LTCH PPS rate year 2005, the following applies:

- Standard federal rate is $36,833.69
- Fixed loss amount is $17,864.00
- Budget neutrality offset is 0.5 percent
- Wage index phase-in percentage for cost reporting periods beginning on or after October 1, 2004 is 3/5th (60 percent)
- Labor-related share is 72.885 percent
- The non-labor related share is 27.115 percent
- The short-stay outlier percentage for "subsection II" LTCHs is 193 percent for this second transition year.

Other Medicare policy changes include the following:

1. ***Expanding the existing interrupted stay policy***

Under the existing interrupted stay policy, implemented at the beginning of the LTCH PPS for cost reporting periods beginning on or after October 1, 2002, if an LTCH patient is discharged to an acute care hospital, an inpatient rehabilitation facility (IRF), or a skilled nursing facility (SNF) and then is readmitted to the LTCH within a fixed period of time, the entire LTCH hospitalization, both before and after the interruption, will be viewed as one episode of care and will generate one LTC-DRG payment. There has been no such policy with regard to LTCH patients discharged and subsequently readmitted if during the interruption they were not inpatients at one of the above inpatient settings.

Effective July 1, 2004, CMS is expanding its interrupted stay policy to include a discharge and readmission to the LTCH within three days, regardless of where the patient goes upon discharge. This means that if a patient is readmitted to the LTCH within three days of discharge, Medicare will pay only one LTC-DRG.

This policy is intended to cover:

- Discharges and readmissions following an outpatient treatment
- Three -day or less inpatient stays
- Discharge and readmission with an intervening patient-stay at home.

Furthermore, Medicare payment for any test, procedure, or care provided on an outpatient basis or for any inpatient treatment during the "interruption" would be the responsibility of the LTCH "under arrangements" with one exception rate year 2005 (July 1, 2004 – June 30, 2005): if treatment at an inpatient acute care hospital would be grouped to a surgical DRG, a separate Medicare payment would be made under the inpatient PPS for that care. (Existing regulations specify that tests or procedures unavailable where a patient is hospitalized should be provided "under arrangement," and paid for by the original hospital with no additional beneficiary liability.)
Therefore, any tests or procedures that were administered to the patient during that period of time, other than inpatient surgical care at an acute care hospital, will be considered to be part of that single episode of LTCH care and bundled into the payment to the LTCH. The LTCH will be required to pay any other providers without additional Medicare program payment liability.

Note: CMS will be implementing this policy in a separate CR in January 2005; however, CMS will make these changes retroactive to July 1, 2004.

2. ***Satellite facilities and remote facilities of hospitals that spin off as separate hospitals and seek LTCH status***

If a satellite or remote location of multi-campus LTCHs "spins-off" to become an independent LTCH, such a facility must comply with existing requirements for LTCH designation by first being certified as an independent hospital and then presenting discharge data to its fiscal intermediary indicating that once it became separate an independent hospital, it met the average length of stay (ALOS) requirement for Medicare patients for at least five of the next six months.

Long Term Care Hospital Prospective Payment System Annual Update (continued)

CMS is distinguishing "voluntary" separation from a parent LTCH from a separation mandated by the mileage requirement of the provider-based rules. In the latter case, CMS is establishing an exception in situations where the satellite facility or remote location of the hospital is required to become separately certified as a result of failing the mileage requirement of the provider-based regulations.

Under the exception, once these satellite facilities or remote locations become separate independent hospitals, they can immediately be paid as an LTCH if they submit to their fiscal intermediaries discharge data gathered during five months of the immediate six months preceding the facility's separation from the main hospital. The data must document that they meet the ALOS requirement.

A satellite that is being "voluntarily" spun-off from a parent LTCH, however, will be paid under the IPPS for at least six months. During this time, it must gather data to demonstrate that as a hospital, it complies with the ALOS requirement.

3. ***Determining ALOS based on the number of days of care for only the patients that were discharged during the hospital's fiscal year***

An LTCH's ALOS will be calculated by using days and discharge data for only those patients discharged during the cost reporting period.

Presently, the days in the hospital and the discharge dates are reported in the cost-reporting period when they occurred, as under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 system. An example of this change is as follows:

For a hospital on a calendar year cost report, the data for the patient that was admitted on December 15, and discharged on January 15, would have no impact on the first cost- reporting period, but would include 31 days and one discharge in calculating the ALOS for the second cost-reporting period.

This change for cases that crosses cost reporting periods would make the methodology for data collection for ALOS purposes consistent with the payment determinations, which under the LTCH PPS are discharged-based.

No LTCH will lose its designation should it fail to meet the ALOS requirement under the new regulations for the first year because of a one-year grandfathering provision that will allow an extra cost reporting period for compliance with the change. Therefore, for cost reporting periods starting between July 1, 2004 and July 1, 2005, for a LTCH that fails to meet the ALOS requirement under new methodology, the fiscal intermediary has been instructed to calculate the ALOS under the previous methodology in order to determine compliance.

Implementation

The implementation date for this instruction is July 6, 2004.

Related Instructions

CMS has several fact sheets related to the LTCH PPS and those fact sheets have been revised to reflect this annual update. The fact sheets are available at: *http://www.cms.hhs.gov/medlearn/ltchpps.asp*.

The Medicare Claims Processing Manual, Pub 100-04, Chapter 3, Section 150 (Long Term Care Hospitals (LTCHs) PPS), is being updated and the following sections are being revised. The updated manual instructions are included in the official instruction issued to your intermediary, which can be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

On that Web page, look for CR 335 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 representatives is 1-877-602-8816. ❖

Related Change Request (CR) Number: 3335
Related CR Release Date: June 18, 2004
Related CR Transmittal Number: 208
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 208, CR 3335

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Fact Sheet Revision for Long Term Care Hospitals

The Centers for Medicare & Medicaid Services (CMS) has revised the fact sheets for long-term care hospital (LTCH) prospective payment system (PPS). These revised fact sheets are now available on the Medicare Learning Network Web site at *http://www.cms.hhs.gov/medlearn/pubs.asp*.

The revised fact sheets are:

- *Updated Final Rule Fact Sheet* – revised June 2004
- *Short-stay Outliers Fact Sheets* – revised June 2004
- *Interrupted-Stay Fact Sheet* – revised June 2004
- *High Cost Outliers Fact Sheet* – revised June 2004. ❖

Source: CMS JSM 338, July 16, 2004

Emergency Hospital Outpatient Billing of Epotein Alfa (EPO) and Darbepoetin Alfa (Aranesp®)

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

Provider Types Affected

Hospitals

Provider Action Needed

STOP – Impact to You

Hospitals are now able to bill end stage renal disease (ESRD)-related anemia on an outpatient visit to the emergency room as described in this article.

CAUTION – What You Need to Know

HCPCS codes Q4054 and Q4055 can be billed on a type of bill (TOB) 13x for ESRD patients requiring EPO or Aranesp® administration for ESRD-related anemia in association with a hospital outpatient visit related to a medical emergency.

GO – What You Need to Do

Keep in mind that the administration for EPO/Aranesp may be required in an outpatient emergency setting and Medicare now pays for that administration.

Payment will be limited to unscheduled EPO/Aranesp administrations for ESRD patients with medical emergencies.

Background

When ESRD patients come to the hospital for a medical emergency, their dialysis-related anemia may also require treatment. For patients with ESRD who are on a regular schedule of dialysis, EPO, or Aranesp may be administered in a hospital outpatient department with EPO being paid by Medicare using the statutory rate for EPO and with Aranesp being paid based on the MMA (Medicare Modernization Act) drug pricing file rate.

Reporting EPO Charges

Report EPO charges under the revenue code 0634 if less than 10,000 units of EPO are used and use revenue code 0635 if more than 10,000 units are administered. Use HCPCS code Q4055 for EPO, reporting the total number of units as a *multiple* of 1000 units in the unit field and place the hematocrit value for the hospital outpatient visit in the value code 49. *Example: 40,000 units of EPO administered; Revenue code 635 and 40 placed in units field.*

Reporting Aranesp Charges

For Aranesp, report charges under revenue code 0636 with HCPCS code Q4054. Report the total number of units as a multiple of 1mcg in the unit field and the value code 49 will contain the hematocrit value for hospital outpatient visit.

Note also that Medicare will calculate a coinsurance based on the payment amount for EPO/Aranesp furnished in a hospital outpatient emergency setting and will apply the Medicare deductible as applicable.

Implementation Dates

While this policy is effective as of January 1, 2004, it will be implemented in Medicare claim processing systems on October 4, 2004.

Additional Information

To view the actual instruction issued by Medicare on this change, please see: *http://www.cms.hhs.gov/manuals/pm_trans/R197CP.pdf*. ❖

Related Change Request (CR) Number: 3184
Related CR Release Date: June 4, 2004
Related CR Transmittal Number: 197
Effective Date: January 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 197, CR 3184

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Clarification for Billing Left Ventricular Assist Devices

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

Provider Types Affected

All providers who bill Medicare for left ventricular assist systems (LVAS) and the medically necessary supplies and replacement accessories.

Provider Action Needed

STOP – Impact to You

Manufacturer(s) may have erroneously suggested that the Centers for Medicare & Medicaid Services (CMS) instructions on page 8 of Program Memorandum AB-02-152 allow providers to bring a recently discharged patient back for an outpatient visit to replace the left ventricular assist device (LVAD) equipment that was furnished under Part A in order to receive extra payment under Part B.

CAUTION – What You Need to Know

This erroneous suggestion may lead hospitals to believe that they can get extra Part B payment for the LVAD equipment in cases where the replacement or supplies are not medically necessary.

GO – What You Need to Do

Please note that Medicare payment is made under Part B for additional ***medically necessary*** supplies and replacement accessories required after the patient has been discharged from the hospital. Cases without medical need for replacement would be considered double billing. Please also refer to the *Background* section below.

Background

The program memorandum described in CR 2378 contains instructions regarding payment for LVAS or LVAD (page 8 of AB-02-152).

The left ventricular assist system is implanted in an inpatient setting and Medicare payment is made under Part A for:

- Hospital inpatient services; and
- Supplies and all necessary accessories for the LVAS (provided in the inpatient setting).

Clarification for Billing Left Ventricular Assist Devices (continued)

Medicare payment is made under Part B for additional ***medically necessary*** supplies and replacement accessories required after the patient has been discharged from the hospital.

Claims for replacement of supplies and accessories used with the LVAS that are furnished by suppliers should be billed to the local carriers. Claims for replacement of supplies and accessories that are furnished by hospitals should be billed to the intermediary. It is the responsibility of the local carrier or intermediary to determine whether the replacement supplies and accessories can be covered and to provide instructions, as needed, on how often these items can be replaced.

Manufacturer(s) may have erroneously suggested that CMS instructions in AB-02-152 allow providers to bring a recently discharged patient back for an outpatient visit to replace the LVAD equipment that was furnished under Part A in order to receive extra payment under Part B. This erroneous suggestion may lead hospitals to believe that they can get extra Part B payment in cases where the replacement or supplies are not medically necessary.

CMS reminds providers, suppliers, and Medicare intermediaries and carriers that payment under Part B can only be made for replacement of components and accessories that are reasonable and necessary.

If the intermediary or carrier gets claims for replacement of items within a relatively short period of time following discharge from the hospital, they will be aware that this may just be an attempt to obtain additional reimbursement for the LVAD under Part B (in those cases where there is not a true replacement need).

For example, the batteries or power sources for these devices require periodic replacement. The manufacturers have indicated that these items should last approximately six months to a year, depending on the brand of device. Therefore, it would not be reasonable and necessary to replace these items anytime before these minimum, expected product lifetimes have expired. For other components and accessories, the product lifetimes will be even longer. Cases without medical need for replacement would be considered double billing.

Additional Information

To view page 8 of the program memorandum AB-02-152, visit:
http://www.cms.hhs.gov/manuals/pm_trans/AB02152.pdf. ❖

Related Change Request (CR) Number: 2378
Effective Date: N/A

Source: CMS Medlearn Matters Special Edition SE0424

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Emergency Correction Regarding Correction to HCPCS Codes for Low-Osmolar Contrast Material

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

Provider Types Affected

All Medicare hospitals and physicians.

Provider Action Needed

Affected providers should note that this instruction provides additional information regarding coding under the Healthcare Common Procedure Coding System (HCPCS) for low-osmolar contrast material. It corrects the effective date for the reinstatement of selected HCPCS codes and the change in status of HCPCS code A9525.

Background

On January 23, 2004, Change Request 3053 – Emergency Correction to Healthcare Common Procedure Coding System (HCPCS) Codes for Low-Osmolar Contrast Material was issued, and it provided the following instructions:

- Reinstatement of Healthcare Common Procedure Coding System (HCPCS) codes A4644 through A4646; and
- Change in status of HCPCS code A9525 to "not payable by Medicare." The effective date for these changes was given as April 1, 2004.

This April 1, 2004, date was incorrect. These changes are to be made retroactive to January 1, 2004.

Thus, codes A4644 through A4646 are reinstated as of January 1, 2004 and code A9525 is invalid for dates of service on or after January 1, 2004.

On February 20, 2004 Change Request 3128 was issued. It updated the Medicare physician fee schedule database as follows:

- **Status indicator E** was assigned to codes A4644 through A4646; and
- **Status indicator I** was assigned to code A9525.

The effective date for these changes was given as January 1, 2004.

This is correct.

Codes A4644 thru A4646 have been reinstated in the HCPCS.

Implementation

The implementation date for this instruction is May 24, 2004.

Additional Information

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.

Emergency Correction Regarding Correction to HCPCS Codes for Low-Osmolar Contrast Material (continued)

From that Web page, look for CR3185 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 representatives is 1-877-602-8816.

Change Request 3053 – Emergency Correction to Healthcare Common Procedure Coding System (HCPCS) Codes for Low-Osmolar Contrast Material, Transmittal 45, dated January 23, 2004, can be found at the following Centers for Medicare & Medicaid Services Medlearn Matters Web site: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3053.pdf*.

Also, Change Request 3128 – First Update to the 2004 Medicare Physician Fee Schedule Database Transmittal 105, dated February 20, 2004, can be found at the following CMS Web site: *http://www.cms.hhs.gov/manuals/pm_trans/R105CP.pdf*. ❖

Related Change Request (CR) Number: 3187
Related CR Release Date: April 23, 2004
Related CR Transmittal Number: 74
Effective Date: January 1, 2004
Implementation Date: May 24, 2004

Source: CMS Pub 100-20 Transmittal 74, CR 3187

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Inpatient Rehabilitation Facility Classification Requirements

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

Provider Types Affected

Rehabilitation hospitals and rehabilitation units: both are referred to as inpatient rehabilitation facilities (IRFs).

Provider Action Needed

Hospitals and rehabilitation units must meet the criteria specified in regulations 42 CFR 412.23 (b), 412.25, and 412.29 to be eligible for payment under the IRF prospective payment systems. A rehabilitation hospital and rehabilitation unit are both now referred to as an IRF. The Centers for Medicare & Medicaid Services (CMS) recently issued guidance to Medicare fiscal intermediaries (FIs) regarding the criteria that a facility must meet to be classified as an IRF. This article summarizes some of that guidance.

Background

Sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii) of the Social Security Act provide authority for defining which inpatient facilities may be classified as inpatient rehabilitation hospitals and as acute care hospital rehabilitation units. An inpatient rehabilitation hospital and an acute care hospital rehabilitation unit are collectively referred to as an inpatient rehabilitation facility (IRF) under the IRF prospective payment system (PPS).

On January 3, 1984, CMS published a final rule, "Medicare Program; Prospective Payment for Medicare Inpatient Hospital Services" (49 FR 234), which specified that for classification as an IRF, 75 percent of the IRF's total patient population during the IRF's cost reporting period must match one or more of the ten medical conditions listed in 42 CFR 405.471. This final rule provision became known as the "75-percent rule." The IRF's FI was responsible for verifying whether the IRF's total patient population met the 75 percent rule.

On March 29, 1985, CMS published a final rule, "Medicare Program; Prospective Payment System for Hospital Inpatient Services: Redesignation of Rules" (50 FR 12740). That rule redesignated the provisions of 42 CFR 405.471 that addressed the 75-percent rule as a provision under 42 CFR 412.23(b) (2).

The regulations at 42 CFR 412.25, 412.29, and 412.30 refer to 42 CFR 412.23(b) (2) as one of the criteria a provider must meet to be classified as an IRF. Hospitals and units that met the criterion specified in 42 CFR 412.23(b) (2), as well as other criteria, were eligible to be paid under the IRF PPS.

An IRF that has already been excluded from the acute care hospital PPS is always subject to verification that it continues to meet the criteria necessary to allow the facility to be excluded from the acute care hospital PPS. The results of the verification procedure are used in determining each facility's classification status for the next cost reporting period.

IRFs that have already been excluded from the acute care hospital PPS need not reapply to be classified as an IRF. However, on an annual basis, an IRF must self-attest (except for the medical condition criterion specified above and certain other criteria) that it still meets all the criteria for being classified as an IRF.

Your FI is always required to verify that your IRF has met the medical condition criterion.

Changes to the Classification Criteria

On May 7, 2004, CMS published a final rule titled "Medicare Program; Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility." In this final rule CMS changed the:

- Percentage of the IRF's total patient population that must match one or more of the medical conditions; and
- Medical conditions previously specified in the regulations.

Medicare Inpatient Rehabilitation Facility Classification Requirements (continued)

Percentages

This final rule specified that during a most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI) the IRF treated an inpatient population that met or exceeded the **minimum percentages of an IRF's total patient population that must have matched one or more of the medical conditions** specified in the "List of Medical Conditions" table:

	Cost reporting period	Percentage
1.	Beginning on or after July 1, 2004 and before July 1, 2005	50 percent
2.	Beginning on or after July 1, 2005 and before July 1, 2006	60 percent
3.	Beginning on or after July 1, 2006 and before July 1, 2007	65 percent
4.	Beginning on or after July 1, 2007	75 percent

List of Medical Conditions

The list of medical conditions and additional comments and requirements pertaining to the condition is shown below:

	Medical Condition	Comments/Requirements
1.	Stroke	
2.	Spinal cord injury	
3.	Congenital deformity	
4.	Amputation	
5.	Major multiple trauma	
6.	Femur fracture (hip fracture)	
7.	Brain injury	
8.	Neurological disorders	Including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.
9.	Burns	
10.	Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies.	The noted conditions must result in significant functional impairment of ambulation and other activities of daily living that: • Have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission; or • Result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation. The related CR3334 provides guidance regarding therapy. However, the medical review staff of the FI has the discretion to define: • What is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission; and • When a systemic disease activation immediately before admission has occurred.
11.	Systemic vasculidities with joint inflammation	The noted condition must result in significant functional impairment of ambulation and other activities of daily living that: • Have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission; or • Result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation. The related CR3334 provides guidance regarding therapy. However, the medical review staff of the FI has the discretion to define: • What is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission; and • When a systemic disease activation immediately before admission has occurred.

Medicare Inpatient Rehabilitation Facility Classification Requirements (continued)

	Medical Condition	Comments/Requirements
12.	Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint	The noted condition must result in significant functional impairment of ambulation and other activities of daily living that: • Have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission; or • Result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation. The related CR3334 provides guidance on therapy. However, the medical review staff of the FI has the discretion to define: • What is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission; and • When a systemic disease activation immediately before admission has occurred. Please note, a joint replaced by prosthesis is no longer considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.
13.	Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay	This condition must also meet one or more of the following specific criteria; the patient: • Underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission; • Is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF; • Is age 85 or older at the time of admission to the IRF

Written Certification

A hospital that seeks classification as an IRF for a cost reporting period that occurs after it becomes a Medicare-participating hospital must provide a written certification that the inpatient population it intends to serve meets the medical condition requirement specified above, instead of showing that it has treated an inpatient population that met the medical condition requirement during its most recent cost reporting period.

The written certification is also effective for a cost reporting period of not less than one month and not more than 11 months occurring between the dates the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

If a hospital, hospital unit, or group of beds is paid under the IRF PPS for a cost reporting period based on a written certification that it will meet the medical condition requirement specified above but does not actually meet the requirement for that cost reporting period, CMS adjusts its payments to the hospital retroactively.

The FI effects this payment adjustment to the hospital by calculating the difference between:

- The amount actually paid for services to Medicare patients in the hospital, hospital unit, or beds during the period of provisional exclusion; and
- The amount that would have been paid if the hospital, unit, or beds had not been excluded from the acute care hospital PPS.

The FI then takes action to recover the resulting overpayment or corrects the underpayment to the hospital.

Additional Information

If you have questions regarding this issue, you may also contact your FI on their toll free number. The toll free number for your intermediary may be found online 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.

The official instruction issued to the intermediary regarding this change can be found online, referenced via CR 3334, 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 CR3334. Click on the link to open and view the file for the CR. ❖

Related Change Request (CR) Number: 3334
Related CR Release Date: June 25, 2005
Related CR Transmittal Number: 221
Effective Date: July 1, 2004
Implementation Date: July 1, 2004

Source: CMS Pub 100-4 Transmittal 221, CR 3334

Hospital Outpatient Claim Processing Problem

The Centers for Medicare & Medicaid Services (CMS), has issued this message to bring your attention to a claim processing issue where some hospital outpatient claims are being paid in error. The claim processing system supporting hospital outpatient claims was modified on July 6, 2004, based on Change Request (CR) 3104. CR 3104 was implemented to accurately process line item medical review denials and line item Medicare secondary payer (MSP) actions on outpatient prospective payment system (OPPS) claims with lines for surgical procedures containing charges of less than $1.01. When programming these changes, an error was made resulting in incorrect payment calculations resulting in overpayments for some of these claims.

We anticipate this problem affects only a small volume of claims. Providers do not need to take any action. All payments made in error will be automatically corrected no later than August 30, 2004. ❖

Source: CMS JSM 285, July 7, 2004

LOCAL MEDICAL REVIEW POLICIES

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

Medical Policy Table of Contents

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

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NEW LCD IMPLEMENTATION

32491: Lung Volume Reduction Surgery (LVRS)—New Policy

Lung volume reduction surgery (LVRS) or reduction pneumoplasty, also referred to as lung shaving or lung contouring, is performed on patients with severe emphysema in order to allow the remaining compressed lung to expand, thereby improving respiratory function.

The Centers for Medicare & Medicaid Services (CMS) developed a national coverage determination (NCD) for LVRS in October 2003. Effective January 1, 2004, the NCD was expanded coverage for LVRS.
CMS instructed contractors to develop ICD-9-CM codes that support medical necessity for LVRS. This LCD was developed to outline the criteria specified in the NCD and to define appropriate ICD-9-CM codes for lung volume reduction surgery.

Effective Date

This new policy is effective for services furnished **on or after September 30, 2004**. The full-text for this LCD will be available on the provider education Web site *www.floridamedicare.com* 45 days prior to the effective date. ❖

ADDITIONS/REVISIONS TO LMRPS/LCDS

29540: Strapping—Revision to Policy

The local medical review policy (LMRP) for strapping – 29540 was previously revised on December 20, 2003. Since that time, revenue codes 420 and 430 have been changed to 42x and 43x respectively. In addition, the LMRP has been converted to the new local coverage determination (LCD) format.

Effective Date

This revision is effective for claims processed **on or after July 22, 2004**. The revised full-text for this LCD is available on the provider education Web site *www.floridamedicare.com* on or after this effective date. ❖

33215: Implantation of Automatic Defibrillators—Revision to Policy

This local medical review policy was last revised effective October 1, 2003. This policy is based on the national coverage decision (NCD Manual Section 204, 310.1) for the implantation of automatic defibrillators.

A revision to this policy was made to remove the following procedure codes since these codes apply to the repositioning, revision, and repair of pacing cardioverter-defibrillators:

33215 33218 33220 33223 33241 33243 33244

In addition, the following ICD-9-CM codes were added to the "ICD-9 Codes that Support Medical Necessity" section of the policy:

427.41	ventricular fibrillation
427.42	ventricular flutter
996.61	infection and inflammatory reaction due to cardiac device, implant, and graft

The policy number was changed from 33215 to 33216 and converted to the new local coverage determination (LCD) format.

Effective Date

These revisions were effective for services furnished **on or after July 6, 2004**. The revised full-text for this LCD is available on the provider education Web site *www.floridamedicare.com* on or after this effective date. ❖

67221: Ocular Photodynamic Therapy (OPT) with Verteporfin—Revision to Policy

The latest revision to the local medical review policy (LMRP) for ocular photodynamic therapy (OPT) – 67221 was effective August 20, 2002. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy has been expanded per Change Request 3191, dated April 1, 2004, as follows:

> Effective April 1, 2004, Medicare will consider OPT with verteporfin medically reasonable and necessary when performed for treating: subfoveal occult with no classic choroidal neovascularization (CNV) associated with AMD and subfoveal minimally classic CNV (where the area of classic CNV occupies <50% of the area of the entire lesion) associated with AMD. These two indications will be considered reasonable and necessary only when: the lesions are small (four disk areas or less in size) at the time of initial treatment or within the three months prior to initial treatment and the lesions have shown evidence of progression within the three months prior to initial treatment. Evidence of progression must be documented by deterioration of visual acuity (at least five letters on a standard eye examination chart), lesion growth (an increase in at least 1 disk area), or the appearance of blood associated with the lesion.

The "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy has also been updated and revised to include:

> Effective for services furnished **on or after August 30, 2004,** Medicare will consider OPT with verteporfin medically reasonable and necessary when performed for treating: Patients with predominantly classic subfoveal CNV associated with macular degeneration, secondary to presumed ocular histoplasmosis or pathologic myopia. In this regard, the following ICD-9-CM codes have been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy:
>
> 115.02 115.92 360.21.

This policy has been converted into the local coverage determination (LCD) format. The revised full-text for this LCD will be available on the provider education Web site *www.floridamedicare.com* on or after this effective date. ❖

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

The local medical review policy (LMRP) for magnetic resonance angiography (MRA) – 70544 was previously revised on June 25, 2003, and published in the Fourth Quarter 2003 *Medicare A Bulletin* (page 36). During that time, the additional ICD-9-CM codes were added to MRA of the abdomen (procedure codes 74185, C8900, C8901, and C8902):

198.0	223.0	223.1	233.9	263.90-236.99	403.00-403.91
404.00-404.93	405.01	405.11	405.91	440.1	441.02 447.3
580.0-580.9	581.0-581.9	582.0-582.9	583.0-583.9	588.0-588.9	593.81 593.9

Effective Date

This addition is effective for services furnished **on or after July 1, 2003**. The revised full-text for this policy is available on the provider education Web site *www.floridamedicare.com* on or after this effective date. ❖

76536: Ultrasound, Soft Tissues of Head and Neck—Revision to Policy

The local medical review policy for ultrasound, soft tissues of head and neck – 76536 was implemented on September 29, 2003. Due to reconsideration, a revision to the policy was made to add ICD-9-CM code V15.3 – Irradiation (previous exposure to therapeutic or other ionizing radiation). This diagnosis is supported under the "Indications and Limitations of Coverage" section of the policy.

This policy has been converted to the new local coverage determination (LCD) format.

Effective Date

This revision is effective for claims processed **on or after June 1, 2004**. The revised full-text for this LCD is available on the provider education Web site *www.floridamedicare.com* on or after this effective date. ❖

93501: Cardiac Catheterization—Revision to Policy

The local coverage determination policy was last updated on July 6, 2004. Since that time, the ICD-9-CM codes were removed from the "ICD-9 Codes that Support Medical Necessity" section of the policy based on a comprehensive data analysis.

Effective Date

This revision was effective for services furnished **on or after July 6, 2004**. The revised full-text for this LCD is available on the provider education Web site *www.floridamedicare.com* on or after this effective date. ❖

93701: Cardiac Output Monitoring by Thoracic Electrical Bioimpedance—Revision to Policy

The local medical review policy (LMRP) for cardiac output monitoring by thoracic electrical bioimpedance – 93701 was last updated October 1, 2002. Per change request 2689, this policy has been revised to offer more explicit guidance and clarification for coverage of thoracic electrical bioimpedance based on a complete and updated literature review.

These changes are effective for services furnished **on or after January 23, 2004.**

In addition, the following diagnosis codes have been added to the "ICD-9 Codes that Support Medical Necessity" section of this policy:

786.05 996.03 V42.1 V53.31 V53.32

These changes are effective for services furnished **on or after November 29, 2004.**

This policy has been converted to the new local coverage determination (LCD) format "Monitoring" and "Thoracic" were added to the title to reflect wording in the national coverage guidelines.

The revised full-text for this LCD will be available on the provider education Web site *www.floridamedicare.com* on or after the appropriate effective dates indicated above. ❖

93975: Duplex Scanning—Addition to Policy

The local medical review policy for duplex scanning – 93975 was last updated July 1, 2002. Since that time, diagnosis codes V42.0, V42.7, V42.83 and 902.29 have been added to the "ICD-9 Codes that Support Medical Necessity" section of this policy for procedure codes 93975 and 93976 and diagnosis codes 440.20 and 440.29 have been added to the "ICD-9 Codes that Support Medical Necessity" section of this policy for procedure codes 93978 and 93979.

In addition, an indication was added to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy for procedure codes 93975 and 93976

This policy has been converted to the local coverage determination (LCD) format.

Effective Date

These additions are effective for services furnished **on or after August 30, 2004**. The revised full-text for this LCD will be available on the provider education Web site *www.floridamedicare.com* on or after this effective date. ❖

NESP: Darbepoetin alfa(Aranesp®)(novel erythropoiesis stimulating protein [NESP])—Revision to Policy

The local medical review policy (LMRP) for Aranesp® was last revised February 23, 2004. Since that time, we have received information from the manufacturer supporting additional criteria for extended dosing. This policy was revised to extend dosing guidelines for patients with anemia associated with chronic renal failure that does not require dialysis.

This LMRP has been converted to the new local coverage determination (LCD) format.

Effective Date

This policy revision is effective for services furnished **on or after June 3, 2004**. The revised full-text for this LCD is be available on the provider education Web site *www.floridamedicare.com* on or after this effective date. ❖

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

The latest revision for local medical review policy (LMRP) for hyperbaric oxygen therapy – C1300 was effective January 1, 2004. Since that time, Program Memorandum 187 (Change Request 3172, dated May 28, 2004) was issued to add CPT code 99183 (*Physician attendance and supervision of hyperbaric oxygen therapy, per session*) to the CPT/HCPCS Codes section of the policy, delete type of bill codes 21x and 22x and add the following instructions (which have been incorporated into the "Coding Guidelines" section of the policy):

> For critical access hospitals (CAHs) electing method I, HBO therapy is reported under revenue code 940 along with HCPCS code 99183. Payment to CAHs (electing Method I) is made under cost reimbursement. For CAHs electing method II, the technical component is paid under cost reimbursement and the professional component is paid under the Medicare physician fee schedule.

This policy has also been converted to the new local coverage determination (LCD) format with an LCD attachment for "Reasons for Denials" and "Coding Guidelines" sections.

Effective Date

These revisions are effective for services **furnished on or after April 1, 2003.** The revised full-text for this LCD is available on the provider education Web site *www.floridamedicare.com* on or after this effective date. ❖

G0104: Colorectal Cancer Screening—Revision to Policy

This policy was last updated on January 1, 2004. A revision is being made based on CMS Pub. 100-04 Transmittal 80, CR 2874 for Extended Coverage for Colorectal Cancer Screenings at Skilled Nursing Facilities (SNF). The following table shows the colorectal cancer screening tests, procedure codes, revenue codes, and frequencies for beneficiaries 50 years or older allowed in SNFs (type of bill 22x or 23x).

Colorectal Ca Screening Test	Procedure Code	Revenue Code	Frequency
Flexible sigmoidoscopy*	G0104	075x	Once every 48 months
Screening barium enema; alternative to G0104	G0106	032x	Once every 48 months
Fecal occult blood, guaiac-based	G0107	030x	Once every 12 months**
Fecal occult blood, immunoassay-based	G0328	030x	Once every 12 months**

*If a lesion or growth is detected during the flexible sigmoidoscopy resulting in the removal of the lesion or growth, the provider should bill the appropriate flexible sigmoidoscopy diagnostic procedure instead of G0104 or G0106.

**Either G0107 or G0328 (but not both) are allowed during a 12-month period.

Effective Date

The effective date of this policy revision for type of bills 22x and 23x is for services furnished **on or after July 1, 2004**. The revised full-text for this LCD is available on the provider education Web site *www.floridamedicare.com* on or after this effective date. ❖

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

The latest revision to the local medical review policy for diabetes outpatient self-management training – G0108 was effective January 1, 2004. Program Memorandum 13 (Change Request 3185, dated May 28, 2004) was issued to communicate revisions for diabetes outpatient self-management training (DSMT). Revisions include changes in definition for diabetes mellitus and criteria for diagnosing diabetes mellitus, and coverage for initial and follow-up training. Revisions were made to the following sections of the policy:

- Indications and Limitations of Coverage and/or Medical Necessity
- Type of Bill Code
- Documentation Requirements
- Utilization Guidelines

This policy has been converted to the local coverage determination format with an attachment that includes coding guidelines.

Effective Date

These revisions are effective for services **furnished on or after January 1, 2004.** The revised full-text for this LCD is available on the provider education Web site *www.floridamedicare.com* on or after this effective date. ❖

J1563: Intravenous Immune Globulin—Revision to Policy

The local coverage determination (LCD) for intravenous immune globulin was last revised April 1, 2003. Since that time, diagnosis 358.0 is not to the highest level of specificity, therefore, diagnosis 358.0 (Myasthenia gravis) has been changed to diagnosis range 358.00-358.01 in the "ICD-9 Codes that Support Medical Necessity" section of the LCD.

Effective Date

This revision was effective for services furnished **on or after October 1, 2003**. The revised full-text for this LCD is available on the provider education Web site *www.floridamedicare.com* on or after this effective date. ❖

J2916: Ferrlecit®—Revision to Policy

The local medical review policy for Ferrlecit® was last updated on January 1, 2003. A revision to the policy was made for clarification regarding the dual diagnoses. Under the "ICD-9 Codes that Support Medical Necessity" section of the policy, the words "for renal disease" were removed. At the end of this section, the previous wording read as follows:

*The billing of Ferrlecit® for renal disease requires a dual diagnosis. ICD-9 codes 585 and one of the secondary codes for iron deficiency anemia (ICD-9 codes 280.0, 280.1, 280.8, or 280.9) must be submitted to ensure reimbursement.

The text now reads as follows:

*The billing of Ferrlecit® requires a dual diagnosis. ICD-9 codes 585 and one of the secondary codes for iron deficiency anemia (ICD-9 codes 280.0, 280.1, 280.8, or 280.9) must be submitted to ensure reimbursement.

This policy has been converted to the new local coverage determination (LCD) format.

Effective Date

This revision is effective for claims processed **on or after May 6, 2004**. The revised full-text for this LCD is available on the provider education Web site *www.floridamedicare.com* on or after this effective date. ❖

J9000: Antineoplastic Drugs—Revision to Policy

The local medical review policy for antineoplastic drugs was last updated on January 1, 2004. A revision to the policy was made to update the following drug codes with the addition of the ICD-9-CM codes listed below based on the Compendia-Based Drug Bulletin and/or the Antineoplastic Drugs Workgroup for diagnoses and/or indications and limitations of coverage.

CPT Codes:	**Diagnoses Codes Added:**
J9000 (Doxorubicin)	152.0-152.9, 153.0-153.9, 155.1, 156.0-156.9, 158.8, 162.0, 164.8, 181, 183.2, 197.6, 198.5, 259.2
J9001 (Doxorubicin, Liposomal)	158.8, 158.9, 170.0-170.9, 171.0-171.9, 197.6, & 203.00-203.01
J9045 (Carboplatin)	151.0, 158.9, 197.6
J9170 (Docetaxel)	158.8, 158.9, 160.0-160.9, 170.0-170.9, 197.6
J9178 (Epirubicin)	158.8, 158.9, 197.6
J9181, J9182 (Etoposide)	158.8, 158.9, 164.8, 181, 183.2, 197.6, 198.5
J9185 (Fludarabine)	204.90-204.91
J9200 (Floxuridine)	155.1, 158.8, 158.9, 197.6
J9201 (Gemcitabine)	158.0-158.9, 164.2, 164.3, 164.8, 164.9, 181, 194.4, 197.6
J9206 (Irinotecan)	162.0
J9265 (Paclitaxel)	158.9, 160.0-160.9, 197.6
J9280, J9290, J9291 (Mitomycin)	154.2, 154.3, 160.0-160.9
J9350 (Topotecan)	158.8, 158.9, 197.6
J9390 (Vinorelbine tartrate)	158.8, 158.9, 197.6

Under the Indications and Limitations of Coverage and/or Medical Necessity, additional off label uses were added, changed, or removed for the following CPT codes:

J9000	J9001	J9045	J9170	J9178	J9181	J9182	J9185
J9200	J9201	J9206	J9263	J9310	J9350	J9390.	

This policy has been converted to the new local medical determination format with a coding guidelines attachment.

Effective Date

These revisions are effective for services furnished **on or after November 29, 2004**. The revised full-text for this LCD will be available on the provider education Web site *www.floridamedicare.com* on or after this effective date. ❖

Zevalin: Ibritumomab Tiuxetan (Zevalin™) Therapy—Revision to Policy

The local medical review policy for ibritumomab tiuxetan (Zevalin™) therapy was last revised January 1, 2004. It has been brought to our attention that services billed with CPT codes 78804 and 79403 were receiving denials when not billed with the ICD-9-CM codes listed in the policy. Although these codes are included in this policy, they are not exclusive to Zevalin. Therefore, the policy has been revised to specify the appropriate CPT and diagnosis codes for use when rendering this service.

This policy has been converted to the new local coverage determination (LCD) format.

Effective Date

This policy revision is effective for claims processed **on or after July 1, 2004**. The revised full-text for this LCD is available on the provider education Web site *www.floridamedicare.com* on or after this effective date. ❖

RETIREMENT OF EXISTING LMRPs

PAINREH: Pain Rehabilitation—Retirement of Policy

The local medical review policy for pain rehabilitation is being retired. It has been determined that the information in the policy is informational only and reflects national coverage guidelines. A policy may be developed in the future, if services become aberrant.

Effective Date

This retirement is effective for services furnished **on or after July 22, 2004**. ❖

CORRECTION TO PUBLISHED ARTICLES

92135: Scanning Computerized Ophthalmic Diagnostic Imaging—Correction to Previously Published Article

An article was published in the Third Quarter 2004 *Medicare A Bulletin* (page 48) indicating revisions to the local medical review policy for scanning computerized ophthalmic diagnostic imaging – 92135. Changes included revisions to the following sections of the policy:

- Description
- Indications and Limitations
- Reasons for Denials
- Utilization Guidelines.

Additional ICD-9-CM codes were added to the "ICD-9 Codes that Support Medical Necessity" section of the policy as well.

The effective date published for the additional ICD-9-CM Codes added to the policy was for services furnished on or after April 23, 2003, and processed on or after May 1, 2004. The correct effective date for the additional ICD-9-CM codes added to the policy is for services **furnished on or after April 21, 2003,** and **processed on or after May 1, 2004.** The remainder of the revisions is effective for services **furnished on or after March 29, 2004.** The revised full-text for this LCD is available on the provider education Web site *www.floridamedicare.com*. ❖

93501: Cardiac Catheterization—Correction to Previously Published Article

An article for the revision of local medical review policy for cardiac catheterization – 93501 was published in the Third Quarter 2004 *Medicare A Bulletin* (page 48). The date of the Program Memorandum, Transmittal A-02-129, was published as January 3, 2001. The correct date for this transmittal is January 1, 2003.

Effective Date

The effective date for this transmittal is for services furnished **on or after January 1, 2003**. The revised full-text for this LCD is available on the provider education Web site *www.floridamedicare.com* on or after this effective date. ❖

EPO: Epoetin alfa and J0207: Amifostine (Ethyol®)—Correction to Previously Published Article

An article regarding local coverage determinations (LCDs) for EPO and J0207, published in the Third Quarter 2004 *Medicare A Bulletin* (page 49) contained incorrect information. In that article, we indicated that effective for services rendered on or after July 6, 2004, providers should use ICD-9-CM code V07.8 when billing epoetin alfa for reduction of allogeneic blood transfusion in surgery patients; and ICD-9-CM code 995.2 when billing amifostine for nephrotoxicity, bone marrow toxicity, and/or neurotoxicity associated with cisplatin and/or cyclophosphamide regimen. However, providers should begin billing these diagnosis codes **effective for claims processed on or after June 1, 2004.**

In addition, the policy was revised to remove all language regarding criteria for serum erythropoetin levels. We apologize for any inconvenience this may have caused.

The revised full-text for this LCD is available on the provider education Web site *www.floridamedicare.com* on or after this effective date. ❖

CORF SERVICES

Arrangements for Physical, Occupational, and Speech-Language Pathology Services

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

Provider Types Affected

Physicians, therapists, providers, clinics.

Provider Action Needed

Physicians, suppliers, and providers should note that this instruction clarifies information regarding arrangements for Medicare Part B outpatient physical therapy, occupational therapy, and speech-language pathology services furnished under arrangements with providers and clinics. Revisions have been made to Chapter 15, Section 220.1 of the *Medicare Benefits Policy Manual (Pub 100-02). Section 220.1 Therapy Services Furnished Under Arrangements with Providers and Clinics* is included in this article for informational purposes. Please note that this information is for clarification purposes only and should not represent any change for providers.

Background

The excerpt from the manual itself is as follows: "A provider or clinic may have others furnish outpatient physical therapy, occupational therapy, or speech language pathology services through arrangements under which receipt of payment by the provider or clinic for the services discharges the liability of the beneficiary or any other person to pay for the service. However, it is not intended that the provider or clinic merely serve as a billing mechanism for the other party. The provider's or clinic's professional supervision over the services requires application of many of the same controls as are applied to services furnished by salaried employees. The provider or clinic must:

- Accept the patient for treatment in accordance with its admission policies.
- Maintain a complete and timely clinical record on the patient which includes diagnosis, medical history, physician's orders, and progress notes relating to all services received.
- Maintain liaison with the attending physician or non-physician practitioner with regard to the progress of the patient and to assure that the required plan of treatment is periodically reviewed by the physician.
- Secure from the physician the required certifications and recertifications.
- See to it that the medical necessity of such service is reviewed on a sample basis by the agency's staff or an outside review group.

In addition, when a clinic provides outpatient physical therapy, occupational therapy, or speech-language pathology services under an arrangement with others, such services must be furnished in accordance with the terms of a written contract, which provides for retention by the clinic of responsibility for and control and supervision of such services. The terms of the contract should include at least the following:

- Provide that the therapy or speech-language pathology services are to be furnished in accordance with the plan of care established by the physician after any necessary consultation with the physical therapist, occupational therapist, or speech-language pathologist as appropriate, the physical therapist who will provide the physical therapy services, the occupational therapist who will provide the occupational therapy services, or the speech-language pathologist who will provide the speech language pathology services.
- Specify the geographical areas in which the services are to be furnished.
- Provide that personnel and services contracted for meet the same requirements as those which would be applicable if the personnel and services were furnished directly by the clinic.
- Provide that the therapist will participate in conferences required to coordinate the care of an individual patient.
- Provide for the preparation of treatment records, with progress notes and observations, and for the prompt incorporation of such into the clinical records of the clinic.
- Specify the financial arrangements. The contracting organization or individual may not bill the patient or the health insurance program.
- Specify the period of time the contract is to be in effect and the manner of termination or renewal."

Additional Information

To view Chapter 15 of the Medicare Benefits Policy Manual, visit: *http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp*.

Once at that site, scroll down to Chapter 15 and select the file version you wish to receive.

The official instruction issued to your 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 CR3134 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 representatives is 1-877-602-8816. ❖

Related Change Request (CR) Number: 3134
Related CR Release Date: April 23, 2004
Related CR Transmittal Number: 9
Effective Date: May 24, 2004
Implementation Date: May 24, 2004

Source: CMS Pub 100-2 Transmittal 9, CR 3134

SKILLED NURSING FACILITY SERVICES

Billing L Codes Under the Skilled Nursing Facility Consolidated Billing

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

Provider Types Affected

Skilled nursing facilities (SNFs) and suppliers

Provider Action Needed

STOP – Impact to You

As of April 1, 2004, suppliers cannot get paid for codes L5673 and L5679 for services provided to a beneficiary in a Part A SNF stay. These codes have replaced codes K0557 and K0558. Codes L5673 and L5679 were inadvertently left off the April 2004 quarterly update edits for SNF consolidated billing.

CAUTION – What You Need to Know

Once corrected, these codes will allow separate payment by Medicare durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs) outside the perspective payment rate for Medicare beneficiaries in Part A SNF stays. These codes will be added to the October quarterly update. When claims for L5679 and L5673 are rejected, the following incorrect messages will appear on your statement: Remittance Advice American National Standards Institute (ANSI) Reason code 109, "Claims not covered by this payer/contractor. Claims must be sent to the correct payer/contractor;" and remark code MA101, "A SNF is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents." Since these codes were mistakenly not added to the edits for services that are separately payable outside of consolidated billing and the PPS rate, the provider or supplier should not contact the SNF for payment on these claims.

GO – What You Need to Do

If your claim for L5679 or L5673 services is not paid from April 1 through September 30, 2004, notify your DMERC or intermediary and request they re-open the claim and use the appropriate override code to process your claim for payment.

Background

Due to an inadvertent programming error, Medicare systems will not process payments for HCPCS codes L5673 and L5679 as of April 1, 2004. These codes are described as follows:

- **L5679 –** Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism, effective January 1, 2004.
- **L5673** and **L5679** replaced K0557 and K0558, which were terminated as of December 31, 2003. K0557 and K0558 are defined as follows:
  - **K0557** – same definition as L5673, terminated December 31, 2003.
  - **K0558** – Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code K0556 or K0557), terminated December 31, 2003.

Where appropriate, Medicare has instructed your DMERC or intermediary to pay interest for delayed payments.

Additional Information

If you have any questions regarding this issue, please contact your DMERC or intermediary at their toll free number. If you do not have that number, you may find it 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.

To view the instruction issued to your carrier/intermediary regarding this issue, please visit: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

Scroll down the CR NUM column on the right and click on CR3295. ❖

Related Change Request (CR) Number: 3295
Related CR Release Date: May 28, 2004
Related CR Transmittal Number: 191
Effective Date: June 28, 2004
Implementation Date: June 28, 2004

Source: CMS Pub 100-4 Transmittal 191, CR 3295

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Services Furnished Under an "Arrangement" with an Outside Entity—Skilled Nursing Facility Consolidated Billing

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

Provider Types Affected

Skilled nursing facilities (SNF), physicians, non-physician practitioners, suppliers, and providers.

Provider Action Needed

STOP – Impact to You

Affected providers should note that this instruction is being issued as a reminder of the applicable consolidated billing requirements that pertain to skilled nursing facilities (SNF) and to the outside suppliers that serve SNF residents.

CAUTION – What You Need to Know

Whenever a SNF resident receives a service that is subject to SNF consolidated billing from an outside supplier, the Social Security Act requires the SNF and the supplier to enter into an "arrangement." Under an "arrangement," Medicare's payment to the SNF represents payment in full for arranged-for services and suppliers must look to the SNF (rather than to Medicare Part B) for their payment.

GO – What You Need to Do

Be aware of the requirements explained below and how they can impact your Medicare payments.

Background

The SNF consolidated billing provisions of the Social Security Act[1] place the Medicare billing responsibility for most of the SNF's residents' services with the SNF itself.

In addition, Part A consolidated billing requires that an SNF must include on its Part A bill:

- Almost all of the services that a resident receives during the course of a ***Medicare-covered* stay**;
- **Except** for those services that are specifically ***excluded*** from the SNF's global prospective payment system (PPS) per diem payment for the covered stay. (These "excluded" services remain separately billable to Part B directly by the outside entity that actually furnishes them.)

Also, Part B consolidated billing makes the SNF itself responsible for submitting the Part B bills for any ***physical, occupational, or speech-language therapy services*** that a resident receives during a ***noncovered*** stay.

Further, for any Part A or Part B service that is subject to SNF consolidated billing, the SNF must either:

- Furnish the service directly with its own resources, or
- Obtain the service from an outside entity (such as a supplier) under an "arrangement," as described in the Social Security Act.[2]

This "arrangement" must constitute a written agreement to reimburse the outside entity for Medicare covered services subject to consolidated billing, i.e., services that are reimbursable only to the SNF as part of its global PPS per diem or those Part B services that must be billed by the SNF.

Problematic Situations

There are various ***problematic situations*** in which an SNF resident receives a service from an outside supplier (or practitioner) that is subject to consolidated billing, in the absence of a valid arrangement between that entity and the SNF.

In some instances, the supplier may have been unaware that the beneficiary was in a Part A stay until its separate Part B claim was denied. In the absence of a written agreement, the supplier may have difficulty in obtaining payment from the SNF, even though the service at issue is a type of service that is Medicare covered and included in the SNF's global PPS per diem.

As discussed in greater detail below, such situations most commonly arise in one of the following scenarios:

- A SNF does not accurately identify services as being subject to consolidated billing when ordering such services from a supplier; or
- A supplier fails to ascertain a beneficiary's status as an SNF resident when the beneficiary (or another individual acting on the beneficiary's behalf) seeks to obtain such services directly from the supplier without the SNF's knowledge.

Whenever a supplier furnishes services that are subject to consolidated billing in the absence of a written agreement with the SNF, the supplier risks not being paid for the services. In addition, the supplier in this situation might improperly attempt to bill Part B directly for the services. The inappropriate submission of a Part B bill for such services could result not only in Medicare's noncoverage of the services themselves, but also in the imposition of civil money penalties, as explained below.

Along with all of the other potentially adverse consequences of such practices, the SNF risks violating the terms of the Medicare provider agreement (which requires a SNF to have a valid arrangement in place whenever a resident receives services that are subject to consolidated billing from any entity other than the SNF itself).

In order to help prevent these types of problems from arising, ***this instruction is being issued as a reminder of the applicable consolidated billing requirements that pertain to SNFs and to the outside suppliers that serve SNF residents.***

Billing Arrangements

Under an arrangement as defined in the Social Security Act[3]**:**

- Medicare's payment to the SNF represents payment in full for arranged-for services; and
- Suppliers must look to the SNF (rather than to Part B) for their payment.

Further, in entering into such arrangements, the SNF cannot function as a mere billing conduit, and must exercise professional responsibility and control over the arranged-for service**.**[4] The long-term care (LTC) facility requirements for program participation further provide that under such an arrangement, the SNF must ***specify in writing*** that it assumes responsibility for the quality and timeliness of the arranged-for service.[5]

Services Furnished Under an "Arrangement" with an Outside Entity—SNF CB (continued)

Medicare does not prescribe the actual terms of the SNF's written agreement with its supplier (such as the specific amount or timing of the supplier's payment by the SNF). These are arrived at through direct negotiation between the parties to the agreement. However, in order for a valid "arrangement" to exist for those services that are subject to consolidated billing, ***the SNF must have a written agreement in place with its supplier***, which specifies how the supplier is to be paid for its services. The existence of such an agreement also provides both parties with a means of resolution in the event that a dispute arises over a particular service.

If an SNF elects to obtain services that are subject to consolidated billing from an outside supplier, but fails to execute a written agreement with that supplier, then there is no valid arrangement for the services as contemplated under the Social Security Act.[6]

Not only would this potentially result in Medicare's noncoverage of the particular services at issue, but the SNF would also risk being found in violation of the terms of its provider agreement. Under the Social Security Act, the SNF's provider agreement includes a specific commitment to comply with the requirements of the consolidated billing provision.[7]

Further, the Social Security Act imposes a civil money penalty on any person who knowingly and willfully presents (or causes to be presented) a bill or request for payment inconsistent with an arrangement or in violation of the requirement for such an arrangement.[8]

Accordingly, whenever an SNF elects to utilize an outside supplier to furnish a service that is subject to consolidated billing, the SNF must have a written agreement in place with that supplier. Conversely, whenever an outside supplier furnishes such a service to an SNF resident, it must do so under a written agreement with the SNF.

Problems with Arrangements

Problems involving the absence of a valid arrangement between an SNF and its supplier typically tend to arise in one of the following two situations:

- The first problem scenario occurs when an SNF elects to utilize an outside supplier to furnish a type of service that would be subject to Part A consolidated billing, but then fails to inform the supplier that the resident receiving the service is in a covered Part A stay.

  This causes the supplier to conclude mistakenly that the service it furnishes to that resident is not subject to consolidated billing. Based on the inaccurate impression that the resident's SNF stay is noncovered, the supplier inappropriately submits a separate Part B claim for the service, and only learns of the actual status of the resident's Medicare-covered SNF stay when that Part B claim is denied. In this scenario, even though the supplier made reasonable efforts to ascertain from the SNF both the beneficiary's status as an SNF resident and the specific nature of the beneficiary's SNF stay, the information from the SNF (on which the supplier relied) proved to be inaccurate.

  While it is recognized that inadvertent errors may occasionally occur in the course of furnishing such information, an SNF should not only make a good faith effort to furnish accurate information to its supplier, but should have a written agreement in place that provides for direct reimbursement of the supplier once such an error is called to its attention.

  By contrast, in the scenario at issue, the SNF refuses to pay the supplier for the service even ***after*** being apprised of the inaccuracy of its initial information. As discussed previously, having a valid arrangement in place for the disputed service would not only ensure compliance with the consolidated billing requirements, but also would provide a vehicle for resolving the dispute itself.

- **The second problem scenario** involves a resident who temporarily departs from the SNF on a brief leave of absence, typically accompanied by a relative or friend. While briefly offsite, the resident (or the relative or friend, acting on the resident's behalf) obtains services that are subject to the consolidated billing requirement, but fails to notify the SNF.

  As in the previous scenario, this results in the services being furnished to the resident by an outside entity in the absence of a valid arrangement with the SNF. In addition, such a practice impedes the SNF from meeting its responsibility to provide comprehensive oversight of the resident's care and treatment.

  SNFs can act to prevent such problems from arising by ensuring that each resident (and, if applicable, his or her representative) is fully aware of the applicable requirements.

  For example, the Medicare law[9] guarantees a beneficiary's free choice of any qualified entity that is willing to furnish services to the beneficiary. However, in selecting a particular SNF, the beneficiary has effectively exercised this right of free choice with respect to the ***entire package*** of services for which the SNF is responsible under the consolidated billing requirement, including the use of any outside suppliers from which the SNF chooses to obtain such services.

In addition, the long term care (LTC) facility participation requirements[10] direct the SNF to advise each resident, on or before admission and periodically during the stay, of any charges for services not covered by Medicare.

In providing such advice periodically throughout each resident's stay, the SNF should take particular care to include any resident who is about to leave the facility temporarily, in order to ensure that the resident (and, if applicable, the resident's representative) understands the need to consult the SNF before obtaining any services offsite.

Moreover, while the SNF itself should take reasonable steps to prevent such problems from arising, the supplier is also responsible for being aware of and complying with the consolidated billing requirements.

This means that prior to furnishing services to a Medicare beneficiary, the supplier should routinely ascertain whether the beneficiary is currently receiving any comprehensive Medicare benefits (such as SNF or home health benefits) for which Medicare makes a bundled payment that

Services Furnished Under an "Arrangement" with an Outside Entity—SNF CB (continued)

could potentially include the supplier's services. If the supplier ascertains that a particular beneficiary is, in fact, a resident of an SNF with which the supplier does not have a valid arrangement in place, then the supplier should contact the SNF before actually furnishing services to that beneficiary.

Implementation

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

Additional Information

The Medicare Claim Processing Manual, Pub 100-04, Chapter 6 (SNF Inpatient Part A Billing), Section 10.3 (Types of Services Subject to the Consolidated Billing Requirement for SNFs) has been revised. The following new sections have also been added:

- Section 10.4 (Furnishing Services that are Subject to SNF Consolidated Billing Under an "Arrangement" with an Outside Entity);
- Subsection 10.4.1 (Written Agreement); and
- Subsection 10.4.2 (SNF and Supplier Responsibilities).

These revised/new portions of the manual are attached to the official instruction issued to your contractor regarding this change. That instruction (CR 3248) may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that web page, look for CR 3248 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 representatives is 1-877-602-8816.

The Medicare General Information, Eligibility, and Entitlement Manual, Pub. 100-1, Chapter 5 (Definitions), Section 10.3 (Under Arrangements) can be found at the following CMS Online Manuals Web site: http://ww.cms.hhs.gov/manuals/cmsindex.asp. ❖

Related Change Request (CR) Number: 3248
Related CR Release Date: May 21, 2004
Related CR Transmittal Number: 183
Effective Date: April 1, 2004
Implementation Date: July 1, 2004

Source: CMS Pub 100-4 Transmittal 183, CR 3248

[1] Social Security Act, Sections 1862(a)(18), 1866(a)(1)(H)(ii), and 1888(e)(2)(A).

[2] Social Security Act, Section 1861(w).

[3] Social Security Act, Section 1861(w).

[4] Medicare General Information, Eligibility, and Entitlement Manual, Pub. 100-1, Chapter 5 (Definitions), Section 10.3 (Under Arrangements).

[5] Code of Federal Regulations, 42 CFR 483.75(h)(2).

[6] Social Security Act, Section 1862(a)(18).

[7] Social Security Act, Section 1866(a)(1)(H)(ii), and the Code of Federal Regulations, 42 CFR 489.20(s).

[8] Social Security Act, Section 1866(g).

[9] Social Security Act, Section 1802.

[10] Code of Federal Regulations, 42 CFR 483.10(b)(6).

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Ambulance Transports to and from a Diagnostic or Therapeutic Site other than a Hospital—Change to the Skilled Nursing Facility Consolidated Billing Edits

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

Provider Types Affected

Skilled nursing facilities (SNF) and suppliers of ambulance services

Provider Action Needed

STOP – Impact to You

Your claim will be denied for ambulance transportation of a Medicare beneficiary in a Part A SNF stay to or from a diagnostic or therapeutic center other than a hospital.

CAUTION – What You Need to Know

Ambulance transports of beneficiaries in Part A SNF stays are considered to be paid as part of the SNF prospective payment system (PPS) rate, and may not be billed as Part B services to the carrier, except in specific instances. Effective October 1, 2004, your carrier has been instructed to deny your Part B claims for ambulance transports of your Medicare Part

Ambulance Transports to and from a Diagnostic or Therapeutic Site other than a Hospital (continued)

A residents to or from a diagnostic or therapeutic site other than a hospital (e.g., a non-hospital setting, such as an independent diagnostic testing facility (IDTF), or a free-standing cancer center, radiation therapy center, or wound care center).

GO – What You Need to Do

Make sure your billing staff are aware that, for beneficiaries in a Part A stay, a separate Part B claim for the ambulance transport of Medicare Part A residents to or from a diagnostic or therapeutic center other than a hospital will be denied.

Background

Section 4432(b) of the Balanced Budget Act (BBA) requires consolidating billing (CB) for SNFs. Under the CB requirement, the SNF must submit all Medicare claims for all the services its residents receive under Part A (except for certain excluded services). In addition, the SNF must also submit Medicare claims for all physical and occupational therapies, and speech-language pathology services its residents receive under Part B.

All Medicare-covered Part A services that are deemed to be within a SNF's scope or capability are considered paid in the SNF PPS rate. As mentioned above, ambulance transports to or from diagnostic or therapeutic sites other than a hospital are considered paid in the SNF PPS rate and may **not** be billed as Part B services to the carrier.

In addition, please note that transport of beneficiaries in Part A stays from one SNF to another before midnight of the same day is also included in the SNF PPS rate and may **not** be billed separately as a Part B service. In this instance, payment is bundled in the first SNF's PPS rate and it is responsible for the costs of the transport.

Please note that this change does not replace existing CB policies as they relate to critical access hospitals (CAHs) and end-stage renal disease (ESRD) facilities.

Additional Information

You can find additional material related to this CR on the CMS Web site at: *http://www.cms.hhs.gov/manuals/transmittals/cr_num_dsc.asp*.

From that Web page, look for 3196 in the CR NUM column on the right, and click on the file for that CR.

Attached to that CR, you can find the revised Medicare manual pages for the Medicare Claims Processing Manual (Publication 100-4), Chapter 6, Section 20.3.1 – Ambulance Services, and Chapter 15, Section 30.2.3 – SNF Billing. These pages will provide further detail on this issue. ❖

Related Change Request (CR) Number: 3196
Related CR Release Date: April 30, 2004
Related CR Transmittal Number: 163
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 163, CR 3196

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Updated Skilled Nursing Facility Help File Available for Calendar Year 2004

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

Provider Types Affected

Providers and suppliers of skilled nursing facility (SNF) services

Provider Action Needed

None. This article provides information only. It alerts you to the calendar year 2004 SNF Help File that is now available for your use.

Background

Annually, after the major Healthcare Common Procedure Coding System (HCPCS) updates are completed, CMS also provides you with an SNF Help File, so that you can see which services are included in SNF consolidated billing under Part A, identify the basis of payment for services under Part B, and better understand your fiscal intermediary's (FIs) explanation of edit results on your claims.

This file, a large Microsoft Excel® spreadsheet that specifies the status of over 11,900 HCPCS and CPT codes for SNF billing and payment, is also updated, as necessary, at other times during the year when there are significant changes to the HCPCS file.

Additional Information

You can find more information about this updated file in Chapters 6 and 7 of the Medicare Claims Processing Manual at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

The following link will take you directly to the SNF Help File: *http://www.cms.hhs.gov/manuals/104_claims/clm104c06snfhelp.pdf*. (This file is directed toward SNFs and suppliers.)

In addition, you can learn more about SNF consolidated billing at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*. (This site is for individuals billing to carriers.) ❖

Related Change Request (CR) Number: 3252
Related CR Release Date: May 28, 2004
Related CR Transmittal Number: 189
Effective Date: January 1, 2004
Implementation Date: June 28, 2004

Source: CMS Pub 100-4 Transmittal 189, CR 3252

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Special Adjustment for Acquired Immune Deficiency Syndrome

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

Provider Types Affected

Skilled nursing facilities (SNF) and swing bed providers.

Provider Action Needed

STOP – Impact to You

Section 511 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) increases by 128 percent the per diem resource utilization group (RUG) payment for an SNF resident with acquired immune deficiency syndrome (AIDS).

This increase will apply to services furnished **on or after October 1, 2004.** Claims with diagnosis code 042 will receive the additional payment.

CAUTION – What You Need to Know

No payment will be made under section 101(a) of the Medicare Balanced Budget Refinement Act of 1999 (BBRA) or under section 314(a) of the Benefits Improvement & Protection Act of 2000 (BIPA) for SNF AIDS residents.

GO – What You Need to Do

Please note the effective date and correct diagnosis code provided above to ensure accurate processing of claims pertaining to SNF residents with AIDS.

Background

Section 101(a) of the BBRA (1999) and Section 314(a) of the BIPA (2000) provide additional payments to SNFs for certain RUG groups. In recognition of the additional costs associated with SNF AIDS residents, Section 511 of the MMA amends paragraph (12) of section 1888(e) (42 U.S.C. 1395yy(e)) to provide a special payment adjustment for care of such residents.

This increase will apply to services furnished on or after October 1, 2004. As of the effective date, claims with diagnosis code 042 will receive the additional payment for SNF residents with AIDS and no payment will be made under section 101(a) of the BBRA or under section 314(a) of the BIPA for SNF AIDS residents.

Additional Information

The toll-free number for your intermediary may be found online 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.

The official instruction issued to the intermediary regarding this change can be found online, referenced via CR 3291, at: *http//www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*. ❖

Related Change Request (CR) Number: 3291
Related CR Release Date: April 30, 2004
Related CR Transmittal Number: 160
Effective Date: October 1, 2004 (Discharges on or after October 1, 2004)
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 160, CR 3291

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Revision to the July 2004 Update to the Skilled Nursing Facility NO PAY File

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

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed

This instruction replaces Change Request (CR) 3275, Transmittal 182, which was issued on May 17, 2004.

Background

As part of the implementing legislation for the skilled nursing facility (SNF) prospective payment system (PPS), the Balanced Budget Act of 1997 requires that all Part B services provided to SNF residents be paid on any existing fee schedule. Additionally, there are certain services that should not be paid to SNFs. The HCPCS codes for these services are provided to fiscal intermediaries (FIs) annually, with quarterly updates as necessary.

As part of its support of SNF consolidated billing (CB), the Centers for Medicare & Medicaid Services (CMS) has provided the FIs with an SNF NO PAY File. This file, initially released November 1, 2002, for April 1, 2003, implementation, contains Healthcare Common Procedure Coding System (HCPCS) codes that cannot be paid to a SNF.

CMS also provides an SNF abstract of the Medicare physician fee schedule to FIs to facilitate their pricing of Part B services billed by SNFs. Fee schedule updates are always effective January 1 of the applicable calendar year.

As a result of this instruction, the SNF NO PAY file is updated with two HCPCS code changes effective July 1, 2004, as follows:

- HCPCS code G0104 is now payable to an SNF as a result of a change in Medicare edits for colorectal screening.
- HCPCS code G0329 has been added to the therapy list in place of HCPCS code G0295, which remains noncovered for Medicare.

Implementation

The implementation date for this instruction is July 6, 2004.

Revision to the July 2004 Update to the SNF NO PAY File (continued)

Related Instructions

The official version of this instruction was issued to your FI and it can be found by going to*:* *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

On that Web site page, look for CR 3338 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 representatives is 1-877-602-8816. ❖

Related Change Request (CR) Number: 3338
Related CR Release Date: June 10, 2004
Related CR Transmittal Number: 202
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 202, CR 3338

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Pharmacy Services Bypass—Update to the Common Working File

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

Provider Types Affected

Hospitals and skilled nursing facilities

Provider Action Needed

This instruction updates the Medicare system edits for its common working file (CWF) for skilled nursing facility (SNF) consolidated billing (CB) to expand the bypass for pharmacy services, and revises the edit(s) to bypass revenue code 25x when billed with an excluded surgery or emergency room service.

Background

All pharmacy charges are excluded from the skilled nursing facility consolidated billing (SNF CB) when related to and billed with an excluded surgery or emergency room visit. SNF CB is required under Section 1888 (e)(2) of the Social Security Act, and SNF CB excludes emergency room services, most surgical procedures, and services related to those exclusions.

Currently, Medicare systems are bypassing the consolidated billing edit on revenue code 250 when billed with a line item date of service matching the date of the emergency room service or surgery. Other pharmacy revenue codes are not being bypassed, causing excluded services to be subject to the (SNF CB) rule in error. In addition, some pharmacy charges billed under revenue code 250 are also being rejected because the revenue code does not require a line item date of service.

This instruction updates the Medicare CWF edits for SNF CB to expand the bypass for pharmacy services, and it revises the CWF edits to bypass revenue code 25x when billed with an excluded surgery or emergency room service.

Implementation

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

Additional Information

The Medicare Claims Processing Manual (Pub 100-04), Chapter 6 (SNF Inpatient Billing) Section 20 (Services Included in Part A PPS Payment Not Billable Separately by the SNF), Subsection 20.1.2 (Other Excluded Services Beyond the Scope of a SNF Part A Benefit), Sub-subsection 20.1.2.1 (Emergency Services are being revised. The revised pages are attached to the official instruction issued to your intermediary on this change.

To view those instructions, go to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3277 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 representatives is 1-877-602-8816. ❖

Related Change Request (CR) Number: 3277
Related CR Release Date: June 10, 2004
Related CR Transmittal Number: 200
Effective Date: For dates of service on or after April 1, 2001 billed within the timely filing period and received on or after October 4, 2004.
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 200, CR 3277

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October 2004 Quarterly Update of HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement

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

Provider Types Affected

Institutional providers billing claims to the Medicare fiscal intermediaries (FIs).

Physicians, practitioners, and suppliers billing Medicare carriers for services.

Provider Action Needed

STOP – Impact to You

HCPCS codes are being added to or removed from the SNF consolidated billing enforcement list.

CAUTION – What You Need to Know

Services included on the SNF consolidated billing enforcement list will be paid to skilled nursing facilities (SNF) Medicare providers only. Services excluded from the SNF consolidated billing enforcement list may be paid to Medicare providers other than SNFs. See *Background* and *Additional Information* sections for further explanation.

GO – What You Need to Do

Be aware of the requirements explained below and how they can impact your Medicare payment.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the list of HCPCS codes that are subject to the consolidated billing provision of the SNF prospective payment system (PPS).

Services appearing on this list submitted on claims to Medicare fiscal intermediaries (FIs) and carriers, including durable medical equipment regional carriers (DMERCs) will not be paid to any Medicare providers, other than a SNF, when included in SNF consolidated billing.

For nontherapy services, the SNF consolidated billing applies only when the services are furnished to a SNF resident during a covered Part A stay. However, the SNF consolidated billing applies to physical, occupational, or speech-language therapy services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. Services excluded from the SNF consolidated billing may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay.

Section 1888 of the Social Security Act codifies SNF PPS and consolidated billing. The new coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services will be added by these routine updates. New updates are required by changes to the coding system, not because the services subject to the SNF consolidated billing are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

The codes below are listed as being added or removed from the annual update, mentioned above.

Deletions from Major Category I F. below, specifically HCPCS code 36489, is being removed because the HCPCS was discontinued as of December 31, 2003. additions to what is noted as Major Category III below means these services may be provided by any Medicare provider licensed to provide them, **except a SNF,** and are excluded from SNF PPS and consolidated billing. Additions to therapy inclusions, Major Category V below, mean SNFs alone can bill and be paid for these services when delivered to beneficiaries in a SNF, whereas codes being removed from this therapy inclusion list now can be billed and potentially paid to other types of providers for beneficiaries NOT in a Part A stay or in a SNF bed receiving ancillary services billed on type of bill 22x.

Outpatient Surgery and Related Procedures (Major Category I F., FI Annual Update, INCLUSION)

Removed *CPT* code *36489* **–** placement of cv catheter

Note: *CPT* code *36489* was discontinued effective December 31, 2003.

Customized Prosthetic Devices (Major Category III, FI Annual Update, EXCLUSION)

- **For FI claim processing**, HCPCS codes K0556, K0557, K0558, K0559 – Addition to lower extremity, below knee/above knee, custom fab – have been **removed**.

  Note: HCPCS codes K0556, K0557, K0558, K0559 were replaced by HCPCS codes L5673, L5679, L5681 and L5683.

- **For carrier claim processing**, these codes will remain payable for dates of service prior to January 1, 2004.

  Added HCPCS code L5673 – addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism

  Added HCPCS code L5679 – addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism

  Note: HCPCS codes L5673 and L5679 are added to the exclusion list retroactive to January 1, 2004.

Chemotherapy Administration (Major Category III, FI Annual Update, EXCLUSION)

Removed *CPT* code *36489* – placement of cv catheter.

Note: CPT code 36489 was discontinued effective December 31, 2003.

Therapies (Major Category V, FI Annual Update, for FI billing use revenues codes 42x (physical therapy), 43x (occupational therapy), 44x (speech-language pathology)

Removed HCPCS code G0295 – Electromagnetic stimulation, to one or more areas. (Not covered by Medicare)

Note: HCPCS code G0295 was erroneously added to file. This code was not previously included on carrier coding files.

October 2004 Quarterly Update of HCPCS Codes Used for SNF Consolidated Billing Enforcement (continued)

Removed HCPCS code G0237 – Therapeutic procd strg endur
Removed HCPCS code G0238 – Oth resp proc, indiv
Removed HCPCS code G0239 – Oth resp proc, group
Removed HCPCS code G0302 – pre-op LVRS service
Removed HCPCS code G0303 – pre-op service LVRS 10-15dos
Removed HCPCS code G0304 – pre-op service LVRS 1-9dos
Removed HCPCS code G0305 – post-op service LVRS min 6dos

Note: These codes are not considered therapy codes and are not payable to a SNF. They were inadvertently added to the table.

Added HCPCS code G0329 – electromagnetic therapy, (unattended), 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

Note: HCPCS code G0329 was added to the therapy inclusion list effective July 1, 2004. (Information concerning this code was not received in time to issue a July 2004 update.)

Additional Information

Each January, separate instructions are published for FIs, Carriers and DMERCs for the annual notice on the SNF consolidated billing. The 2004 Annual Updates for FIs can be found on the CMS web site at: *www.cms.hhs.gov/manuals/pm_trans/R19CP.pdf*.

This instruction is referred to as CR2926.

Overall information regarding SNF CB can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

Quarterly updates now apply to FIs, Carriers and DMERCs. There has been one joint FI/Carrier/DMERC quarterly update published subsequent to the 2004 Annual Updates. This update can be found at: *www.cms.hhs.gov/manuals/pm_trans/R92CP.pdf*.

That instruction is also known as CR3070.

The official instruction issued to your 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 CR3348 in the CR NUM column on the right, and then click on the file for that CR. ❖

Related Change Request (CR) Number: 3348
Related CR Release Date: July 9, 2004
Related CR Transmittal Number: 224
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 224, CR 3348

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ESRD SERVICES

Clarification of Billing for Separately Billable End-Stage Renal Disease Drugs

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

Provider Types Affected

Hospital-based and independent dialysis facilities

Provider Action Needed

STOP – Impact to You

This instruction clarifies the billing procedures for separately billable end stage renal disease (ESRD) injectable drugs and administration-supply charges. It also includes a correction to the provider series numbers for dialysis providers: 3300- 3399 (children's hospitals excluded from prospective payment system).

CAUTION – What You Need to Know

Separately billable drugs furnished in ESRD dialysis centers must be of the appropriate category of drugs, and the most appropriate method of administration supply will be paid for these separately billable injectable drugs. The payment for these administration-supplies will be on a reasonable cost basis.

GO – What You Need to Do

Refer to the *Background* and *Additional Information* sections of this article for further details regarding these changes.

Background

Multiple categories of drugs are not included in the ESRD composite rate. These drugs are considered to be separately billable drugs when used to treat the patient's renal condition. The separately billable injectable drugs allow for an administration-supply charge. The allowable administration-supply charges are determined by the most appropriate method of administration.

This instruction clarifies the billing procedures for separately billable ESRD injectable drugs and administration-supply charges. Separately billable drugs furnished in ESRD dialysis centers must be of the appropriate category of drugs, and the most appropriate method of administration-supply will be paid for these separately billable injectable drugs. The instruction also includes corrections to the provider series numbers for dialysis providers: 3300-3399 (children's hospitals).

Separately Billable ESRD Drugs

The following categories of drugs are separately billable when furnished in hospital-based facilities or independent dialysis facilities to treat the patient's renal condition:

- Antibiotics
- Analgesics
- Anabolics
- Hematinics
- Muscle relaxants
- Sedatives
- Tranquilizers
- Thrombolytics: used to declot central venous catheters.

Note: Erythropoietin replacement therapies are separately billable and paid at established rates through appropriate billing methodology: epotein (EPO) alfa (Epoetin®) and darbepoetin alfa (Aranesp®) (see the Medicare Claims Processing Manual, Pub. 100-04, Sections 60.4 and 60.7). Also, note that there is an exception for separate payment for antibiotics. Antibiotics are included in the composite rate when used at home by a patient to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis.

These separately billable drugs may only be billed by an ESRD facility if they are actually administered in the facility by the facility staff. Staff time used to administer separately billable drugs is covered under the composite rate and may not be billed separately. However, the supplies used to administer these drugs may be billed in addition to the composite rate and paid on a reasonable cost basis.

Drugs Furnished in Dialysis Facilities

Payment is made for drugs furnished in independent dialysis facilities and paid outside the composite rate, based on:

1) The lower of billed charges; or
2) Ninety five percent average wholesale price (AWP) for the calendar year 2004.

Coinsurance and deductible are applied to billed charges.

Hospital-based facilities are paid at cost with applicable coinsurance and deductibles. The *Medicare Benefit Policy Manual, Chapter 11* provides a description of drugs that are part of the composite rate and when other drugs may be covered. Except for epoetin alfa (Epogen, EPOGEN®) and darbepoetin alfa (Aranesp, DPA), drugs and biologicals, such as blood, may be covered in the home dialysis setting only if the "incident to a physician's services" criteria are met (i.e., it is not covered under the composite rate).

Therefore, payment is limited to the reimbursement that would be made for the generic form of the drug or the lowest cost-equivalent drug. Payment for the additional price of a brand name drug in excess of the price of the generic drug may be made only if the FI determines that the brand name drug is medically necessary.

Dialysis Provider Number Series

There are multiple facilities that provide dialysis services to ESRD beneficiaries. To ensure that provider data is correct, facilities are required to use a provider number based on facility type issued by the Centers for Medicare & Medicaid Services (CMS).

The provider number series for dialysis providers are as follows:

- 2300-2499 – Chronic renal dialysis facilities (hospital–based)
- 2500-2899 – Non-hospital renal facilities

Clarification of Billing for Separately Billable End-Stage Renal Disease Drugs (continued)

- 2900-2999 – Independent special purpose renal dialysis facility
- 3300-3399 – Children's hospitals (excluded from PPS)
- 3500-3699 – Renal disease treatment centers (hospital satellites)
- 3700-3799 – Hospital-based special purpose renal dialysis facilities.

All facilities should use their appropriately assigned provider numbers on type of bill 72x. In the event that a facility changes from one type to another, the provider number must reflect the facility's present provider type. Listings of the provider numbers series may be found in the *National Listing of Medicare Providers Furnishing Kidney Dialysis and Transplant Services.* Two Web sites provide this information:

http://cms.hhs.gov/esrd/8.asp

http://cms.hhs.gov/esrd/8e.pdf

Implementation

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

Related Instructions

Transmittal 39 (Change Request (CR) 2963) dated January 6, 2004, Change in Coding on Medicare Claims for Darbepoetin Alfa (trade name Aranesp®) and Epoetin Alfa (trade name Epogen®, EPOGEN®) for Treatment of Anemia in End Stage Renal Disease (ESRD) Patients on Dialysis, can be found at the following CMS Web site: *http://www.cms.hhs.gov/manuals/pm_trans/R39OTN.pdf*.

Also, Transmittal 118 (Change Request (CR) 2984) dated March 5, 2004, Frequency Limitations for Darbepoetin Alfa (trade name Aranesp®) for Treatment of Anemia in End Stage Renal Disease (ESRD) Patients on dialysis, can be found at the CMS Web site: *http://www.gamedicare.com/provider/NewCMSTransmits/CR%202984%20Darbepoetin.htm*.

Additional Information

As a result of these changes, the following sections are being revised or added to the Medicare Claims Processing Manual, Pub. 100-04, Chapter 8 (Outpatient ESRD Hospital, Independent Facililty, and Physician/Supplier Claims):

- 10.9 – Dialysis Provider Number Series – revised
- 60.2 – Drugs Furnished in Dialysis Facilities – revised
- 60.2.1 – Billing Procedures for Drugs for Facilities – revised
- 60.2.1.1 – Separately Billable ESRD Drugs – new
- 60.2.2 – Drug Payment Amounts for Facilities – revised.

These revised manual sections can be viewed as an attachment to CR 3176. The official instruction issued to your intermediary regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R146CP.pdf*.

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 representatives is 1-877-602-8816. ❖

Related Change Request (CR) Number: 3176
Related CR Release Date: April 23, 2004
Related CR Transmittal Number: 146
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 146, CR 3176

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End Stage Renal Disease 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 providers

Provider Action Needed

Physicians, suppliers, and providers should note that this instruction expands the implementation of certain processing rules to all bill types for automated multi-channel chemistry (AMCC) tests for end-stage renal disease beneficiaries.

Background

The Office of Inspector General (OIG) conducted several studies that identified Medicare payments for end stage renal disease (ESRD) laboratory related services which were not being paid in compliance with Medicare payment policy.

In response to the payment vulnerabilities identified by the OIG, the claim processing instructions contained in the *Medicare Claims Processing Manual* (Pub 100-04, Transmittal 79, Chapter 16, Section 40.6.1) directed all contractors to implement changes to ensure that all ESRD laboratory claims are paid in accordance with Medicare payment policy.

This instruction expands the implementation of procedures for reimbursement of AMCC tests to all bill types for ESRD beneficiaries.

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

Implementation

The implementation for this instruction is October 4, 2004.

Related Instructions

Medicare will apply the rules identified in the Medicare Claims Processing Manual, Pub 100-04, Chapter 16 (Laboratory Services from Independent Labs, Physicians, and Providers), Section 40.6.1 (Automated Multi-Channel Chemistry (AMCC) Tests for ESRD Beneficiaries – FIs) to all bill types for AMCC tests for ESRD beneficiaries. This chapter can be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

An extract of Section 40.6.1 is included as follows:

40.6.1 – Automated Multi-Channel Chemistry (AMCC) Tests for ESRD Beneficiaries – FIs

This section will be updated July 2004 – Visit *http://www.cms.hhs.gov/manuals/pm_trans/R79CP.pdf* to view updated section.
(Rev. 1, 10-01-03)
A-03-033

Medicare will apply the following rules to AMCC tests for ESRD beneficiaries:

- Payment is at the lowest rate for services performed by the same provider, for the same beneficiary, for the same date of service.
- The facility must identify, for a particular date of service, the AMCC tests ordered that are included in the composite rate and those that are not included. See Chapter 8 for the composite rate tests for hemodialysis, intermittent peritoneal dialysis (IPD), continuous cycling peritoneal dialysis (CCPD), hemofiltration, and continuous ambulatory peritoneal dialysis (CAPD).
- If 50 percent or more of the covered tests are included under the composite rate payment, then all submitted tests are included within the composite payment. In this case, no separate payment in addition to the composite rate is made for any of the separately billable tests.
- If less than 50 percent of the covered tests are composite rate tests, all AMCC tests submitted for that date of service (DOS) for that beneficiary are separately payable.
- A noncomposite rate test is defined as any test separately payable outside of the composite rate or beyond the normal frequency covered under the composite rate that is reasonable and necessary. (See section 100.6 for details regarding pricing modifiers.)

The FI shared system must calculate the number of AMCC tests provided for any given date of service. The FI sums all AMCC tests with a CD modifier and divides the sum of all tests with a CD, CE, and CF modifier for the same beneficiary and provider for any given date of service. If the result of the calculation for a date of service is 50 percent or greater, the FI does not pay for the tests.

If the result of the calculation for a date of service is less than 50 percent, the FI pays for all of the tests.

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

The organ and disease oriented panels (80049, 80051, 80054, and 80058) are subject to the 50 percent rule.

Laboratory tests that are not covered under the composite rate and that are furnished to CAPD end stage renal disease (ESRD) patients dialyzing at home are billed in the same way as any other test furnished home patients.

Additional Information

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 3239 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 representatives is 1-877-602-8816. ❖

Related Change Request (CR) Number: 3239
Related CR Release Date: May 28, 2004
Related CR Transmittal Number: 190
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 190, CR 3239

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CRITICAL ACCESS HOSPITAL SERVICES

July 2004 Update to the Medicare Outpatient Code Editor for Non-PPS Hospitals—Version 19.2

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

Provider Types Affected

Hospitals and other providers that are NOT paid for outpatient services under the outpatient prospective payment system (OPPS).

Provider Action Needed

This instruction informs fiscal intermediaries that the Outpatient Code Editor (OCE) used to process bills from hospitals not paid under the OPPS has been updated with new additions, changes, and deletions to the Healthcare Common Procedure Coding System (HCPCS) codes to ensure correct billing.

Background

The non-OPPS OCE has been updated with new additions, changes, and deletions to Healthcare Common Procedure Coding System/Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4) codes. This OCE is used to process bills from hospitals not paid under the OPPS. Affected hospitals and providers should take note of these changes and advise billing staff accordingly.

The following are the changes made to version 19.2 of the non-OPPS OCE:

The following codes have been deleted from the list of noncovered procedures, effective April 1, 2002:

44132 44133 44135 44136

The following codes have been added to the list of nonreportable procedures, effective April 1, 2002:

44132 44133 44135 44136

The following new codes have been added to the to the valid HCPCS list, effective January 1, 2004:

C9213 C9214 C9215 C9216 C9217
C9399 C9401

Note: Transmittal 20 (CR 3155) incorrectly listed C9406 in the valid HCPCS list, effective 1/1/04.

The following codes have been added to the list of Non-Reportable procedures, effective January 1, 2004:

A9525 C9213 C9214 C9215 C9216
C9217 C9399 C9401

Note: Transmittal 20 (CR 3155) incorrectly listed C9406 in the list of Non-Reportable procedures, effective January 1, 2004.

The following code has been deleted from the valid HCPCS list, effective April 1, 2004:

E1065

The following new codes have been added to the list of valid HCPCS, effective July 1, 2004:

C9716 G0329 K0650 K0651 K0652 K0653
K0654 K0655 K0656 K0657 K0658 K0659
K0660 K0661 K0662 K0663 K0664 K0665
K0666 K0667 K0668 K0669

The following codes have been added to the list of nonreportable procedures, effective July 1, 2004:

C9716 K0650 K0651 K0652 K0653 K0654
K0655 K0656 K0657 K0658 K0659 K0660
K0661 K0662 K0663 K0664 K0665 K0666
K0667 K0668 K0669

Implementation

The implementation dates for this instruction is July 6, 2004.

Additional Information

For complete details please see the official instruction issued to 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 3319 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 representatives is 1-877-602-8816. ❖

Related Change Request (CR) Number: 3319
Related CR Release Date: May 28, 2004
Related CR Transmittal Number:186
Effective Date: Various dates as described in this article
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 186, CR 3319

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Critical Access Hospital Distinct Part Units

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

Provider Types Affected

Critical access hospitals (CAH)

Provider Action Needed

STOP – Impact to You

For the cost reporting periods beginning on or after October 1, 2004, CAHs may establish distinct part units (up to 10 beds) for psychiatric and rehabilitation use.

This change in policy is driven by Section 405 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, PL 108-173.

CAUTION – What You Need to Know

To establish distinct part units for psychiatric and rehabilitation care, the facility must be certified as a CAH by CMS. The distinct part units must meet the conditions of participation for hospitals as well as any additional requirements that would apply if the unit was established in an acute care hospital. A maximum of 10 beds are allowed in the units; however, they are excluded from the 25 total bed count limit for CAHs. Please refer to the *Additional Information* section for payment methodology information.

GO – What You Need to Do

Please ensure that the criteria (mentioned in the *Caution* section) are met when establishing distinct part units for psychiatric and rehabilitation use.

Additional Information

Payment for services provided in the distinct part units will be made according to the same payment method used as if the unit was established in an acute care (non-CAH) paid under the hospital inpatient prospective payment system (PPS). Inpatient rehabilitation facilities are paid under the inpatient rehabilitation facility PPS. (Information on billing requirements can be found in the *Medicare Claims Processing Manual, Pub. 100-04, Chapter 3, Section 140*.) Inpatient psychiatric units are paid on a reasonable cost basis until a prospective payment system is created (projected for 2005).

The official instruction issued to your fiscal 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 3175 in the CR NUM column on the right, and click on the file for that CR.

Also, Chapter 3 of the *Claims Processing Manual* may be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*. ❖

Related Change Request (CR) Number: 3175
Related CR Release Date: April 23, 2004
Related CR Transmittal Number: 144
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 144, CR 3175

Bonus Payments for Services in Health Professional Shortage Areas

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

Provider Types Affected

Critical access hospitals and psychiatrists

Provider Action Needed

This instruction clarifies MM3108 by adding critical access hospital (CAHs) as eligible for the mental care health professional shortage area (HPSA) bonus payment. This bonus is designed for psychiatric services rendered in an eligible CAH.

To be eligible, the CAH must receive payment under the optional method (method II) payment rules and is located in a mental health area.

Background

If a CAH, which has elected the optional method (method II), is located within a mental care HPSA, psychiatrists providing (outpatient) professional services in the CAH are eligible for the mental care HPSA bonus payments. When billing for this service, the CAH must bill using revenue code 961 plus the applicable HCPCS.

This mental care HPSA bonus will be paid to the CAH on a quarterly basis by their Medicare fiscal intermediary (FI). Also, the CAH should note that if their area is designated as both a mental care HPSA and a primary medical care HPSA, only one 10 percent bonus payment will be paid for the service.

Additional Information

This change will be implemented by your FI on July 6, 2004 and will apply to services rendered **on or after July 1, 2004.** To view the actual instruction issued to your FI, go to: *http://www.cms.hhs.gov/manuals/pm_trans/R203CP.pdf*.

Also, please see the related article, MM3108, at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3108.pdf*.

Related Change Request (CR) Number: 3336
Related CR Release Date: June 10, 2004
Related CR Transmittal Number: 203
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

FCSO Additional Information

A link to a complete list of geographic HPSA designations is available through our provider education Web site *http://www.floridamedicare.com*. Once on this site, select "Links" and scroll to "Links: Other Resources" and select "Health Professional Shortage Areas (HPSA) – Shortage Designations" to search the HRSA (Health Resources and Services Administration) database. ❖

Source: CMS Pub 100-4 Transmittal 203, CR 3336

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HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Payment for Drugs, Biologicals, and Radiopharmaceuticals—July 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 outlines changes in the outpatient prospective payment system (OPPS) for the July 1, 2004, quarterly update. Unless otherwise noted, all changes in this instruction are effective for services furnished on or after July 1, 2004.

Background

This instruction describes changes to the hospital OPPS, to be implemented in the July 2004 update. The July 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 other revisions identified in this notification. Unless otherwise noted, all changes addressed in this notification are effective for services furnished on or after July 1, 2004.

Certain information provided reflects changes resulting from enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) on December 8, 2003. An interim final rule with comment period describing these changes was published in the *Federal Register* on January 6, 2004, (69 FR 820). In addition, Change Requests CR 3144 and CR 3145, issued February 27, 2004, and CR 3154, issued March 30, 2004, also addresses changes resulting from the MMA.

1. Payment for Drugs and Biologicals Recently Approved by the FDA

a. Beginning in 2004, the MMA requires payment at 95 percent of average wholesale price (AWP) for new drugs and biologicals after FDA approval but before it receives a product-specific HCPCS code.

b. For services furnished on or after the designated effective date in Table B1, through June 30, 2004, payment for the drugs and biologicals in Table B1 will be made at 95 percent of AWP.

c. For services furnished on or after the designated effective date in Table B1, through June 30, 2004, beneficiary copayment will equal 20 percent of the designated payment rate.

d. Effective July 1, 2004, the drugs and biologicals in Table B1 are approved for payment as pass-through drugs and biologicals (see section 2, below).

e. Hospitals that used a different HCPCS code to bill for the drugs and biologicals listed in Table B1 that were furnished prior to installation of the July 2004 release may submit adjustment bills.

f. The "Effective Date of Payment Rate" listed in Table B1 reflects the date the drug or biological received FDA approval. Claims submitted with dates of service prior to these effective dates will receive OCE edit code 67, "Service provided prior to FDA approval." OCE edits are also addressed in the July 2004 OCE update (CR 3314).

Table B1 – Payment for Drugs and Biologicals Recently Approved by the FDA

HCPCS	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment	Payment Rate Effective Date
C9213	K	9213	Injection, pemetrexed	Injection, pemetrexed, per 10 mg	$46.31	$9.26	February 4, 2004
C9214	K	9214	Injection, bevacizumab	Injection, bevacizumab, per 10 mg	$65.31	$13.06	February 26, 2004
C9215	K	9215	Injection, cetuximab	Injection, cetuximab, per 10 mg	$54.72	$10.94	February 12 2004
C9216	K	9216	Abarelix, inject suspension	Abarelix for injectable suspension, per 10 mg	$89.72	$17.94	January 1, 2004
C9217	K	9300	Injection, omalizumab	Injection, omalizumab, per 5 mg	$17.14	$3.43	January 1, 2004

Payment for Drugs, Biologicals, and Radiopharmaceuticals—July 2004 Update of the Hospital OPPS (continued)

2. Drugs and Biologicals Newly-Approved for Pass-Through Payment

a. The drugs and biologicals listed in Table B2 have been designated as eligible for pass-through payment under the OPPS effective July 1, 2004. The effective date of pass-through status for C9213, C9214, C9215, C9216 and C9217 coincides with the date of assignment of product-specific HCPCS codes for each of these drugs.

b. Pass-through payment for the drugs and biologicals listed in Table B2 equals 95 percent of AWP.

c. The minimum unadjusted copayment amounts for the drugs and biologicals listed in Table B2 is calculated in accordance with pass-through payment rules and, therefore, is different from the minimum unadjusted copayment amounts listed in Table B1.

Table B2 – Drugs and Biologicals Newly Approved for Pass-Through Payment

HCPCS	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment	Pass-Through Status Effective Date
C9213	G	9213	Injection, pemetrexed	Injection, pemetrexed, per 10 mg	$46.31	$6.92	July 01, 2004
C9214	G	9214	Injection, bevacizumab	Injection, bevacizumab, per 10 mg	$65.31	$9.76	July 01, 2004
C9215	G	9215	Injection, cetuximab	Injection, cetuximab, per 10 mg	$54.72	$8.18	July 01, 2004
C9216	G	9216	Abarelix, inject suspension	Abarelix for injectable suspension, per 10 mg	$89.72	$13.41	July 01, 2004
C9217	G	9300	Injection, omalizumab	Injection, omalizumab, per 5 mg	$17.14	$2.56	July 01, 2004

3. Billing and Payment for Fulvestrant, J9395

Effective January 1, 2004, CMS is correcting the payment rate for J9395, Injection, fulvestrant, per 25 mg.

Medicare fiscal intermediaries shall mass adjust payment for claims with J9395 that were incorrectly paid for services furnished January 1, 2004 through June 30, 2004 and which were processed prior to installation of the July 2004 OPPS PRICER by the fiscal intermediaries. Providers need take no action to effect these adjustments.

HCPCS	SI	APC	Short Descriptor	Payment Rate	Minimum Unadjusted Copayment
J9395	G	9120	Injection, Fulvestrant, per 25 mg	$81.57	$13.63

4. Misclassified Radiopharmaceutical: Billing and Payment for Strontium-89, Chloride, Generic versus Brand Name Form

In the January 6, 2004 interim final rule, CMS inadvertently misclassified strontium-89, chloride as a sole source product. Strontium-89, chloride should have been listed 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 this CR, CMS addressed coding and payment for innovator multiple-source (brand name) drugs and non-innovator multiple-source (generic) drugs, and implemented HCPCS codes and payment amounts for brand name drugs that CMS was not able to implement in the January 6, 2004, interim final rule.

The new HCPCS codes implemented in the April 2004 OPPS update were required to enable differentiation between the payment amount required under the MMA for a brand name drug and the payment amount required under the MMA for its generic form.

Effective January 1, 2004, strontium-89, chloride is classified as a ***multi-source product*** and is implemented with both a generic and brand name HCPCS code and payment amount. Fiscal intermediaries shall mass adjust claims with A9600 that were incorrectly paid for services furnished January 1, 2004, through June 30, 2004, and which were processed prior to installation by the intermediaries of the July 2004 OPPS PRICER. Providers need take no action to effect these adjustments.

HCPCS	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment	Effective Date
A9600	K	0701	Strontium-89 chloride	Supply of Therapeutic Radiopharmaceutical, Strontium-89 Chloride, per mCi	$402.85	$80.57	January 1, 2004
C9401	K	9401	Strontium-89 chloride, brand	Supply of therapeutic radiopharmaceutical, strontium-89 chloride, brand name	$402.85	$80.57	January 1, 2004

Payment for Drugs, Biologicals, and Radiopharmaceuticals—July 2004 Update of the Hospital OPPS (continued)

5. Change in Long Descriptor for C9125, Injection, Risperidone, Long Acting, per 12.5 mg

The long descriptor for C9125 is changed, effective July 1, 2004, from "Injection, risperidone, per 12.5 mg" to "Injection, risperidone, long acting, per 12.5 mg."

6. Clarification: Positron Emission Tomography (PET) Scans for Thyroid Cancer and Perfusion of the Heart Using Ammonia N-13

In the October 2003 update of the hospital OPPS, Transmittal A-03-076, Change Request 2887, CMS provided instructions concerning PET scans for thyroid cancer and perfusion of the heart using ammonia N-13.

In the October 2003 instruction, CMS incorrectly stated that Q3000 and Q4078 were reportable with G0296. CMS is clarifying this issue and specifying, according to Transmittal AB-03-092, CR 2687, that Q3000 and Q4078 are not reportable with G0296. Rather, Q3000 and Q4078 are only reportable with HCPCS code series G0030-G0047.

7. Reporting Line Item Date of Service for Revenue Code without a HCPCS

In order to accurately determine hospital costs for purposes of updating payment rates for drugs and all other services paid under the hospital OPPS, and in order to package services appropriately, CMS relies on the service line date. Therefore, it is extremely important that the date and charge reported with a revenue code on a line without a HCPCS code represent a single date of service rather than a range of dates.

8. Coverage Determinations

The fact that a drug, device, procedure, or service has a HCPCS code and a payment rate under the OPPS does ***not*** imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid ***if*** covered by the program.

Fiscal intermediaries shall determine whether a drug, device, procedure, or service meets all program requirements for coverage, for example, that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Implementation

The implementation date for this instruction is July 6, 2004.

Additional Information

For complete details, please see the official instruction issued to the intermediary, which may be viewed by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R194CP.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 representatives is 1-877-602-8816. ❖

Related Change Request (CR) Number: 3322
Related CR Release Date: June 4, 2004
Related CR Transmittal Number: 194
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 194 CR 3322

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Guidelines for New Drugs and Biologicals after FDA Approval

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

Provider Types Affected

Providers who bill under the outpatient prospective payment system (OPPS).

Impact on Providers

Providers should note that beginning January 1, 2004, hospital outpatient departments may bill for new drugs and biologicals that are approved by the Food & Drug Administration (FDA) **on or after January 1, 2004,** for which pass-through status has not been approved, and a product-specific C-code and an ambulatory payment classification (APC) allowance have not been assigned.

Background

Section 621 (a) of the Medicare Modernization Act (MMA) amends Section 1833 (t) of the Social Security Act by adding paragraph (15), "Payment for New Drugs and Biologicals until HCPCS Code is Assigned."

This provision applies only to payments under the OPPS. According to the provision, payment for an outpatient drug or biological that is furnished as part of covered outpatient department services, for which a product-specific Healthcare Common Procedure Coding System (HCPCS) code has not been assigned, shall be paid an amount equal to 95 percent of the average wholesale price (AWP).

Guidelines for New Drugs and Biologicals after FDA Approval (continued)

Thus, for drugs/biologicals provided on or after January 1, 2004, that are approved by FDA on or after that date and for which pass-through status has not been approved and a product-specific C-code and APC allowance have not been assigned, outpatient departments may bill for the drug as follows:

- For drugs receiving FDA approval on or after January 1, 2004, hospitals may bill for the drug/biological using a new "unclassified HCPCS code of C9399 (unclassified drug or biological).
- For the ANSI ASC X12N 837 I, hospital outpatient departments will report on TOB = 13x, containing revenue code 0636, HCPCS code C9399, and NDC (national drug code) number present in loop 2400 LIN 03 of the 837 I. Alternatively, the hospital may report in the "Remarks" section of Form CMS-1450 or its electronic equivalent (UB-92 flat file version 6.0), the NDC for the drug, the quantity of the drug that was administered, expressed in the unit of measure applicable to the drug or biological, and the date the drug was furnished to the beneficiary.

Medicare intermediaries will manually calculate the payment for the drug or biological at 95 percent of the AWP. The intermediary will pay 80 percent of that calculated payment to the hospital; beneficiaries will be responsible for the 20 percent co-pay after the deductible is met.

Providers should note that drugs or biologicals that are manually priced under these instructions will not be eligible for outlier payment. Also, the fact that CMS establishes a code and sets a payment rate for a drug or biological does not imply coverage by the Medicare program, but indicates only how the drug or biological may be paid if covered by the program. Fiscal intermediaries determine whether a drug or biological meets all program requirements for coverage, for example, that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Also, beginning January 1, 2004, CMS will assign a drug/biological, product-specific HCPCS C-code and APC allowance to a drug or biological approved by the FDA after January 1, 2004, that is approved for pass-through status. The process to apply for pass-through status for a drug or biological is explained on the CMS Web site at: *http://www.cms.hhs.gov/regulations/hopps/d&bfr101002.pdf*.

C-codes and APC allowances for drugs and biologicals approved for pass-through status are implemented prospectively beginning in July 2004.

CMS will issue further instructions in the future regarding billing and payment under the 2005 OPPS for drugs and biologicals approved by the FDA after January 1, 2004, for which a product-specific C code has been assigned.

Additional Information

For further information, see the instruction issued to your intermediary regarding this issue, which can be found by going to*: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

Once at that site, scroll down the CR NUM column on the right and click on the file for CR 3287.

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 representatives is 1-877-602-8816. ❖

Related Change Request (CR) Number: 3287
Related CR Release Date: May 28, 2004
Related CR Transmittal Number: 188
Effective Date: January 1, 2004
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 188, CR 3287

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Billing for New Drugs and Biologicals Using HCPCS Code C9399

Hospital outpatient departments billing Medicare under the outpatient prospective payment system (OPPS) may bill for new drugs and biologicals that are approved by the Food & Drug Administration (FDA) **on or after January 1, 2004,** for which pass-through status has not been approved, and the Centers for Medicare & Medicaid Services (CMS) has not yet assigned a product-specific C-code and an ambulatory payment classification (APC) allowance.

Billing Guidelines

The following billing requirements applied is the FDA has approved the new drug or biological on or after January 1, 2004:

- Report the service using HCPCS code C9399.
- Bill for the service on a type of bill 13x. No other type of bill is accepted for HCPCS code C9399.
- Use revenue code 0636.

Services billed with HCPCS code C9399 must include the following information:

- Name of drug
- National drug code (NDC) number
- Quantity (dosage) administered per billing unit
- Specific date(s) drugs administered.

Claims received with missing or invalid information will be returned to the provider (RTP) with reason code W7066. Providers may correct and resubmit the claim if appropriate.

Payment will be calculated based on 95 percent of the average wholesale price (AWP) as listed in the RedBook. ❖

Source: CMS Pub 100-4 Transmittal 188, CR 3287

July 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 outlines changes in the outpatient prospective payment system (OPPS) for the July 1, 2004, quarterly update. Unless otherwise noted below, all changes in this instruction are effective for services furnished on or after July 1, 2004.

Background

This instruction describes changes announced by the Centers for Medicare & Medicaid Services (CMS) to the outpatient prospective payment system (OPPS) for the July 2004 update. Also, the July 2004 outpatient code editor (OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS) codes and ambulatory payment classification (APC) changes, additions, and other revisions identified in this instruction.

Changes in payment for certain drugs, biologicals, and radiopharmaceuticals mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) are being implemented in the July 1, 2004, quarterly OPPS update, under Change Request (CR) 3322 which is being issued separately. CR 3322 addresses OPPS additions, changes, and other revisions for drugs, biologicals and radiopharmaceuticals.

1. Service Added to New Technology APC

The following service is assigned for payment in a new technology APC under the OPPS OCE, effective July 1, 2004.

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
C9716*	July 1, 2004	S	1519	Radiofrequency energy to anus	Creation of thermal anal lesions by radiofrequency energy	$1,750.00	$350.00

*This procedure is used for the treatment of fecal incontinence and involves the application of radiofrequency energy to the internal sphincter complex of the anus.

2. Drug-Eluting Stents

In the July 2003 update of the OPPS, Transmittal A-03-051, Change Request 2771, issued June 13, 2003, CMS provided billing instructions for drug-eluting stents. The Food & Drug Administration (FDA) approved drug-eluting stents effective April 24, 2003. This notification provides updated billing instructions for the placement of drug-eluting stents, especially with the January 1, 2004, reinstitution of device C-codes for cost reporting purposes.

Effective for services furnished on or after July 1, 2003:

In Transmittal A-03-051, CR 2771, CMS implemented payment under APC 0656, transcatheter placement of drug-eluting coronary stents, for two HCPCS codes that describe drug-eluting stents and their placement. CMS did not establish new HCPCS codes for the drug eluting coronary stents; however, CMS indicated that hospitals could include the charge for the drug-eluting stent in the charge for G0290 and G0291.

CMS also indicated that, alternatively, hospitals could bill separately for the stent using an appropriate revenue code, making certain that the charge for the G0290 and G0291 did not include the charge for the stent. Payment for placement of the stents, and the stents themselves, are made under APC 0656.

As of January 1, 2004, CMS reinstituted C-codes for devices for cost reporting and cost tracking purposes.

Therefore, hospitals have a third option to report charges for drug eluting stents. That is, hospitals may report HCPCS code C1874, "Stent, coated/covered, with delivery system" with an appropriate revenue code to report their charge for drug eluting coronary stents. When using HCPCS code C1874 to bill separately for drug eluting stents, hospitals should make certain that the charge for G0290 and G0291 for placement of the stents does not include the stent charge. Payment for C1874 is packaged into the payment for APC 656, but reporting a separate charge for the stent(s) provides important data that affects future updates of the OPPS.

3. Payment Change for CPT code 96567, "Photodynamic tx, skin"

Effective July 1, 2004, CPT code 96567, "Photodynamic tx, skin" is assigned to APC 1504.

4. Reporting Line Item Date of Service for Revenue Code without a HCPCS

In order to accurately determine hospital costs for purposes of updating payment rates for drugs and all other services paid under the hospital OPPS, and in order to package services appropriately, CMS relies on the service line date. Therefore, it is extremely important that the date and charge reported with a revenue code on a line without a HCPCS code represent a single date of service rather than a range of dates.

July 2004 Update of the Hospital Outpatient Prospective Payment System (continued)

5. Reminder Regarding Monthly Reporting of Repetitive Services

Hospitals shall not bill the following revenue codes monthly, as these services are not repetitive Part B services:

Type of Service	Revenue Code(s)
Pharmacy	0250-0259
IV Therapy	0260-0269
Medical/Surgical Supplies	0270-0279
Medical/Surgical Supplies	0620-0624
Drugs Requiring Specific ID	0631-0637

6. Coverage Determinations

The fact that a drug, device, procedure, or service has a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Medicare fiscal intermediaries shall determine whether a drug, device, procedure, or service meets all program requirements for coverage, for example, that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

7. Summary of July 2004 Modifications

The official version of this instruction includes Attachment A which is the OPPS OCE Final Summary of Data Changes Effective July 1, 2004. Appendix A of that instruction 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 for the July 1, 2004 quarterly release.

To see Appendix A of the actual instruction for all these details, go to: *http://www.cms.hhs.gov/manuals/pm_trans/R195CP.pdf*.

Note that unless otherwise stated, all changes in this instruction are effective for services furnished on or after July 1, 2004.

Implementation

The implementation date for this instruction is July 6, 2004.

Related Instructions

The official version of this instruction was issued to your contractor, and can be found by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R195CP.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 representatives is 1-877-602-8816. ❖

Related Change Request (CR) Number: 3324
Related CR Release Date: June 4, 2004
Related CR Transmittal Number: 195
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 195, CR 3324

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July 2004 Update to Outpatient Prospective Payment System Code Editor

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

Provider Types Affected

Hospitals and other providers paid under the outpatient prospective payment system (OPPS).

Provider Action Needed

Affected hospitals and providers should note that this CR reflects the specifications that were issued for the April release of the OPPS OCE (version 5.1), as well as changes for the July version (version 5.2).

Background

Full details regarding the OPPS OCE are contained in CR 3314 and providers who bill under the OPPS are likely to be familiar already with the OCE specifications contained in that CR. A key part of CR 3314 is Appendix J, which summarizes the modifications being made in version 5.2 of the OCE. These modifications include the following:

- A new edit (# 65) for revenue codes not recognized by Medicare
- A new packaging flag related to "Artificial charges for surgical procedure"
- A new edit (# 66) for codes that will require manual pricing
- A new edit (# 67) for dates of services for service provided prior to FDA approval
- Implementation of Version 10.1 of the NCCI file.

Implementation

The implementation dates for this instruction is July 6, 2004.

Additional Information

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

Related Change Request (CR) Number: 3314
Related CR Release Date: May 28, 2004
Related CR Transmittal Number: 184
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 184, CR 3314

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PROVIDER AUDIT ISSUES

Redistribution of Unused Resident Positions

Editor Note: *This article was posted to our provider education Web site on May 7, 2004, and included a section titled "Provider Action Needed." This section has been removed from this article since providers had to submit the required documentation by June 14, 2004.*

The Centers for Medicare & Medicaid Services (CMS) has provided instructions related to the redistribution of unused residency positions for purpose of direct graduate medical education (GME) payments and indirect medical education (IME) payments, in preparation for implementation of section 422 of the Medicare Modernization Act of 2003 (MMA), Public Law 108-173 that will be effective July 1, 2005.

Background

The Social Security Act (the Act) under sections 1886(d)(5)(B)(v) for IME and section 1886(h)(4)(F), for direct GME establishes a cap on the number of allopathic and osteopathic residents that a hospital may count for purposes of IME and direct GME payments, respectively. Generally, each hospital's caps, often referred to as the "1996" FTE caps, are based on the number of allopathic and osteopathic residents that the hospital trained in its most recent cost reporting period ending on or before December 31, 1996. The Act also provides for an increase to an urban hospital's FTE cap in limited circumstances for new residency programs, while hospitals in rural areas may receive an increase to their FTE caps for any newly approved programs, in addition to receiving a 130 percent increase to their "1996" FTE caps. Further, under certain conditions, hospitals that have shared residency rotational relationships may elect to combine their hospital-specific FTE resident caps into an aggregate FTE cap by entering into a Medicare GME affiliated group agreement.

While Medicare only makes direct GME and IME payments for the number of FTE residents up to a hospital's FTE caps, some hospitals have trained allopathic and osteopathic residents in excess of their FTE caps. However, there are a number of hospitals that have reduced their resident counts to a level below their caps. Section 422 of P. L. 108-173 redistributes the "unused" resident positions. Generally, under section 422, CMS is to remove 75 percent of the unused resident slots from the FTE caps of hospitals that were below their resident caps in a specified period. Rural hospitals with less than 250 beds are exempt from reductions to their FTE caps. CMS is to redistribute the estimated number of reduced resident slots in the following priority order: first to rural hospitals, second to urban hospitals not located in large urban areas, and third to hospitals that are the only ones with a particular specialty residency training program in that state. No hospital would be allowed more than 25 new FTEs. The provision is effective for portions of cost reporting periods beginning on or after July 1, 2005.

In the fiscal year (FY) 2005 hospital inpatient prospective payment system (PPS) proposed rule, CMS will be proposing procedures for determining the number of "unused" residency positions, as well as an application process for hospitals that seek additional residency slots, and specific criteria that CMS will use in determining which hospitals will receive the additional residency positions. However, since the procedures would not be finalized before publication of the FY 2005 hospital inpatient PPS final rule (by August 1, 2004), and the provisions of that final rule would not become effective until October 1, 2004 (at least 60 days after publication of the final rule), CMS is notifying FIs and the provider community of certain information that is needed in order to determine in a timely fashion the number of unused resident positions available for redistribution.

Determining the Estimated Number of FTE Resident Slots Available for Redistribution

Section 422 provides that if a hospital's "reference resident level" is less than its "otherwise applicable resident limit," then its "otherwise applicable resident limit" will be reduced by 75 percent of the difference between its "otherwise applicable resident limit" and its "reference resident level." The "resident level" in section 422 generally refers to the number of unweighted allopathic and osteopathic FTE residents that are training at a hospital in a given cost reporting period. (Generally, the direct GME unweighted allopathic and osteopathic FTE count would be the number on worksheet E-3 Part IV of the Medicare cost report, CMS-2552-96, line 3.05, and the IME allopathic and osteopathic FTE count would be the number on worksheet E Part A of the Medicare cost report, CMS-2552-96, line 3.08[1]). The "otherwise applicable resident limit" in section 422 generally refers to a hospital's FTE resident cap, which is the 1996 FTE cap, as adjusted in a particular period by any other applicable FTE cap adjustments, such as a new program adjustment or an adjustment under a Medicare GME affiliation agreement. (The direct GME FTE cap would be the number on worksheet E-3 Part IV of the Medicare cost report, CMS-2552-96, line 3.04, and the IME FTE cap would be the number on worksheet E Part A of the Medicare cost report, CMS-2552-96, line 3.07). Because hospitals paid under the inpatient PPS have two FTE caps, one for direct GME and one for IME, a separate determination will be made for direct GME and IME to determine whether one, or both of a hospital's FTE caps, should be reduced. (Note that teaching hospitals that are excluded from the inpatient PPS would only have a direct GME FTE resident cap).

Redistribution of Unused Resident Positions (continued)

Note: As mentioned above, rural hospitals (as defined at 42 CFR section 413.62(f)(iii)) with less than 250 beds are exempt from reductions to their FTE caps. The FI will determine if a rural hospital has less than 250 beds by using the number of available beds on the rural hospital's most recent cost report ending on or before September 30, 2002. (Use worksheet S-3, Part I of the Medicare cost report, CMS-2552-96, column 2, the sum of lines 1 and 6 through 10, divided by the number of days in the cost reporting period).

CMS is directed by section 422 to use a hospital's most recent cost reporting period ending on or before September 30, 2002, for which a cost report has been settled (or if not, submitted [subject to audit]) to determine if a hospital's direct GME FTE cap or IME FTE cap, or both, should be reduced[2], unless the hospital submits a timely request to utilize the cost report that includes July 1, 2003, due to an expansion of an existing residency training program that is not reflected on the most recent **settled** cost report. A hospital should refer to its most recently settled cost report as of the issuance of this notification (April 30, 2004), to determine whether the hospital believes it has expanded an existing program in a cost reporting period subsequent to the one for that most recently settled cost report. If the hospital submits such a timely request, after audit and subject to the discretion of CMS, the resident level for such a hospital will be the unweighted count of allopathic and osteopathic FTE residents for the cost reporting period that includes July 1, 2003.

Timely Request

To be considered timely and proper, a hospital's request to use its cost reporting period that includes July 1, 2003 must be signed and dated by the hospital's chief financial officer (or equivalent), and submitted to its FI on or before June 14 2004. In its timely request, the hospital must include the following:

1. The FTE resident caps for direct GME and IME, and the number of unweighted allopathic and osteopathic FTE residents for direct GME and IME in its most recent settled cost report (i.e., its cost report that is most recently settled as of April 30, 2004).
2. FTE resident caps for direct GME and IME, and the unweighted allopathic and osteopathic FTE residents for direct GME and IME from each cost report after its most recently settled cost report, up to and including its cost report including July 1, 2003. If the cost reporting period that includes July 1, 2003 has not ended as of June 14, 2004, the hospital shall report the estimated number of unweighted allopathic and osteopathic residents for that cost reporting period.
3. If not already included in steps 1 or 2, the FTE resident caps for direct GME and IME, and the number of unweighted allopathic and osteopathic FTE residents for direct GME and IME in its most recent cost reporting period ending on or before September 30, 2002.

The cost report worksheets and lines from which the resident caps and number of unweighted allopathic and osteopathic residents for direct GME and IME are to be obtained are identified in the first paragraph of this subsection.

Expansions Under Newly Approved Programs

A hospital may also submit a timely request (in accordance with the instructions above) that its unweighted FTE resident level in either the most recent cost reporting period ending on or before September 30, 2002, or its cost reporting period that includes July 1, 2003, be adjusted to include the number of residents for which a new program was accredited by the appropriate accrediting body, that is, the Accreditation Council on Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) before January 1, 2002, but which was **not** in operation during the hospital's most recent cost reporting period ending on or before September 30, 2002, **or** the cost report including July 1, 2003, as explained below.

Example: A hospital that has a fiscal year end of June 30 received accreditation in October 2001 to train ten residents in a new surgery program. The hospital first begins to train residents in the new surgery program on July 1, 2002. The surgery residents are not reflected on the hospital's June 30, 2002, cost report, which is the hospital's most recent cost reporting period ending on or before September 30, 2002. Thus, the hospital may submit a timely request to increase its unweighted allopathic and osteopathic FTE resident level for its cost reporting period ending June 30, 2002 by ten to reflect the residents approved for the new surgery program. However, if the hospital's fiscal year end would be September 30, a program accredited in October 2001 and begun on July 1, 2002, would be in operation during the hospital's cost report ending on September 30, 2002, and the hospital would not qualify to have its unweighted allopathic and osteopathic FTE resident level for its cost reporting period ending September 30, 2002, increased to reflect the residents in the new surgery program.

As directed by section 422, a hospital may only request that its resident level for the cost reporting period that includes July 1, 2003, (rather than its most recent cost reporting period ending on or before September 30, 2002) be adjusted to reflect residents in a new program if (1) the new program was **not** in operation during the cost reporting period that includes July 1, 2003; and (2) if the hospital also qualifies to use its cost report that includes July 1, 2003, due to an expansion of an existing program that is not reflected on its most recent settled cost report. (This will be explained further in the FY 2005 hospital inpatient PPS proposed rule).

To be considered timely and proper, a hospital's request to have the number of unweighted allopathic and osteopathic FTE residents for direct GME and IME adjusted to reflect residents in a newly approved program must be signed and dated by the hospital's chief financial officer (or equivalent),

and submitted to its FI on or before June 14, 2004. In addition, the hospital must include a copy of the accreditation letter for the program and (if not included the in the approval letter), information as to the number of approved residency slots for the program, and, if more than one hospital serves as the training site for residents in the new program, an estimate of the number of FTE residents that will train at the requesting hospital. Furthermore, the hospital must indicate the cost reporting period for which it requests an adjustment to the unweighted allopathic and osteopathic FTE resident level to include the residents in the newly approved program. (This cost reporting period must be either the most recent cost reporting period ending on or before September 30, 2002 or, where there was an expansion of an existing residency training program that is not reflected on the most recent settled cost report, the cost reporting period that includes July 1, 2003).

Hospitals that Are Members of a Medicare GME Affiliated Group

In determining whether particular hospitals' FTE resident caps should be reduced, section 1886(h)(7)(A)(iii) of the Act directs CMS to consider hospitals "which are members of the same affiliated group… as of July 1, 2003." Hospitals that are affiliated "as of July 1, 2003," means hospitals that have in effect a Medicare GME affiliation agreement as defined at 42 CFR section 413.86(b) for the program year July 1, 2003, through June 30, 2004, and have submitted a Medicare GME affiliation agreement by July 1, 2003, to their FIs with a copy to CMS. These hospitals may have already been affiliated prior to July 1, 2003, or may have affiliated for the first time on July 1, 2003.

Under a Medicare GME affiliation agreement, hospitals form an aggregate cap, and individual hospitals' caps are adjusted within that aggregate cap. Thus, we determine if a hospital's FTE resident cap should be reduced on a hospital-specific basis. In order to determine whether a hospital's FTE cap should be reduced, the FI would measure a hospital's July 1, 2003 "affiliated" FTE caps (based on the Medicare GME affiliation agreement that the hospital submitted to the FI by July 1, 2003) against the unweighted allopathic and osteopathic FTE counts in either the hospital's most recent cost report ending on or before September 30, 2002, or the hospital's cost report that includes July 1, 2003, as appropriate.

Audits of the Reference Cost Reporting Periods

A hospital's unweighted allopathic and osteopathic FTE resident counts that are used for the purposes of determining possible FTE cap reductions may be subject to audit by the fiscal intermediaries. Fs will perform desk reviews or more detailed audits related to section 422 using instructions that will be issued in a separate document.

In general, if a hospital does not submit a timely request to the FI asking that its cost report that includes July 1, 2003, be used, the FI would use the most recent cost report ending on or before September 30, 2002, to determine if and by how much a hospital's FTE resident caps should be reduced. ❖

Source: CMS CMS Pub 100-20 Transmittal 87, CR 3247

[1] Note that line 3.05 for direct GME and line 3.08 for IME may not reflect the *total* number of FTE residents that are "training at a hospital in a given cost reporting period" for all hospitals (for example, for a hospital that never trained residents before January 1, 1995, and, under 42 CFR §413.86(g)(6)(i), started a new program). In such an instance, the fiscal intermediary should contact CMS for instructions on how to determine the total number of unweighted allopathic and osteopathic FTE residents.

[2] Section 1886(h)(7)(A) of the Act, as added by section 422 of the MMA, does not apply to a teaching hospital that filed a low utilization (i.e., abbreviated) Medicare cost report for its most recent cost reporting period ending on or before September 30, 2002, since there is no reference resident level for such a hospital.

Changes in Determining Rural Status of Hospitals 2004 Transitional Outpatient Payments

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

Provider Types Affected

Hospitals

Provider Action Needed

This instruction clarifies the policy and business requirements in Transmittal 30 (CR 3015) relating to changes in the hospital outpatient prospective payment system (OPPS) for services furnished during calendar years 2004 and 2005. This instruction revises the method for determining whether a hospital is considered rural for purposes of transitional outpatient payments (TOPs). Changes to Transmittal 30 (CR 3015) are indicated in bold print.

Background

As of January 1, 2004, TOPs are being discontinued for all community mental health centers (CHMCs) and all hospitals except for the following:

- Rural hospitals that have 100 or fewer beds.
- Sole community hospitals (SCHs), as described in the Social Security Act (Section 1886 (d) (5) (D)(iii)), which are located in rural areas.
- Cancer hospitals and children's hospitals as described in the Social Security Act (Sections 1886(d) (1) (B) (iii) and (v)).

The interim TOPs for these hospitals will be calculated as 85 percent of the hold-harmless amount (the amount by which the provider's charges multiplied by its cost-to-charge ration (CCR), **then multiplied by its payment-to-cost ratio,** exceeds the provider's OPPS payments.)

Be advised that for the CMHCs and hospitals for which TOPs will be discontinued, interim TOPs will be paid for services furnished through December 31, 2003.

Changes in Determining Rural Status of Hospitals 2004 Transitional Outpatient Payments (continued)

Medicare fiscal intermediaries (FIs) are responsible for permanently continuing to hold harmless interim TOPs for cancer hospitals and children's hospitals in accordance with the provisions of the Statute. Also, hold-harmless TOPs will continue through December 31, 2005 for rural hospitals that have 100 or fewer beds, in accordance with the provisions of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003.

Hold-harmless TOPs will also apply to SCHs that are located in rural areas, with respect to services furnished during the period that begins with the provider's first cost reporting period beginning on or after January 1, 2004, and ends on December 31, 2005, in accordance with the provisions of the MMA.

Note that if a qualifying SCH has a cost reporting period that begins on a date ***other*** than January 1, TOPs and interim TOPs will not be paid for services furnished after December 31, 2003 and before the beginning of provider's next cost reporting period.

If a hospital qualifies as both a rural hospital that has 100 or fewer beds and as a SCH located in a rural area, for purposes of receiving TOPs and interim TOPs the hospital will be treated as a rural hospital that has 100 or fewer beds.

For purposes of TOPs, a hospital is considered rural if it is:

- **Geographically rural;**
- **Classified to rural for wage index purposes; or**
- **Classified to rural for the standardized amount.**

For example, a hospital that is geographically rural is always considered rural for TOPs, even if it is reclassified to urban for the wage index and/or standardized amount. A hospital that is geographically urban, but reclassified to rural for the wage index and/or standardized amount is considered rural for purposes of TOPs.

If the FI identifies additional hospitals that are eligible for TOPs payments, the FI shall make appropriate interim payments retroactive to January 1, 2004 for small rural hospitals and retroactive to the provider's first day of the cost reporting period beginning on or after January 1, 2004 for rural SCHs with 101 or more beds.

Implementation

The implementation dates for this instruction are as follows:

- By June 1, FIs must make needed adjustments to their provider-specific files so they can begin making monthly interim TOPs payments to eligible hospitals and begin making such payments.
- No later than July 1, 2004, FIs are to make retroactive payments to account for any TOPs interim payments that are due to providers retroactively to January 1, 2004 for small rural hospitals or to the first day of the cost reporting period beginning on or after January 1, 2004 for rural sole community hospitals that have more than 100 beds.
- Beginning January 1, 2005, FIs must use the outpatient provider specific file fields to determine the number of beds and whether a hospital is considered to be rural for purposes of TOPS payments.

Additional Information

The official instruction issued to your FI 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 3214 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 representatives is 1-877-602-8816.

Also, Transmittal 30 (CR 3015), Changes in Transitional Outpatient Payment (TOP) for 2004, dated December 19, 2003, can be found at the following Centers for Medicare & Medicaid Services Website: *http://www.cms.hhs.gov/manuals/pm_trans/R30OTN.pdf*. ❖

Related Change Request (CR) Number: 3214
Related CR Release Date: April 16, 2004
Related CR Transmittal Number: 72
Effective Dates: January 1, 2004 and October 1, 2004
Implementation Dates: Multiple Dates as indicated above

Source: CMS Pub 100-20 Transmittal 72, CR 3214

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THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Medicare Need for Specific Line Item Date of Service for Each Revenue Code

Clarification for Medlearn Matters 3031—Outpatient and Inpatient Part B Claims

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

Provider Types Affected

All providers submitting outpatient and inpatient Part B claims to Medicare

Provider Action Needed

STOP – Impact to You

Using a date range instead of a single date in the LIDOS (line item date of service) field on outpatient and inpatient Part B claims will not be accepted by Medicare on or after October 1, 2004.

CAUTION – What You Need to Know

Medicare business rules rely on a single date in the LIDOS field of these claims in order to ensure accurate payment. Effective October 1, 2004, Medicare will reject claims that use a range of dates in the LIDOS field on these claims.

GO – What You Need to Do

Refer to the *Background* and *Additional Information* sections below for full details on this requirement and make sure that your billing staffs are aware of this change.

Background

Transmittal 107 (CR 3031) issued on February 24, 2004, requires Medicare claims processing systems to make certain changes to implement the HIPAA X12N 837 institutional 837 transaction. (See *http://www.cms.hhs.gov/manuals/pm_trans/R107CP.pdf*.)

These changes are needed to resolve issues with coordination of benefits (COB) transactions with third-party payers.

Business requirement 3031.1, within CR3031, requires Medicare fiscal intermediaries (FIs) to edit outpatient claims to ensure each contains a line item date or dates of service for each revenue code.

However, effective for claims submitted on or after October 1, 2004, the Centers for Medicare & Medicaid Services (CMS) will require an single date in the LIDOS field on all outpatient claims and inpatient Part B claims. Medicare fiscal intermediaries will reject any such claims where the LIDOS field contains a range of dates.

In determining the national payment rates under the outpatient prospective payment system (OPPS), CMS uses the dates of service in order to correctly attribute the costs of packaged services and items to the procedure for which they are used. This requires the single LIDOS, not a date range.

Also, in order to ensure that CMS does not pay for services on a separate claim that were paid as part of a bundle on another claim, Medicare edits outpatient claims using the LIDOS. This applies to all services on inpatient hospital claims and all but a few specified exceptions on an inpatient SNF claim. This requires separate dates of service as opposed to a date range.

Thus, so that CMS may support these business rules and facilitate recalibration of OPPS payment rates in future years, Medicare FIs will reject as unprocessable all outpatient claims and inpatient Part B claims that contain a range of dates in the LIDOS field.

Additional Information

Effective October 1, 2004, all claims submitted on bill types 12x, 13x, 14x, 22x, 23x, 24x, 32x, 33x, 34x, 71x, 72x, 73x, 74x, 75x, 76x, 81x, 82x, 83x, and 85x must contain a single date in the LIDOS field or the claim will be rejected as unprocessable.

The complete instruction issued by CMS to your FI may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R199CP.pdf*.

If you have any questions regarding 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 representatives is 1-877-602-8816. ❖

Related Change Request (CR) Number: 3337
Related CR Release Date: June 10, 2004
Effective Date: October 1, 2004
Implementation Date: October 4, 2004
Transmittal Number: 199

Source: CMS Pub 100-4 Transmittal 199, CR 3337

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X12N 837 Health Care Claim Implementation Guide ICD-9-CM and Direct Data Entry Instruction

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

Provider Types Affected

Hospitals

Provider Action Needed

STOP – Impact to You

Medicare will no longer accept outpatient claims [including Direct Data Entry (DDE)] with ICD-9-CM procedure codes. Claims containing an ICD-9-CM procedure will be rejected. Medicare will also begin editing all occurrences of certain codes to ensure that they are valid.

CAUTION – What You Need to Know

While ICD-9-CM procedure codes are the acceptable HIPAA code set for inpatient claims, HCPCS/CPT codes are the valid set for outpatient claims. In addition, other invalid codes, as noted below, will also cause claims to be rejected.

GO – What You Need to Do

Remind billing staffs to use the appropriate codes when submitting inpatient and outpatient claims to assure prompt and correct processing by Medicare. Also, ensure they are aware of the other modifications presented in this article.

Background

ICD-9-CM procedure codes are considered the Health Insurance Portability and Accountability Act (HIPAA) standard medical code set for inpatient hospital procedures and the HCPCS/CPT codes are the HIPAA standard medical code set for physician services and other health care services (including outpatient hospital procedures). In the past, Medicare did not reject outpatient claims if they contained ICD-9-CM procedure codes. However, this practice resulted at times in non-compliant coordination of benefits (COB) claims.

As a result, effective October 1, 2004, Medicare will now edit outpatient claims (as defined in Transmittal 107 – CR3031), including those received via DDE to ensure that the pertinent data do not contain ICD-9-CM procedure codes. Claims containing an ICD-9-CM procedure code will be rejected.

Medicare will also edit all claims submitted via DDE as well as outpatient and inbound HIPAA X12N 837 claims (as defined in Transmittal 107 - CR3031) to make sure that all occurrences of the data element do not contain invalid codes (these may include an E-code, diagnosis code, value code, occurrence code, or occurrence span code). An invalid code is one that is not listed in the external code source referenced by the HIPAA 837 institutional implementation guide (IG). Any claims containing these invalid codes will be rejected.

Although CMS is committed to implementing the institutional 837 per the HIPAA IG, CMS does not plan to modify the claim correction DDE screen(s) since this transaction is not a covered transaction under HIPAA.

The DDE process does not accept as many ICD-9-CM codes as does an 837. Therefore, if a submitter needs to submit more diagnosis codes, value codes, occurrence codes, or occurrence span codes than CMS processes through the Direct Data Entry system, the submitter will have to send in an 837. If a claim correction is needed, he or she will have to send a corrected 837. The claim correction DDE cannot be used since it does not support as many of the codes that are allowed on the 837.

Finally, the purpose of this article is to inform affected providers that one of the requirements listed in CR 3031 (Medlearn Matters article MM3031) has been changed. Specifically, item 7 on page 3 of MM3031 should read "All **outpatient** HIPAA X12N 837 claims that contain revenue codes of 045x, 0516, or 0526 must also contain an HI02-1 code of "ZZ", along with a compliant "Patient Reason for Visit" diagnosis code.

Additional Information

Providers must note that, effective July 1, 2004, the Medicare intermediaries will NOT require a line item date or date of service for 22X (inpatient Part B Skilled Nursing Facility) claims. 22X is being removed from business requirement 3031.1 within CR3031.

Providers must also note that, effective October 1, 2004, the Medicare intermediaries will apply the following edits:

1. All inbound **HIPAA X12N** claims and all claims submitted by DDE will be edited to ensure that:
   - All occurrences of the **E-code** are valid;
   - All occurrences of the **diagnosis code** are valid;
   - All occurrences of the **value code** are valid;
   - All occurrences of the **occurrence code** are valid; and
   - All occurrences of the **occurrence span code** are valid.
2. All outpatient **HIPAA X12N 837** claims will be edited to ensure that all occurrences of the data element do not contain an ICD-9-CM procedure code.
3. All **outpatient claims received via DDE** will be edited to ensure that all occurrences of the data element do not contain ICD-9-CM procedure codes.

Claims failing these edits will be rejected.

Providers that use Medicare's free billing software are encouraged to download, test, and implement the most current version as soon as possible after it is released.

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 3264 in the CR NUM column on the right, and click on the file for that CR. ❖

Related Change Request (CR) Number: 3264
Related CR Release Date: May 14, 2004
Related CR Transmittal Number: 175
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 123, CR 3293

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Reporting Medicare Secondary Payer Information on HIPAA X12N 837 Created Via the Free Billing Software

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

Provider Types Affected

All providers who use free billing software from Medicare for the HIPAA 837.

Provider Action Needed

STOP – Impact to You

All providers who use free (or low cost) billing software from Medicare for the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 837 must receive a software upgrade related to Medicare secondary payer (MSP) from their carrier, durable medical equipment regional carrier, or intermediary. Changes included in the updated software will be required for electronic submission of such claims (when there is one primary payer to Medicare). **Note that the HIPAA 837 does not accommodate the data Medicare needs when there is more than one primary payer. Providers must submit these types of MSP claims to Medicare on paper.**

CAUTION – What You Need to Know

Please be sure to submit claims in the correct format to avoid delays in claim processing.

GO – What You Need to Do

If you use the billing software supplied by a Medicare carrier or intermediary, please obtain the required software upgrade after October 4, 2004, from your carrier/intermediary to ensure accurate electronic claim processing.

Additional Information

If you have questions regarding this issue, contact your carrier or intermediary on their toll-free number. If you bill for Medicare Part A services, including outpatient hospital services, the toll free number for your carrier/intermediary may be found online at: *http://www.cms.hhs.gov/providers/edi/anum.asp*.

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

If you bill for Medicare Part B services, the toll-free number may be found at: *http://www.cms.hhs.gov/providers/bnum.asp*.

The official instruction issued to the carrier/intermediary regarding this change can be found online, referenced via CR NUM 3284, 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 CR3284 and click on the file for that CR. ❖

Related Change Request (CR) Number: 3284
Related CR Release Date: May 28, 2004
Related CR Transmittal Number: 84
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub 100-20 Transmittal 84, CR 3284

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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

Be aware of the current remittance advice remark and reason codes to understand actions taken on your claims.

Background

The Centers for Medicare & Medicaid Services (CMS) maintains the remittance advice remark code list, one of the code lists mentioned in the ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG).

The complete list of these codes may be found at: *http://www.wpc-edi.com/codes/Codes.asp*.

The list is updated three times per year.

By July 6, 2004 all Medicare carriers and fiscal intermediaries (FIs), including the durable medical equipment carriers (DMERCs) and the regional home health intermediaries (RHHIs), will have incorporated all current remark code changes in their Medicare systems.

Remark Codes Changes

The following table summarizes remark code changes made from November 1, 2003 to February 29, 2004.

New	Codes
N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.
N214	Missing/incomplete/invalid history or history of the related initial surgical procedure(s).
N215	A payer providing supplemental or secondary coverage shall not require a claims determination for this service from a primary payer as a condition of making its own determination.
N216	Patient is not enrolled in this portion of our benefit package.

Modified Remark Codes (Effective April 1, 2004)

M119	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code.
N115	This decision is based on a local medical review policy (LMRP) or local coverage determination (LCD). An LMRP/LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd*, or if you do not have Web access, you may contact the contractor to request a copy of the LMRP/LCD.

Modified Remark Codes (Effective February 1, 2004)

M51	Missing/incomplete/invalid procedure code(s) and/or dates.
M69	Paid at the regular rate because you did not submit documentation to justify the modified procedure code.
MA53	Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.
MA92	Missing/incomplete/invalid plan information for other insurance.

Deactivated Remark Codes

None

Claim Adjustment Reason Code Changes

The Health Care Code Maintenance Committee maintains the health care claim adjustment reason codes.

The committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about changes, additions, modifications, and retirement of reason codes. The updated list is posted three times per year, after each meeting, and the list may be found at: *http://www.wpc-edi.com/codes/Codes.asp*.

The committee approved the following reason codes as new codes as of February 2004:

Code	Current Narrative
161	Provider performance bonus
162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks code for specific explanation. ❖

Related Change Request (CR) Number: 3227
Related CR Release Date: April 30, 2004
Related CR Transmittal Number: 154
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 154, CR 3227

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FRAUD AND ABUSE

The Medicare Integrity Program—How It Addresses Health Care Fraud

Congress established the Medicare integrity program in 1996 to help reduce payment errors and protect and strengthen the Medicare trust fund. The Centers for Medicare & Medicaid Services (CMS) and its contractors work in a wide range of Medicare program areas such as cost report auditing, medical review, anti-fraud activities, and the Medicare secondary payer program to improve payment accuracy.

In 1996, the Inspector General's office estimated that 14 percent of Medicare payments were made improperly. Since then, that error rate has been cut roughly in half. The credit for such improvement in payment accuracy goes to all the stakeholders and partners in the system who have worked to improve it. The partners and stakeholders include health care providers, Medicare recipients, Medicare contractors, federal agencies such as the Department of Health and Human Services' Office of the Inspector General (DHHS OIG) and the U.S. Department of Justice (USDOJ), state agencies, Congress, and CMS.

What the Medicare Integrity Program Does Not Do

Health care providers and Medicare recipients should know about the Medicare integrity program and understand how it works. But first, there are misconceptions that must be dispelled:

- Many do not know how the program is funded and believe that funding is generated by recovered overpayments. Actually the program uses funding appropriated by Congress. Overpayments recovered, fines and penalties do not finance the Medicare integrity program – they are returned to the Medicare trust fund.
- There is a belief that health care providers are penalized for making "honest mistakes" and that providers who make errors are reported to law enforcement agencies, thus undermining the public's confidence in the health care community. To the contrary, health care providers are very seldom referred to law enforcement agencies for possible investigation and prosecution. Most payment problems and errors are addressed administratively.

Program Funding

Congress created the Medicare integrity program as part of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. In 1999, $560 million was provided to support a wide range of efforts by the Medicare program, including cost report audits, medical review, anti-fraud activities, and the Medicare secondary payer program. The total budget, although seemingly large in the absence of any context, is less than one percent of the total amount of paid claims for fiscal year 1999 ($170.1 billion).

The Medicare integrity program represents a breakthrough in how Medicare can support and sustain its integrity efforts. Prior to the Medicare integrity program, no special funds were set-aside for this purpose, and it was difficult to plan integrity work when program appropriations could vary from year to year. Recognizing how such efforts pay for themselves many times over, by preventing and recouping financial losses, Congress and the Department of Health and Human Services (DHHS) worked in a bipartisan effort to ensure that Medicare could undertake these critical activities.

It is a common misconception that CMS receives its funding only by generating "returns" through overpayment recoveries. In creating the Medicare integrity program, Congress and DHHS expressly rejected this approach, and instead set out in advance the amount available each year to fund program integrity activities. Overpayments recovered are returned to the Medicare trust fund.

Law Enforcement

At the same time it created the Medicare integrity program, Congress also provided more funds for law enforcement agencies, such as the DHHS OIG and USDOJ, for investigation and prosecution of health care fraud – not only for the Medicare program, but also for state Medicaid agencies and even private insurers. In 1999, these law enforcement agencies received $203 million for such activities.

CMS does not direct the activities or resources of law enforcement agencies. It only refers suspected fraud to DHHS OIG for investigation, and provides technical assistance to law enforcement (e.g., obtaining Medicare data or understanding Medicare program requirements) as cases are developed and pursued. Law enforcement agencies are an important partner with CMS in protecting the integrity of the Medicare program, but they are independent from CMS.

Key Activities Under the Medicare Integrity Program

The primary activities of the Medicare integrity program are:

- Cost report audits;
- Medical review;
- Anti-fraud activities; and
- Medicare secondary payer activities.

Taken together, these activities utilize the vast majority of the Medicare integrity program funds. The funds are also used to support special provider enrollment initiatives, education and outreach, and software to automatically review claims for errors. Contractors selected by CMS for these purposes carry out program integrity functions. In the past, these activities were carried out by the same contractors who process the Medicare claims and provide customer service functions.

The Medicare Integrity Program—How It Addresses Health Care Fraud (continued)

What Is a Program Safeguard Contractor?

As part of HIPAA of 1996, CMS was granted the authority to separately contract with organizations other than the traditional Medicare contractors to perform program integrity functions. These companies are known as program safeguard contractors (PSC). In 1999, CMS selected 12 organizations to operate as PSCs for the Medicare program. A PSC can perform some, all, or any sub-set of the work associated with the following payment safeguard functions: medical review, cost report audit, data analysis, provider education, and fraud detection and prevention.

The functions performed by PSCs should be transparent to the health care community and Medicare recipients – most customer contact with Medicare remains with the Medicare carriers and intermediaries as they are responsible for claims processing and customer service functions. Although a PSC may be responsible for anti-fraud activities, allegations of suspected fraudulent activities should be reported to the Medicare contractor who processes the claim. It is the responsibility of the Medicare contractor to screen all initial allegations of fraud to rule out billing errors, processing errors, or misunderstandings. Allegations of fraud are forwarded to a PSC only after errors or misunderstandings have been ruled out.

The following table lists the PSCs/contractor benefit integrity units for Florida, Puerto Rico, and the U.S. Virgin Islands:

Claim Type	State(s)	Contractor Name(s)	Contractor Type
Part A (including home health/hospice)	FL	TriCenturion Integriguard	PSC
Part A – Home health & hospice only	PR VI	TrustSolutions	PSC
Part A – (except home health & hospice)	PR VI	TriCenturion	PSC
Part B (except DMEPOS)	FL PR VI	TriCenturion	PSC
Part B – DMEPOS only	FL PR VI	Palmetto GBA	Carrier – Benefit Integrity Unit

The majority of health care providers who furnish medical services and items to Medicare recipients are honest, careful, and conscientious. However, there are some who enter the Medicare program solely intending to run a scam. Some are drawn into illegal activity by others. There are those who consistently cheat the program by padding lots of bills " a little at a time." Some desire to participate in the Medicare program and receive payments, but "deliberately ignore" or "recklessly disregard" problems in their operations that lead to Medicare overpayments.

Health care providers sometimes express concern that, with the attention being paid to anti-fraud activities in health care by the government, two problems will result. First, they fear providers who make "honest mistakes" will be assumed to be fraudulent and penalized. Second, they are concerned that publicizing the problem and involving beneficiaries and others in identifying and reporting suspected fraud undermine the public's confidence in the health care community.

It is understood that honest mistakes can and do happen. In fact, most overpayments that Medicare contractors find, or that providers find and report themselves, are handled administratively. The Medicare program does not routinely refer providers to law enforcement agencies for investigation, except where there is a clear indication of fraud. Law enforcement agencies then evaluate the referral to determine if it merits further investigation. If the Medicare program has reliable evidence of fraud, it can initiate measures to protect the Medicare program from further losses. But most overpayment situations do not merit such actions. The Medicare program does not seek to penalize honest mistakes; but it does seek to recover overpayments when they are made, regardless of the reason the overpayment occurred. No matter the reason for the overpayment, the funds are collected solely for providing health care to the elderly and disabled; thus, the overpayments must be recovered.

Medicare recipients, health care providers, and other are encouraged to report suspected fraud. Often such complaints are resolved by communication and education, or by collecting an overpayment, without referral to law enforcement. In fact, Medicare recipients are encouraged to first contact the health care provider if they have questions about their bills or Medicare statements, since this simple step can often resolve their questions. While recognizing that fraud is a serious threat to the Medicare program which needs to be addressed, most questions can be resolved through simple communication with a health care provider. In addition, beneficiaries sometimes misunderstand their notices or question services that are otherwise proper and correct. Just as a person might review their credit card bill to check for errors, it is appropriate for Medicare beneficiaries to do the same when reviewing their Medicare notices and medical. ❖

Source: Source: CMS Division of Benefit Integrity, submitted by TriCenturion, Inc.

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Please see the registration form on page 74.

Visit our provider education Web site at *http://www.floridamedicare.com* for more details.

FIRST COAST SERVICE OPTIONS, INC.
PRESENTS

A *FREE*
Evaluation and Management Documentation Seminar
FOR PHYSICIANS ONLY

First Coast Service Options, Inc. (your Florida Medicare Contractor) is excited about hosting our second 2004 Medifest Symposium. Our educational symposium, which encourages open dialogue between the Medicare contractor and healthcare professionals, provides something for everyone. We are extending a special invitation to those physicians who may not be able to attend our regularly scheduled day sessions. If you have ever had questions about documentation guidelines for Evaluation and Management services you can't afford to miss this session. We have made special arrangements with our Medical Policy Department to facilitate an evening session especially for you.

This free session is being scheduled in conjunction with Medifest, to be held:

Date	Location
September 1, 2004 6:30 pm to 8:00 pm	Gaylord Palms Resort 6000 W. Osceola Parkway Kissimmee FL 34746

Provider Name

Street Address

City, State, ZIP Code

Telephone Number Provider Number (PIN)

Email Address or Fax Number

You may register by faxing this completed form to (904) 791-6035, or by completing our online registration at *http://www.floridamedicare.com* in the Education section.

Please see pages 72 and 74, or visit our Web site for additional information on our Medifest Symposium.

MEDIFEST Class Schedule and Registration Form

$169.00

For complete class descriptors, please visit our provider education Web site at *http://www.floridamedicare.com*.

September 1-2, 2004
Gaylord Palms Resort
6000 W. Osceola Parkway
Kissimmee, FL 34746
Please contact hotel for directions and/or reservations 1-(407)-586-0000

Select one class per session (time slot)

DAY 1
Wednesday, September 1

9:00AM - 10:30AM SESSION 1/DAY 1
- o Direct Data Exchange (DDE) (A)
- o Fraud & Abuse (A/B)
- o Diagnostic Cardiology(B)
- o Hospital Outpatient Prospective Payment System (HOPPS) (A)
- o Urology (B)
- o Navigating FCSO's Web site (A/B)

10:45 AM – 12:15 PM SESSION 2/DAY 1
- o Modifier 57, 78, & 79 Workshop (B)
- o MSP for Part A Providers (A)
- o SNF (Consolidated Billing) (A/B)
- o ARNP/PA (B)
- o Understanding LMRPs/LCDs (A/B)
- o Preventive Services (B)

1:30PM - 4:30PM SESSION 3/DAY 1/WORKSHOPS
- o ANSI 101 (HIPAA) (A/B)
- o Evaluation and Management Services (B)
- o Life after a Claim Denial (B)
- o MSP for Part B Providers (B)
- o Provider Enrollment (B)
- o Rehab Services (A/B)

6:30PM - 8:00PM SESSION 4/DAY 1
- o E/M Documentation Guidelines (B)*

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

DAY 2
Thursday, September 2

9:00AM – 12:00PM SESSION 1/DAY 2/WORKSHOPS
- o ANSI 101 (HIPAA) (A/B)
- o Evaluation and Management Services (B)
- o Life after a Claim Denial (B)
- o MSP for Part B Providers (B)
- o Billing Noncovered Services to the Fiscal Intermediary (A)
- o Rehabilitation Services (A/B)

1:30AM - 3:00PM SESSION 2/DAY 2
- o Anesthesia/Pain Management (B)
- o Appeals Process for Part A Providers (A)
- o Global Surgery (B)
- o Medicaid (B)
- o Fraud & Abuse (A/B)
- o Preventive Services (B)

3:30PM - 5:00PM SESSION 3/DAY 2
- o Modifier 57, 78, & 79 Workshop (B)
- o Diagnostic Radiology (B)
- o Navigating FCSO's Web site (A/B)
- o Reason Code Resolution (A)
- o Understanding LMRPs/LCDs (A/B)

For complete class descriptors, please visit our Web site at http://www.floridamedicare.com

Registrant's Name	Telephone Number
Email Address	Fax Number
Provider's Name	
Street Address	
City, State, ZIP Code	

FAXED REGISTRATION

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

CONFIRMATION NOTICE

Faxed registration: A confirmation notice will be faxed or emailed to you within 14 days of receiving your registration form. If you do not receive a confirmation notice (not the confirmation form generated from your fax machine, but the confirmation notice provided by Medicare Education and Training), please contact us at **1-(904)-791-8103.**

Online registration: When registering online for an education event, you will automatically receive your confirmation via email notification.

ORDER FORM - PART A MATERIALS

The following materials are available for purchase. To order, please complete and submit this form along with your check/money order (PAYABLE TO: BCBSFL-FCSO, account number 700284).

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
_____	***Medicare A Bulletin* Subscriptions –** The *Medicare A Bulletin* is available free of charge online at *http://www.floridamedicare.com*. Hardcopy or CD-ROM distribution is limited to one copy per medical facility who has billed at least one Part A claim to the fiscal intermediary in Florida for processing during the twelve months prior to the release of each issue. **Beginning with publications issued after June 1, 2003**, providers who meet these criteria must register to receive the *Bulletin* in hardcopy or CD-ROM format. Qualifying providers will be eligible to receive one hardcopy or CD-ROM of each issue, if a valid reason can be shown why the electronic publication available free of charge on the Internet cannot be used. Non-providers (e.g., billing agencies, consultants, software vendors, etc.) or providers who need additional copies at other office facility locations may purchase an annual subscription. This subscription includes all Medicare bulletins published during calendar year 2004 (back issues sent upon receipt of the order). Please check here if this will be a: [ ] Subscription Renewal or [ ] New Subscription	700284	$65.00 (Hardcopy) $30.00 (CD-ROM)

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Tax **(add % for your area)** $ _____

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Mail this form with payment to:

First Coast Service Options, Inc.

Medicare Publications - ROC 10T

P.O. Box 45280

Jacksonville, FL 32232-5280

Facility Name:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Attention:_____ Area Code/Telephone Number:_____

Please make check/money order payable to: BCBSFL- FCSO Account #700284

(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)

ALL ORDERS MUST BE PREPAID -

DO NOT FAX - PLEASE PRINT

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

A

B

C

C (continued)

D

O (continued)

P

R

T (continued)

S

T

T (continued)

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 Representatives
Toll-Free
1-877-602-8816

BENEFICIARY

Toll-Free
1-800-MEDICARE
1-800-633-4227
Hearing Impaired
1-800-754-7820

ELECTRONIC MEDIA CLAIMS

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

Electronic Eligibility
1-904-791-8131

Electronic Remittance Advice
1-904-791-6865

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

PC-ACE Support
1-904-355-0313

Testing
1-904-791-6865

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

Medicare Web Sites

PROVIDERS

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

BENEFICIARIES

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

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY

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

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)

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

RAILROAD MEDICARE

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

MEDICARE A BULLETIN

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