Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

Features

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

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

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

Routing Suggestions:

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

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Publication Staff

Millie C. Pérez
Kimberly McCaw
Bill Angel
Betty Alix

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

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

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

A PHYSICIAN'S FOCUS

Humanitarian Use Device

Coverage and payment of medical devices for Medicare beneficiaries is governed by the interplay of two agencies, the *Food and Drug Administration* (Is device safe and effective? Is the device substantially equivalent to a predicate device?) and the *Centers for Medicare & Medicaid Services* (Does the device fit a benefit category? Is the use of the device reasonable and necessary to treat an illness or injury?). Each agency evolved from different statutory purposes and consequently employs different evaluation criteria per mandates. FDA decisions determine if a manufacturer can market a product in the United States. CMS and its contractor decisions establish if a provider can seek payment for a device from the Medicare program if used in the treatment of a Medicare beneficiary.

The FDA defines a **humanitarian use device** as one that is intended to benefit patients in the treatment and diagnosis of diseases or conditions that affect or is manifested in fewer than 4,000 individuals in the United States per year. A manufacturer must apply to the FDA for this designation and if so deemed must then apply for a **humanitarian device exemption** (HDE). An HDE is an application that is similar to a premarket approval application, but exempt from the effectiveness requirements. An approved HDE authorizes marketing of a humanitarian use device. See *http://www.fda.gov/cdrh/devadvice/pma/app_methods.html*

Is there Medicare Coverage for a Humanitarian Use Device?

Generally, the Medicare program covers devices approved for marketing by the FDA if:

- there exists a benefit category and the device is not statutorily excluded,
- there is not a national coverage determination of noncoverage,
- or absent a national coverage determination, there is not local contractor noncoverage (or local medical review policy coverage limitation – soon to be called local coverage decisions),
- and the device is used in an episode of care that is reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member.

If there is a national or local coverage limitation, criteria have to be met for coverage.

As noted, the FDA must approve a humanitarian use device for marketing. Before using a humanitarian use device for traditional Medicare patients, please provide FCSO with the following information:

- Details about the specific device, including its humanitarian device exemption number and pertinent FDA approval data.
- A description of the clinical situations where you plan to use the device, *CPT*/HCPCS codes to be submitted with charges and invoice price if applicable.
- Institutional review board (IRB) approval document. Per the FDA, a humanitarian use device may only be used in facilities that have established a local IRB to supervise clinical testing of devices and, after an IRB has approved the use of the device, to treat or diagnose the specific disease. See *http://www.fda.gov/cdrh/ode/guidance/1381.html*.

Please submit the information to the Office of the Medical Director or *medical.policy@fcso.com*. FCSO will review your submission and respond as soon as possible. We may ask you to provide more information in some instances. Though there is no prior approval in traditional Medicare and all payment decisions are made when the claims are submitted, this process will help ensure Medicare beneficiaries are receiving covered services without unnecessary financial liability. Also, given the possible risk for the patient, the FDA IRB requirement establishes informed consent.

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

About *The Medicare A Bulletin*

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

Publication Name	Publication Date	Effective Date of Changes
First Quarter 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 6).

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

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

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

What Is in the *Bulletin*?

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

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

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

Do You Have Comments?

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

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

Sign up to our *eNews* electronic mailing list

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

Distribution of the *Medicare A Bulletin*

Use of the Internet has become an accepted standard of communication throughout the world. Publications produced by First Coast Service Options, Inc. (FCSO) for our Medicare Florida Part A customers are available on our provider education Web site *http://www.floridamedicare.com*. Our Medicare publications are posted to the Web sites in PDF (portable document format) and may be viewed, printed, or downloaded free of charge.

Hardcopy publications, by contrast, nationally cost Medicare a substantial amount of money for printing and postage. Reducing the number of hardcopies produced is one way Medicare contractors can reduce costs that may be better utilized elsewhere. In addition, enhancements to online publications can be made that are not possible in print.

Providers Must Qualify and Register to Receive the *Medicare A Bulletin* in Hardcopy or CD-ROM Format

Hardcopy or CD-ROM distribution of the *Medicare A Bulletin* is limited to individual providers and medical facilities billed at least one Part A claim to Florida Medicare fiscal intermediary for processing during the twelve months prior to the release of each issue. **Medicare providers who meet these criteria have to register with us to receive the *Bulletin* in hardcopy or CD-ROM format.** Qualifying providers will be eligible to receive one hardcopy or CD-ROM of that issue, *if* a valid reason can be shown why the electronic publication available on the Internet cannot be utilized. "I just prefer hardcopy" is an invalid reason – a valid reason might be lack of a personal computer with Internet access, lack of a CD-ROM drive, or another technical or other barrier.

If you believe you meet these criteria and wish to receive hardcopies or CD-ROMs, you must complete and return the registration form that follows. You will be required to re-register annually. If you registered previously and no longer need a hardcopy, please indicate this on the form.

If you are willing and able to receive the *Bulletin* electronically from the Internet, you do not need to reply to us. Providers and other entities that do not meet the criteria and desire a hardcopy or CD-ROM may purchase an annual subscription to the *Bulletin* (please see the "2004 Part A Materials" order form on the inside back cover of this issue).

Note: If you have a paid subscription, you will receive hardcopies or CD-ROMs of the *Medicare A Bulletin* through your subscription period.

Features of the Electronic Publication

There are advantages to accessing the *Bulletin* online: the electronic version is posted to the Web before print copies are distributed, and you can view, print, or download only those articles important to your business.

In addition, we will be enhancing the format of electronic and CD-ROM newsletters to provide helpful features that do not appear in the current hardcopy format, including hyperlinks. A hyperlink is an element in an electronic document that links the user to another place in the same document, to an entirely different document, or to a Web site. This feature will provide users instant access to the following items:

- *Articles of Interest* – The publication table of contents will include hyperlinks to each article, therefore a provider can choose an article(s) of particular interest to his/her medical practice.
- *Third-Party Web sites* – All third-party Web sites referenced within articles will include hyperlinks to the applicable information on that Web site. (*Online publications only*.)
- *References within the Contractor Web sites* – All additional resources or reference materials mentioned in the newsletter will include hyperlinks to that information within the FCSO Medicare Web sites (e.g., full-text versions of local medical review policies, prior publications, forms, online registration, etc.). Additionally, links to unique Web pages will allow access to information applicable to the user's specialty classification. (*Online publications only*.)

The enhanced electronic publications are available at no charge through the FCSO Medicare Web sites and on CD-ROM at a minimal cost. In addition, you may sign up for the *FCSO eNews*, our free electronic mailing list. Subscribers receive an email notice when new publications are posted to our Web sites, plus frequent notification of other items of interest. Anyone with an email address may sign up for *eNews*; you don't have to be at the office. ❖

Medicare A Bulletin Hardcopy/CD-ROM Registration Form

To receive the *Medicare A Bulletin* in hardcopy or CD-ROM format, you must complete this registration form. Please complete and fax or mail it to the number or address listed at the bottom of this form. To receive a hardcopy or CD-ROM of the Third Quarter 2004 *Bulletin* your form must be faxed or postmarked on or before April 30, 2004.

Please note that you are not obligated to complete this form to obtain information published in the *Medicare A Bulletin* – issues published beginning in 1997 are available free of charge on our provider education Web site *http://www.floridamedicare.com*.

Provider/Facility Name:

_____

Medicare Provider Identification Number (PIN):

_____

Address:

_____

City, State, ZIP Code:

_____

Contact Person/Title:

_____

Telephone Number:

_____

Rationale for needing a hardcopy:

Does your office have Internet access? YES ❑ NO ❑

Do you have a PC with a CD-ROM drive? YES ❑ NO ❑

Other technical barrier or reason for needing publications hardcopy or on CD-ROM:

_____

_____

_____

Mail your completed form to:

Medicare Communication and Education - Publications
P.O. Box 45270
Jacksonville, FL 32232-5270

or fax to 1 (904) 791-6292

Please let us know your concerns or questions regarding this initiative:

_____

_____

_____

Please do not contact our customer service call center regarding this initiative. Additional questions or concerns may be submitted via the Web site in the "contact us" section.

GENERAL INFORMATION

Billing Noncovered Charges to Fiscal Intermediaries

The Centers for Medicare & Medicaid Services (CMS) has issued transmittal 25, change request 2634, summarizing existing instructions related to billing of noncovered charges by providers submitting fee-for-service claims to Medicare fiscal intermediaries (FIs). While inpatient facilities have been able to bill these charges for some time, Medicare systems have only had end-to-end capacity to process noncovered charges for outpatient providers on claims with other covered charges since April 2002. These guidelines provide more specific instructions on certain aspects of billing, and apply broader concepts to all bill types, especially in association with liability related notices such as the advance beneficiary notice (ABN).

With the issuance of transmittal 25, CR 2634, a new section will be added to the CMS Manual System, Pub. 100-4, Medicare Claim Processing, Chapter One, Section 60. This new section is available on the CMS Web site at *http://cms.hhs.gov/manuals/pm_trans/R25CP4.pdf* "General Billing Requirements – Provider Billing of Noncovered Charges to Fiscal Intermediaries" (pages 9-42). Section 60 addresses the following issues:

60.1 General Information on Noncovered Charges

60.1.1 Notification Requirements Related to Noncovered Charges Prior to Billing

60.1.2 Services Excluded by Statute

60.1.3 Claims with Condition Code 21

60.1.4 Summary of All Types of No Payment Claims

60.1.5 General Operational Information on Noncovered Charges

60.2 Noncovered Charges on Inpatient Bills

60.3 Noncovered Charges on Demand Bills

60.3.1 Traditional Demand Bills (Condition Code 20)

60.3.2 General Demand Bills Instructions, Inpatient and Outpatient (Other than HH PPS and Part A SNF)

60.3.3 Summary of Methods for Demand Billing

60.4 Noncovered Charges on Outpatient Bills

60.4.1 Billing with an ABN (Use of Occurrence Code 32) Comparable to Traditional Demand Bills

60.4.2 Line-Item Modifiers Related to Reporting of Noncovered Charges When Covered and Noncovered Services Are on the Same Claim

60.4.3 Clarifying Instructions for Outpatient Therapies Billed as Noncovered, on Other than HH PPS Claims, and for Critical Access Hospitals (CAHs) Billing the Same HCPCS Requiring Specific Time Increments

60.4.4 New Instructions for Noncovered Charges on Ambulance Claims

5.5.5 Clarification of Liability for Preventive Screening Benefits Subject to Frequency Limits

A chart addressing the definition of fee-for-service ("traditional" or "original") Medicare inpatient and outpatient services by bill type is available on the CMC Web site at *http://cms.hhs.gov/manuals/pm_trans/R25CP2.pdf*.

Billing noncovered charges to fiscal intermediaries under these new and revised guidelines are effective for claims submitted on or after April 1, 2004, for services furnished on or October 1, 2000, within the timely filing period. ❖

Source: CMS Pub. 100-04 Transmittal 25, CR 2634

Revisions to Form CMS-1450 (UB-92)

The National Uniform Billing Committee (NUBC) has approved a new revenue code, updated existing codes, and made changes to several revenue codes categories. Form CMS-1450 (UB-92) for inpatient and outpatient bills has been updated to include the following changes with an effective date of October 16, 2003:

- Revenue code 100x (Behavioral health accommodation) has been added.
- Subcategories for revenue codes 009x, 079x, 090x, and 091x have been changed.
- All reference to state fields has been discontinued and reclassified as reserved for national assignments in the following form locators:
  - Patient status code (FL22)
  - Occurrence code (FL 35)
  - Occurrence span code (FL 36)
  - Value code (FL39)
- Patient status code 43 (Discharged/transferred to a federal hospital has an effective date of October 1, 2003.
- A typographical error for revenue code 3109 (other adult care) has been corrected from revenue code 3106 to 3109

General instructions for the completion of Form CMS-1450 (UB-92) may be found on CMS Manual System, Pub. 100-4 Medicare Claim Processing, chapter 25, section 60 at the following Web site address: *http://www.cms.hhs.gov/manuals/104_claims/clm104c25.pdf*. ❖

Source: CMS Transmittal 1894, CR 2848

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

Correction to the Annual Update of HCPCS Codes Used for Home Health Consolidated Billing

An article addressing the 2004 annual update of HCPCS (Healthcare Common Procedure Coding System) codes used for home health consolidation billing was published in the First Quarter 2004 *Medicare A Bulletin* (page 10). Since then, the Centers for Medicare & Medicaid Services (CMS) has issued a correction to the master code list for calendar year 2004 and the following HCPCS codes will **not** be added to home health consolidated billing enforcement:

A7525 Tracheostomy mask, each
A7526 Tracheostomy tube collar/holder, each

Section 1842(b)(6) of the Social Security Act requires that payment for home health services provided under a home health plan of care is made to the home health agency. This requirement is found in Medicare regulations at 42 CFR 409.100.

The corrected HH consolidated billing master list is available at *http://www.cms.hhs.gov/providers/hhapps/#billing*. ❖

Source: CMS Pub. 100-4 Transmittal 62, CR 3024

Claims Crossover Consolidation Process—National Coordination of Benefits Agreement

The Centers for Medicare & Medicaid Services (CMS) has decided to streamline the claims crossover process to better serve our customers. Medicare complementary insurers (i.e., non- Medigap plans), Title XIX State Medicaid Agencies, and Medigap plans—collectively known as coordination of benefit (COB) trading partners—that are eligible to receive Medicare paid claims directly from CMS for purposes of calculating their secondary liability will no longer have to sign separate agreements with individual Medicare contractors. Each COB trading partner will now enter into one national Coordination of Benefit Agreement (COBA) with CMS' consolidated claims crossover contractor, the Coordination of Benefits Contractor (COBC).

Likewise, each COB trading partner will no longer need to prepare and send separate eligibility files to Medicare intermediaries or carriers nor receive numerous crossover files. The COBC shall be designated to collect crossover fees from all COB trading partners (except for Title XIX State Medicaid Agencies which are exempt from such fees) on behalf of CMS. Sections of the Medicare Claims Processing Manual will be added or revised to capture the scope of the many changes that will result from the claims crossover consolidation process.

This will be accomplished via a phased-in approach. **Phase I** will include analysis, design and programmer coding for the January 2004 system release. **Phase II** will include testing and address any additional programmer coding or other specifications necessary as a result of testing, and will be completed with the April 2004 system release. **Phase III** (future instructions) will include the claim-based crossover and recovery of claims processes, and is the portion that will affect our customers. We will provide information concerning future instructions as soon as it is available. ❖

Source: CMS Pub 100-4 Transmittal 29, CR 2961
CMS Pub 100-4 Transmittal 28, CR 2962

Financial Cycle Processing During Holidays

In previous years, First Coast Service Options, Inc., did not run a financial cycle or make payments to the providers when the holiday fell on a Monday, Wednesday, or Friday.

Effective Friday, December 26, 2003, the financial cycles will run on all Mondays, Wednesdays and Fridays regardless of the holiday schedule. Providers should expect payment on those days. ❖

Ambulance Claims with Modifier QL

On April 15, 2003, the Centers for Medicare & Medicaid Services (CMS) issued instructions to fiscal intermediaries (FIs) to hold all ambulance claims processed **on or after April 16, 2003,** containing modifier QL (patient pronounced dead) until CMS issued instructions on billing noncovered ambulance miles. At that time, CMS expected the instructions to be issued as part of the October 2003 shared system release. CMS has instructed FIs to continue to hold these claims until the instructions in Change Request 2634 are implemented in April 2004. ❖

Source: CMS Notification Dated November 3, 2003

New Enrollee Rights, New Provider Responsibilities in M+C Program

The following is a provider education article issued by the Centers for Medicare & Medicaid Services (CMS).

Introduction

Beginning on January 1, 2004, enrollees of Medicare+Choice (M+C) plans will have the right to an expedited review by a quality improvement organization (QIO) when they disagree with their M+C plan's decision that Medicare coverage of their services from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) should end. This new right stems originally from the Grijalva lawsuit and was established in regulations in a final rule published on April 4, 2003 (68 FR 16652). It is similar to the longstanding right of a Medicare beneficiary to request a QIO review of a discharge from an inpatient hospital.

What is "Grijalva"?

"Grijalva" is Grijalva v. Shalala – a class action lawsuit that challenged the adequacy of the Medicare managed care appeals process. The plaintiffs claimed that beneficiaries in Medicare managed care plans were not given adequate notice and appeal rights when coverage of their health care services was denied, reduced or terminated. Following extended legal negotiations – and significant changes to appeals procedures that resolved many issues – CMS reached a settlement agreement with plaintiffs and published a proposed rule based on that agreement in January 2001, and the final rule in April 2003.

New Regulations

Based on the provisions of the April 2003 final rule, SNFs, HHAs, and CORFs must provide an advance notice of Medicare coverage termination to M+C enrollees no later than two days before coverage of their services will end. If the patient does not agree that covered services should end, the enrollee may request an expedited review of the case by the QIO in that state, and the enrollee's M+C plan must furnish a detailed notice explaining why services are no longer necessary or covered. The review process generally will be completed within less than 48 hours of the enrollee's request for a review.

The new SNF, HHA, and CORF notification and appeal requirements distribute responsibilities under the new procedures among four parties:

1) The *M+C organization* generally is responsible for determining the discharge date and providing, upon request, a detailed explanation of termination of services. (In some cases, M+C organizations may choose to delegate these responsibilities to their contracting providers.)
2) The *provider* is responsible for delivering the Notice of Medicare Non-Coverage (NOMNC) to all enrollees no later than two days before their covered services end.
3) The *patient/M+C enrollee* (or authorized representative) is responsible for acknowledging receipt of the NOMNC and contacting the QIO (within the specified timelines) if they wish to obtain an expedited review.
4) The *QIO* is responsible for immediately contacting the M+C organization and the provider if an enrollee requests an expedited review and making a decision on the case by no later than the day Medicare coverage is predicted to end.

Again, these new notice and appeal procedures go into effect on January 1, 2004. You should be aware that the Medicare law (section 1869(b)(1)(F) of the Social Security Act) establishes a parallel right to an expedited review for "fee-for-service" Medicare beneficiaries, and we expect to implement similar procedures for these beneficiaries later in 2004.

What Do the New SNF, HHA, and CORF Notification Requirements Mean for Providers?

Notice of Medicare Non-Coverage (NOMNC)

The NOMNC (formerly referred to as the Important Medicare Message of Non-Coverage) is a short, straightforward notice that simply informs the patient of the date that coverage of services is going to end and describes what should be done if the patient wishes to appeal the decision or needs more information. CMS is developing a single, standardized NOMNC that is designed to make notice delivery as simple and burden-free as possible for the provider. The NOMNC essentially includes only two variable fields (i.e., patient name and last day of coverage) that the provider will have to fill in.

When to Deliver the NOMNC

Based on the M+C organization's determination of when services should end, the provider is responsible for delivering the NOMNC no later than two days before the end of coverage. If services are expected to be fewer than two days, the NOMNC should be delivered upon admission. If there is more than a 2-day span between services (e.g., in the home health setting), the NOMNC should be issued on the next to last time services are furnished. We encourage providers to work with M+C organizations so that these notices can be delivered as soon as the service termination date is known. A provider need not agree with the decision that covered services should end, but it still has a responsibility under its Medicare provider agreement to carry out this function.

How to Deliver the NOMNC

The provider must carry out "valid delivery" of the NOMNC. This means that the member (or authorized representative) must sign and date the notice to acknowledge receipt. Authorized representatives may be notified by telephone if personal delivery is not immediately available. In this case, the authorized representative must be informed of the contents of the notice, the call must be documented, and the notice must be mailed to the representative.

Expedited Review Process

If the enrollee decides to appeal the end of coverage, he or she must contact the QIO by no later than noon of the day before services are to end (as indicated in the NOMNC) to request a review. The QIO will inform the M+C organization and the provider of the request for a review and the

New Enrollee Rights, New Provider Responsibilities in M+C Program (continued)

M+C organization is responsible for providing the QIO and enrollee with a detailed explanation of why coverage is ending. The M+C organization may need to present additional information needed for the QIO to make a decision. Providers should cooperate with M+C organization requests for assistance in getting needed information. Based on the expedited timeframes, the QIO decision should take place by close of business of the day coverage is to end.

Importance of Timing/Need for Flexibility

Although the regulations and accompanying CMS instructions do not require action by any of the four responsible parties until 2 days before the planned termination of covered services, we want to emphasize that whenever possible, it's in everyone's best interest for an M+C organization and its providers to work together to make sure that the advance termination notice is given to enrollees as early as possible.

Delivery of the NOMNC by the provider as soon as it knows when the M+C organization will terminate coverage will allow the patient more time to determine if they wish to appeal. The sooner a patient contacts the QIO to ask for a review, the more time the QIO has to decide the case, meaning that a provider or M+C organization may have more time to provide required information.

We understanding the challenges presented by this new process and have tried to develop a process that can accommodate the practical realities associated with these appeals. Many QIOs are closed on weekends (except for purposes of receiving expedited review requests), as are the administrative offices of M+C organizations and providers. Thus, to the extent possible, providers should try to deliver termination notices early enough in the week to minimize the possibility of extended liability for weekend services for either M+C enrollees or M+C organizations, depending on the QIO's decision.

Similarly, SNF providers may want to consider how they can assist patients that wish to be discharged in the evening or on weekends in the event they lose their appeal and do not want to accumulate liability. Tasks such as ensuring that arrangements for follow-up care are in place, scheduling equipment to be delivered (if needed), and writing orders or instructions can be done in advance and, thus, facilitate a faster and more simple discharge. We strongly encourage providers to structure their notice delivery and discharge patterns to make the new process work as smoothly as possible.

We recognize that these new requirements will be a challenge – at least at first – and that there may be unforeseen complications that will need to be resolved as the process evolves. We intend to work together with all involved parties to identify problems, publicize best practices, and implement needed changes.

More Information

Further information on this process, including the NOMNC and related instructions can be found on the CMS Web site at *http://www.cms.hhs.gov/healthplans/appeals*. (Also, see regulations at 42 CFR 422.624, 422.626, and 489.27 and Chapter 13 of the M+C manual.) ❖

Source: CMS Pub 100-20 Transmittal 41, CR 3044

Signature Requirements

Medicare requires a legible identity for services provider/ordered. The method used (e.g., hand written, electronic, or signature stamp) to sign an order or other medical record documentation for medical review purposes in determining coverage is not a relevant factor. Rather, an indication of a signature in some form needs to be present.

Providers using alternative signature methods (e.g., a signature stamp) should recognize that there is a potential for misuse or abuse with a signature stamp or other alternate signature methods. For example, a rubber stamped signature is much less secure than other modes of signature identification. The individual whose name is on the alternate signature method bears the responsibility for the authenticity of the information being attested to. Physicians should check with their attorneys and malpractice insurers in regard to the use of alternative signature methods.

All state licensure and state practice regulations continue to apply. Where state law is more restrictive than Medicare, the contractor applies the state law standard. The signature requirements described here do not assure compliance with Medicare conditions of participation.

This instruction does not supersede the prohibition for certificates of medical necessity (CMN). CMNs are a term specifically describing particular durable medical equipment forms. As stated on CMN forms, "Signature and date stamps are not acceptable" for use on CMNs. No other forms or documents are subject to this exclusion. ❖

Source: CMS Pub. 100-8 Transmittal 59, CR 2937

Correction to HCPCS Codes for Low Osmolar Contrast Material

Healthcare Common Procedure Coding System (HCPCS) codes A4644 thru A4646 have been used to bill for low osmolar contrast material since 1994. The HCPCS Alpha-Numeric Editorial Panel added a new single code A9525 for low or iso-osmolar contrast material and deleted codes A4644 thru A4646 effective January 1, 2004.

CMS has determined that this change may result in incorrect coding of low osmolar contrast material and that providers should continue to use HCPCS codes A4644 thru A4646 rather than new code A9525. Therefore, **effective April 1, 2004,** we will continue to process claims for low osmolar contrast material coded under HCPCS A4644 thru A4646.

In addition, for claims received **on or after April 1, 2004,** HCPCS code A9525 will be invalid for Medicare claims processing purposes. Iso-osmolar products should continue to be coded using the appropriate low osmolar code A6444, A4645, or A4646. ❖

Source: CMS Pub 100-20 Transmittal: 45, CR 3053

April Quarterly Update for 2004 DMEPOS Fee Schedule

The durable medical equipment prosthetic, orthotic, and supply (DMEPOS) fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly updates process for the DMEPOS fee schedule is located in the CMS Manual System, Pub 100-4 Medicare Claims Processing Manual, Chapter 23, Section 60.

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic and orthotic devices, and surgical dressings by sections 1834(a), (h), and (i) of the Social Security Act.

Effective for services furnished **on or after April 1, 2004,** the following new "K" codes have been established for billing spinal orthotics.

K0627 Traction equipment, cervical, free-standing, pneumatic, applying traction force to other than mandible

K0630 Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment

K0631 Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated

K0632 Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment

K0633 Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels placed over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated

K0634 Lumbar orthosis, flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated, includes fitting and adjustment

K0635 Lumbar orthosis, sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebrae, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0636 Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0637 Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0638 Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom fabricated

K0639 Lumbar-sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0640 Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0641 Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated

K0642 Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0643 Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated

April Quarterly Update for 2004 DMEPOS Fee Schedule (continued)

K0644 Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0645 Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, custom fabricated

K0646 Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0647 Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated

K0648 Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xiphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid plastic and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0649 Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xiphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid plastic and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, custom fabricated. ❖

Source: CMS Pub 100-4 Transmittal #58, CR 3014
CMS Pub 100-4 Transmittal #50, CR 2967

Revised 2004 Update of the Clinical Laboratory and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedules

Section 628 of the Medicare Prescription Drug, Improvement, and Modernization Act (DIMA) of 2003 specifies that the fee update for clinical laboratory services for fiscal year 2004 through 2008 is **0 percent**. The revised fee update for clinical laboratory services requires revised fees for traveling to perform a specimen collection for either a nursing home or homebound patient. For dates of service **January 1, 2004, though December 31, 2004**, the payment for HCPCS code P9603 (per mileage trip basis) is $.825 and for HCPCS code P9604 (flat rate trip basis) is $8.25.

In accordance with section 302(c) of the DIMA, the fee schedule update factors for 2004 for DME, other than items classified as class III devices by the Food and Drug Administration), prosthetic devices, prosthetics, orthotics and surgical dressings are equal to **0 percent**. In addition, the 2004 payment limits for therapeutic shoes will be frozen at the 2003 amounts.

Section 418 of the DIMA eliminates the application of the clinical laboratory fee schedule by a hospital laboratory with fewer than 50 beds in a qualified rural area for outpatient laboratory testing for cost reporting periods beginning during the two-year period beginning on July 1, 2004. Payment for these outpatient laboratory tests will be reasonable costs during the applicable time period. Additional instructions regarding which qualified rural areas apply to this provision will be provided in a separate instruction. ❖

Source: CMS Pub. 100-20, Transmittal 31, CR 3013

2004 Medicare Physician Fee Schedule Increase

On December 8, 2003, President Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act (DIMA) of 2003, which included provisions to increase payment to physicians and other health care professionals for services reimbursed under the Medicare physician fee schedule by an average of more than 1.5 percent for calendar year 2004. These new higher rates become effective January 1, 2004.

The new act also changes the geographic practice costs indices (GPCIs) for some areas and requires Medicare to revise relative value units for drug administration and other services. On average, Medicare Physician Fee Schedule (MPFS) rates will increase approximately 1.5 percent. However, because there are changes to relative value units and GPCIs, the increase for any specific service in a particular area may be more or less than 1.5 percent. ❖

Source: CMS Pub 100-20 Transmittal 28, CR 3009

2004 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

In accordance with section 1833(h)(2)(A)(i) of the Social Security Act (the Act), the annual update to the local clinical laboratory fees for 2004 is 2.6 percent.

Payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA).

Payment for a cervical or vaginal smear test (Pap smear) is the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (Pap smear), payment may also not exceed the actual charge.

The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National Minimum Payment Amounts

Section 1833(h)(7) of the Act requires that payment for a cervical or vaginal smear test (Pap smear) to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The 2004 national minimum payment amount is $15.14 ($14.76 plus 2.6 percent update for 2004). The affected codes for the national minimum payment amount are:

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

National Limitation Amounts (Maximum)

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

Pricing Information

The 2004 laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes G0001, P9612, and P9615). The fees have been established in accordance with section 1833(h)(4)(B) of the Act.

For 2004, the clinical laboratory fee schedule will continue to include code G0001 – Routine venipuncture for collection of specimen(s). Laboratories should continue to bill code G0001 for Medicare payment of venous blood collection by venipuncture. *CPT* code *36415 – Collection of venous blood by venipuncture* and *CPT* code *36416 – Collection of capillary blood specimen (e.g., finger, heel, ear stick)* remain invalid for Medicare purposes.

The 2004 laboratory fee schedule also includes codes that have a 'QW' modifier to both identify codes and determine payment for tests performed by a laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

Instructions on separately payable fees for traveling to perform a specimen collection for either a nursing home or homebound patient were issued in June 1999. There are two codes:

- code P9603 for a per mileage trip basis, or
- code P9604 for a flat rate trip basis where the average round trip is generally less than 20 miles (or an average of 10 miles per leg of the trip).

To bill either code requires documentation of the number of specimens performed per trip (for both Medicare and non-Medicare patients) to compute the Medicare prorated fee. Code P9604 requires the laboratory to determine the appropriateness of billing on an average round trip basis for all trips during a one-year time period. Thus, payment for travel under code P9604 is made to reasonably pay on average for a varying range of trip miles so that the laboratory should not also require payment with another basis (e.g., code P9603).

Payment for HCPCS codes P9603 and P9604 reflects personnel and transportation costs. For dates of service January 1, 2004 through December 31, 2004, the personnel payment is $.46 per mile. For dates of service January 1, 2004 through December 31, 2004, the standard mileage rate for transportation costs is $0.375. The 2004 payment for code P9603 is $.835 and for code P9604 is $8.35.

Mapping rates have been revised for codes *80157, 83663, 83664, 87046, 87071, 87073, 87254, 87300,* and *88400.* Mappings have been established for *82274* and *82274QW*. Mappings have also been established for new codes G0328 and G0328QW – Colorectal cancer screening; fecal-occult blood test, immunoassay, 1-3 simultaneous determinations.

Complete Blood Count Testing

A complete blood count (CBC) consists of measuring a blood specimen for levels of hemoglobin, hematocrit, red blood cells, white blood cells, and platelets. Also, a differential white blood cell (WBC) count measures the percentages of different types of white blood cells. This

2004 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services ... (continued)

hematology testing is commonly ordered by physicians to diagnose and treat a wide array of disorders such as liver, heart, and pulmonary disease, hemorrhage, dehydration, and infections.

CPT codes representing component tests of CBC testing (with differential WBC testing) include:

85004 Blood count; automated differential WBC count
85007 Blood count; microscopic examination with manual differential WBC count
85008 Blood count; microscopic examination without manual differential WBC count
85009 Blood count; manual differential WBC count, buffy count
85013 Blood count; spun hematocrit
85014 Blood count; hematocrit (Hct)
85018 Blood count; hemoglobin (Hgb)
85032 Blood count; manual cell count (erythrocyte, leukocyte, or platelet)
85041 Blood count; red blood cell (RBC), automated
85048 Blood count; leukocyte (WBC), automated
85049 Blood count; platelet, automated

CPT codes representing the bundled testing services include:

85025 Complete CBC, automated (Hgb, Hct, RBC, WBC, and platelet count) and automated WBC differential
85027 Complete CBC, automated (Hgb, Hct, RBC, WBC, and platelet count)

National Correct Coding Initiative (NCCI) edits have been established to promote correct coding and prevent inappropriate payments. For example, test codes *85027* and *85004* should not be billed along with code *85025*, which represents the bundled testing service. Further information on the NCCI edits is available at http*://www.cms.hhs.gov/physicians/cciedits/default.asp*.

Based on comments, codes G0306 and G0307 have been established to permit continued billing of common bundled CBC testing services without a platelet count.

G0306 Complete (CBC), automated (HgB, HCT, RBC, WBC, without platelet count) and automated differential WBC count
G0307 Complete (CBC), automated (HgB, HCT, RBC, WBC, without platelet count)

If additional CBC component test(s) are medically necessary, only the medically necessary components (e.g. hemoglobin (Hgb) or hematocrit (Hct)) should be ordered and performed. Billing modifiers can assist in reporting additional medically necessary CBC component test(s) or bundling testing service for the same patient on the same date of service, such as modifier 91 – Repeat clinical laboratory test.

Organ or Disease Oriented Panel Codes

Similar to prior years, the 2004 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the fee schedule amount or the NLA for each individual test code included in the panel code.

Laboratory Costs Subject to Reasonable Charge Payment in 2004

For outpatients, the following codes are paid under a reasonable charge basis. In accordance with section 42 CFR 405.502 – 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12- month period ending June 30, updated by the inflation-indexed update. The inflation indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as prescribed by section 1842(b)(3) of the Act and section 42 CFR 405.509(b)(1). The inflation-indexed update for year 2004 is 2.1 percent.

Manual instructions for determining the reasonable charge payment may be found in the CMS Manual System, Pub. 100-04, Medicare Claim Processing, chapter 23, section 80-80.8. If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When these services are performed for independent dialysis facility patients, the CMS Manual System, Pub. 100-04, Medicare Claim Processing, chapter 8, section 60.3 instructs that the reasonable charge basis applies. However, when these services are performed for hospital based renal dialysis facility patients, payment is made on a reasonable cost basis.

Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system.

Blood Products

P9010	P9011	P9012	P9016	P9017
P9019	P9020	P9021	P9022	P9023
P9031	P9032	P9033	P9034	P9035
P9036	P9037	P9038	P9039	P9040
P9044	P9050	P9051	P9052	P9053
P9054	P9055	P9056	P9057	P9058
P9059				

Also, the following codes should be applied to the blood deductible as instructed in Pub. 100-01, chapter 3, section 20.5-20.54:

P9010	P9016	P9021	P9022	P9038
P9039	P9040	P9051	P9054	P9055
P9056	P9057	P9058		

Note: Biologic products not paid on a cost or prospective payment basis are paid based on section 1842(o) of the Act. The payment limits based on section 1842(o), including the payment limits for codes P9041, P9043, P9045, P9046, P9047 and P9048 are obtained from the single drug PRICER.

Transfusion Medicine

86850	*86860*	*86870*	*86880*	*86885*
86886	*86890*	*86891*	*86900*	*86901*
86903	*86904*	*86905*	*86906*	*86920*
86921	*86922*	*86927*	*86930*	*86931*
86932	*86945*	*86950*	*86965*	*86970*
86971	*86972*	*86975*	*86976*	*86977*
86978	*86985*	G0267		

2004 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services ... (continued)

Reproductive Medicine Procedures

89250	*89251*	*89253*	*89254*	*89255*
89257	*89258*	*89259*	*89260*	*89261*
89264	*89268*	*89272*	*89280*	*89281*
89290	*89291*	*89335*	*89342*	*89343*
89344	*89346*	*89352*	*89353*	*89354*
89356				

2004 Clinical Laboratory Test Codes

The new codes for the year 2004 are effective for services furnished on or after January 1, 2004. The Centers for Medicare & Medicaid Services (CMS) provides a three-month grace period for discontinued HCPCS codes. The grace period applies to claims received prior to April 1, 2004, which include 2003 discontinued codes for dates of service January 1, 2004, through March 31, 2004.

New Codes

84156	*84157*	*85055*	*87269*	*87329*
87660	*89225*	*89235*	*89268*	*89272*
89280	*89281*	*89290*	*89291*	*89335*
89342	*89343*	*89344*	*89346*	*89352*
89353	*89354*	*89356*	G0306	G0307
G0328	G0328QW	P9051	P9052	P9053
P9054	P9055	P9056	P9057	P9058
P9059				

Discontinued Codes

89252	*89256*	*89355*	*89365*

Gap-fill Payments for New Laboratory Test

For 2004, there are no new test codes to be gap-filled.

Public Comments

Comments after the release of the 2004 laboratory fee schedule may be submitted to the following address so that CMS may consider them for the development of the 2005 laboratory fee schedule. A comment must be in written format and include clinical, coding, and costing information. Comments must be submitted **before August 1, 2004**, for CMS to incorporate changes, if needed, with the January 2005 implementation.

Centers for Medicare & Medicaid Services (CMS)
Center for Medicare Management
Division of Ambulatory Services
Mailstop: C4-07-07
7500 Security Boulevard
Baltimore, Maryland 21244-1850. ❖

Source: CMS Pub 100-20 Transmittal 20, CR 2959

Treatment of Certain Dental Claims as a Result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

The following is a provider education article issued by the Centers for Medicare & Medicaid Services (CMS).

Provider Types Affected

Dentists

Provider Action Needed

Providers who submit dental claims for services provided to Medicare beneficiaries need to be aware of the new law related to claims submissions to supplemental or other group health insurers of Medicare beneficiaries.

STOP

As of February 8, 2004 for **outpatient** dental services that are not covered by Medicare, you do not need to submit a claim to Medicare and receive a denial if the beneficiary has group secondary or supplemental coverage. Group health plans are prohibited from requiring such determinations as of February 8 for such services.

CAUTION

A group health plan may continue to require such determinations in cases involving or appearing to involve inpatient dental hospital services, or other dental services covered by Medicare.

GO

Please amend your procedures regarding dental service claims for Medicare patients as reflected by the new legislation. See the Additional Information section for further illumination.

Background

Under present law, the Medicare benefit does not include coverage of most dental services. Some insurers have required dentists to receive a claim denial from Medicare before they will process a claim from the dentist for a Medicare beneficiary holding coverage from that group health insurer. Under section 950 of the Medicare Prescription Drug, Improvement, and Modernization act of 2003, a group health plan providing supplemental or secondary coverage to Medicare beneficiaries cannot require dentists to obtain a claim denial from Medicare for dental services that are not covered by Medicare before paying the claim However, a claims determination, i.e., a submission of a claim to Medicare**, may be required** for inpatient dental hospital services or dental services **specifically covered** by Medicare. (Payment may be made under part A for these services.)

Treatment of Certain Dental Claims as a Result of the Medicare Prescription Drug, Improvement, ... (continued)

This section of the new legislation is to be effective 60 days after enactment of the legislation, which was enacted on December 8, 2003. Thus, this provision is effective as of February 8, 2004.

Additional Information

For your convenience, the actual text of Section 950 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 reads as follows:

"Sec. 950. Treatment of Certain Dental Claims

(a) In General—Section 1862 (42 U.S.C. 1395y) is amended by adding at the end, after the subsection transferred and redesignated by section 948 (a), the following new subsection:

(k) (1) Subject to paragraph (2), a group health plan (as defined in subsection (a) (1) (A) (v) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a Medicare claims determination under this title for dental benefits specifically excluded under subsection (a) (12) as a condition of making a claims determination for such benefits under the group health plan.

(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.

(b) **Effective Date**—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of the enactment of this Act." ❖

Medlearn Matters Number: SE0402,
Related Change Request (CR) #: N/A
Effective Date: February 8, 2004
Implementation Date: February 8, 2004

Source: JSM-49, Dated January 16, 2004

OUTPATIENT REHABILITATION SERVICES

2004 Changes to Outpatient Rehabilitation Services

The following changes have been made to the list of applicable outpatient rehabilitation therapy CPT/HCPCS codes effective for services furnished **on or after January 1, 2004.**

- *CPT* code *97755* has been added to the list.
- *CPT* code *97010* has been added to the list, however this code must be bundled with any therapy code. Regardless of whether it is billed alone or in conjunction with another therapy code, this code is not paid separately. If the code is billed alone, it will be denied.
- *CPT* codes *92601, 92602, 92603, 92604,* and HCPCS codes V5362, V5363, V5364 have been removed from the list. These codes are no longer applicable outpatient rehabilitation therapy codes for services furnished **on or after January 1, 2004.**

Billing Requirements

Billing requirements and guidelines for outpatient rehabilitation services were published in the First Quarter 2004 *Medicare A Bulletin* (pages 17-18). ❖

Source: CMS Pub 100-4 Transmittal 30, CR 2973

Renewed Moratorium on Outpatient Rehabilitation Therapy Caps

The Centers for Medicare & Medicaid Services (CMS) recently issued the following provider education article concerning the renewed moratorium on outpatient rehabilitation therapy caps.

This affects providers of outpatient physical therapy, speech-language pathology, and occupational therapy services.

Impact to You

Beginning December 8, 2003, and continuing through December 31, 2005, there are no payment caps on claims received for the physical therapy, speech-language pathology, and occupational therapy services. The payment caps for these services remain in effect for claims received on September 1, 2003, through December 7, 2003, for services rendered during that timeframe.

What You Need to Know

The recently enacted Medicare Prescription Drug Modernization Act of 2003 renewed the moratorium on physical therapy, speech-language pathology, and occupational therapy services payment caps, effective on December 8, 2003, and continuing through calendar year 2005. The payment cap on services provided and for which claims were received from September 1, 2003 through December 7, 2003 for outpatient physical therapy and speech-language pathology services combined remains $1590 and for outpatient occupational therapy services remains $1590. These caps are based on the allowed incurred expenses, which are defined as the Medicare physician fee schedule (MPFS) amount before the application of any beneficiary deductible and/or coinsurance. Caps apply to claims received during the time caps were in effect.

What You Need to Do

You need to know that the payment caps for these services will not be in effect on claims received from December 8, 2003, through December 31, 2005; therefore, you should not limit services or charge beneficiaries for these covered services based on therapy caps. Essentially, the Medicare payment policies with regard to the cap are the same as those prior to September 1, 2003. Note that the use of therapy modifiers is still required.

Background

The Balanced Budget Act (BBA) of 1997 required payment under a prospective payment system for outpatient rehabilitation services (physical therapy, speech-language pathology, and occupational therapy), and set financial limitations for these services.

The Balanced Budget Refinement Act (BBRA) of 1999 placed a two-year moratorium on these limitations effective January 1, 2000 through December 31, 2001. This moratorium was further extended through December 31, 2002 by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.

In 2003, although there was not a moratorium on these payment limitations, their implementation was delayed until September 1, 2003. The financial limitations remain in effect for services provided and claims received for those services from September 1, 2003 through December 7, 2003, when the Medicare Prescription Drug Modernization Act of 2003 renewed the moratorium until the end of calendar year 2005.

Important Dates to Know

This change request is effective and implemented on December 8, 2003.

Related Instructions

To learn more about these issues, look for CR3005 on the CMS Web site page for 2003 transmittals. For example, that transmittal contains some specific examples of how the caps are computed for the period from September 1, 2003, through December 7, 2003. The transmittal page may be accessed at:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

If you have any questions, please contact us via the toll-free number 1-877-602-88167, or visit our Web site *http://www.floridamedicare.com.* ❖

Source: CMS Pub. 100-20 Transmittal: 40, CR 3045
Medlearn Matters number MM3005

GENERAL COVERAGE

Ventricular Assist Devices for Destination Therapy

This provider education article discusses the expansion in Medicare coverage for ventricular assist devices (VADs) for destination therapy for certain services performed **on and after October 1, 2003.** The article also discusses VAD claims processing and provides VAD information resources.

Background

For services performed **on and after October 1, 2003,** coverage has been expanded for VADs when used as destination therapy under the following conditions:

- The VAD has received approval from the Food and Drug Administration (FDA) for that purpose.
- The VAD is used according to FDA-approved labeling instructions.
- The patient meets specified criteria.
- The procedure is performed in specified facilities.

Note: All other indications for the use of VADs remain the same.

VAD Claim Processing Information

Services Provided to Patients in a Medicare+Choice (now Medicare Advantage) Plan

Until Medicare capitation rates to M+C organizations are adjusted to account for expanded VAD coverage, the following guidelines providers will be paid on a fee-for-service basis for VAD services that fall under the new indication for destination therapy.

Medicare did not have system changes in place to pay claims for risk M+C patients until January 5, 2004, therefore Medicare contractors held claims for risk M+C patients under the new indications for VADs submitted with modifier KZ or condition code 78 from October 1, 2003, until December 31, 2003.

Medicare contractors released these claims for payment with any applicable interest on or after January 5, 2004.

Services Provided to Fee-for-Service Patients

ICD-9-CM procedure code 37.62 was incorrectly included in diagnosis related group (DRG) 525 when it was created in 2003. Code 37.62 is clinically and financially dissimilar to the other procedures in DRG 525. Therefore, the following changes regarding the mapping of codes assigned to DRG 525 have been completed:

- ICD-9-CM procedure code 37.62 (implant of other heart assist system has been removed and assigned to DRG 104 (cardiac valve) and DRG 105 (other major cardiothoracic procedures with and without cardiac catheterization).
- Procedure codes that still map to DRG 525 are 37.63 (replacement and repair of heart assist system), 37.65 (implant of an external, pulsatile heart assist system), and 37.66 (implant of an implantable, pulsatile heart assist system).
- Payment for cases remaining in DRG 525 has been increased from approximately $75,000 to $90,000.
- Payment for cases with procedure code 37.62 has been decreased from approximately $75,000 to $35,000.
- CMS implemented a new GROUPER software program in place to correctly group these services on November 1, 2003; therefore, claims submitted between October 1, 2003 and October 31, 2003 were grouped and paid under the software programs in place on October 1, 2003.
- Claims with DRGs 104, 105, and 525 were adjusted on or after November 1, 2003 in order to correctly pay these services.

VAD Information Resources

http://www.cms.hhs.gov/manuals/cmsindex.asp
CMS Manual System, Pub. 100-3 Medicare National Coverage Determination, section 20.9. ❖

Source: CMS Pub 100-3 Transmittal 4, CR 2985

Expanded Colorectal Cancer Screening Fecal-Occult Blood Tests

Effective for services furnished **on or after January 1, 2004,** Medicare covers the new colorectal cancer screening fecal-occult blood test (FOBT) – HCPCS code G0328. Screening FOBT (HCPCS code G0328) may be paid as an alternative to HCPCS code G0107 for beneficiaries who have attained age 50. Medicare will pay for a covered FOBT (either G0107 or G0328, but not both) at a frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed).

HCPCS Codes

G0107 Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations; (effective for services furnished on or after January 1, 1998)

G0328 Colorectal cancer screening; fecal-occult blood test, immunoassay, 1-3 simultaneous determinations (effective for services furnished on or after January 1, 2004)

Coverage Guidelines

Effective for services furnished on or after January 1, 2004, one screening FOBT (HCPCS code G0107 **or** G0328) is covered for beneficiaries who have attained age 50, at a frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed).

Screening FOBT means:

(1) a guaiac-based test for peroxidase activity in which the beneficiary completes it by taking samples from two different sites of three consecutive stools **or**,

(2) an immunoassay (or immunochemical) test for antibody activity in which the beneficiary completes the test by use of a spatula to collect the appropriate number of samples or the use of a special brush for the collection of samples, determined by the individual manufacturer's instructions.

Both screenings require a written order from the beneficiary's attending physician. The term "attending physician" is defined to mean a doctor of medicine or osteopathy (as defined in section 1861(r)(10 of the Social Security Act) who is fully knowledgeable about the beneficiary's medical condition, and who would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.

Billing Guidelines

Hospitals bill the fiscal intermediary on Form CMS-1450 (UB-92) or its electronic equivalent using type of bill 13x, 83x, or 85x. In addition, the hospital bills revenue code 030x for HCPCS codes G0107 or G0328.

Payment Methodology

HCPCS code G0328 or G0328QW is payable under the clinical laboratory fee schedule methodology. G0328QW identifies a laboratory registered with a certificate of waiver under the Clinical Laboratory Improvement Amendments of 1988.

HCPCS code G0328 or G0328QW furnished in a critical access hospital is payable under the reasonable cost basis methodology. ❖

Reference Resources:

CMS Manual System, Pub. 100-2 Benefit Policy, chapter 15, section 280.2

CMS Manual System, Pub. 100-3, Medicare National Coverage, chapter 1, section 210.3

CMS Manual System, Pub. 100-4, Medicare Claim Processing, chapter 18, section 60

Source: CMS Pub 100-2 Transmittal 3, CR 2996

April 2004 Changes to the Laboratory National Coverage Determination

The Centers for Medicare & Medicaid (CMS) is adding the following diagnosis codes to the list of "ICD-9-CM Codes Covered by Medicare" for the serum iron studies to the laboratory national coverage (NCD) edit software:

403.01 Hypertensive renal disease, malignant, with renal failure
403.11 Hypertensive renal disease, benign, with renal failure
403.91 Hypertensive renal disease, unspecified, with renal failure
404.02 Hypertensive heart and renal disease, malignant, with renal failure
404.03 Hypertensive heart and renal disease, malignant, with heart and renal failure
404.12 Hypertensive heart and renal disease, benign, with renal failure
404.13 Hypertensive heart and renal disease, benign, with heart and renal failure
404.92 Hypertensive heart and renal disease, unspecified, with renal failure
404.93 Hypertensive heart and renal disease, unspecified, with heart and renal failure

These codes are effective for services furnished **on or after April 5, 2004.** ❖

Source: CMS Pub 100-4 Transmittal 71, CR 3032 & 3072

DRUGS AND BIOLOGICALS

Medicare Drug Payment under Part B

This replaces information that was posted to our provider education Web site on January 30, 2004, based on CMS Pub. 100-04, Rev. 54, which was issued on December 24, 2003. Since then, CMS has issued revised pricing files. The new amounts are provided in this article.

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

The Medicare payment limits for drugs and biologicals not paid on a cost or prospective payment basis, and furnished **on or after January 1, 2004,** through **December 31, 2004,** are as described below:

- The payment limits for blood clotting factors are 95 percent of the AWP reflected in the published compendia as of September 1, 2003.
- The payment limits for new drugs or biologicals are based on 95 percent of the AWP reflected in the published compendia as of September 1, 2003. The payment limits for new drugs or biologicals without AWP listings in the published compendia as of September 1, 2003 are based on 95 percent of the AWP reflected in the published compendia as of the first of the month the payment limit for the drug or biological is determined. For the purposes of this instruction, a new drug is an unlisted drug (not currently covered by a specific HCPCS code; i.e., a HCPCS code other than a NOC code such as J3490, J9999, etc.) approved by the Food and Drugs Administration (FDA) subsequent to April 1, 2003. A drug is not considered to be new if: the brand or manufacturer of the drug changes; a new vial size is developed; the drug receives a new indication; or the drug is a combination of existing drugs.
- The payment limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP reflected in the published compendia as of September 1, 2003.
- The payment limits for certain drugs studied by the OIG and GAO are based on the percentages of the AWP reflected in the published compendia as of April 1, 2003 specified in Table 1 in section 20 of Chapter 17 of the Medicare Claim Processing Manual, Pub. 100-04.
- The payment limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2004 are 95 percent of the AWP reflected in the published compendia as of October 1, 2003 regardless of whether or not the durable medical equipment is implanted.
- The payment limits for drugs and biologicals furnished in connection with dialysis and billed by independent dialysis facilities are based on 95 percent of the AWP reflected in the published compendium as of September 1, 2003. The payment limits in the FI file are all based on 95 percent of the AWP reflected in the published compendium as of September 1, 2003.
- Drugs and biologicals not described above are paid at 85 percent of the AWP reflected in the published compendium as of April 1, 2003.

Payment limits determined under this instruction shall not be updated during 2004.

The 2004 MMA drug payment limits effective January 1, 2004 are as follows:

Code	2004 Payment Limit for FI Processed Drugs	Code	2004 Payment Limit for FI Processed Drugs	Code	2004 Payment Limit for FI Processed Drugs
90371	$649.80	90716	$68.83	J0207	$452.97
90375	$72.85	90717	$59.17	J0210	$11.88
90376	$78.11	90718	$11.52	J0215	$31.51
90385	$34.77	90720	$37.59	J0256	$2.66
90585	$160.13	90721	$48.84	J0270	$0.34
90632	$74.54	90732	$18.62	J0280	$1.04
90633	$29.80	90733	$69.45	J0282	$16.05
90634	$29.80	90735	$79.76	J0285	$10.39
90645	$24.32	90740	$110.92	J0287	$21.85
90658	$9.95	90743	$27.05	J0288	$15.20
90659	$9.95	90744	$27.05	J0289	$35.80
90675	$136.16	90746	$55.46	J0290	$1.65
90691	$42.00	90747	$110.92	J0295	$7.42
90700	$22.41	J0130	$513.02	J0300	$2.66
90703	$14.37	J0150	$37.71	J0330	$0.20
90704	$19.43	J0151	$229.26	J0360	$16.04
90705	$15.03	J0152	$76.42	J0380	$1.27
90706	$16.74	J0170	$2.34	J0390	$19.68
90707	$39.04	J0200	$19.04	J0395	$182.40
90713	$25.71	J0205	$37.52	J0456	$25.38

Code	2004 Payment Limit for FI Processed Drugs
J0460	$1.19
J0470	$23.67
J0475	$215.18
J0476	$79.80
J0500	$17.06
J0515	$3.90
J0520	$5.34
J0530	$11.92
J0540	$23.40
J0550	$50.12
J0560	$9.89
J0570	$19.78
J0580	$39.56
J0583	$1.74
J0585	$4.95
J0587	$8.79
J0592	$1.03
J0595	$4.40
J0600	$44.10
J0610	$1.44
J0620	$6.42
J0630	$38.41
J0636	$1.38
J0637	$32.95
J0640	$3.56
J0670	$2.07
J0690	$2.25
J0692	$8.13
J0694	$10.69
J0696	$14.92
J0697	$6.42
J0698	$9.51
J0702	$4.98
J0704	$1.07
J0706	$3.44
J0713	$6.75
J0715	$4.96
J0720	$7.22
J0725	$3.09
J0735	$55.16
J0740	$843.60
J0743	$15.87
J0744	$13.69
J0745	$0.87
J0760	$7.07
J0770	$54.15
J0780	$8.84
J0800	$92.94
J0835	$81.00
J0850	$712.07
J0880	$23.69
J0895	$15.63
J0900	$1.63
J0945	$0.95
J0970	$1.62
J1000	$1.90
J1020	$2.68
J1030	$4.13
J1040	$8.27
J1051	$5.04
J1056	$24.61
J1060	$4.46
J1070	$4.95
J1080	$9.43
J1094	$0.71
J1100	$0.10
J1110	$36.10
J1120	$20.52
J1160	$1.79
J1165	$0.86
J1170	$1.55
J1180	$9.02
J1190	$233.97
J1200	$1.61
J1205	$10.49
J1212	$44.60
J1230	$0.75
J1240	$0.38
J1245	$5.70
J1250	$4.74
J1260	$16.45
J1270	$5.50
J1320	$2.40
J1325	$18.06
J1327	$12.83
J1335	$23.74
J1364	$3.59
J1380	$0.53
J1390	$1.07
J1410	$61.51
J1435	$0.57
J1436	$76.95
J1438	$156.25
J1440	$185.90
J1441	$314.07
J1450	$97.61
J1452	$950.00
J1455	$13.07
J1460	$12.17
J1470	$24.35
J1480	$36.56
J1490	$48.69
J1500	$60.87
J1510	$72.88
J1520	$85.12
J1530	$97.38
J1540	$109.66
J1550	$121.72
J1563	$78.38
J1564	$0.85
J1565	$18.12
J1570	$35.24
J1580	$2.07
J1590	$0.90
J1595	$33.67
J1600	$13.52
J1610	$45.60
J1620	$201.98
J1626	$18.54
J1630	$6.83
J1631	$9.12
J1642	$0.06
J1644	$0.40
J1645	$15.69
J1650	$6.47
J1652	$8.27
J1655	$3.83
J1670	$119.70
J1700	$0.34
J1710	$5.57
J1720	$2.07
J1730	$122.95
J1742	$251.35
J1745	$65.70
J1750	$17.91
J1756	$0.66
J1785	$3.75
J1790	$2.80
J1800	$11.63
J1810	$9.44
J1815	$0.10
J1830	$66.40
J1835	$38.65
J1840	$3.30
J1850	$0.49
J1885	$3.56
J1890	$10.26
J1910	$16.14
J1940	$0.93
J1950	$517.32
J1955	$34.20
J1956	$20.81
J1960	$3.76
J1980	$8.90
J1990	$24.99
J2000	$3.99
J2001	$0.98
J2010	$3.31
J2020	$38.98
J2060	$3.14
J2150	$3.27
J2175	$0.53
J2180	$4.50
J2185	$4.92
J2210	$4.10
J2250	$1.28
J2260	$51.58
J2270	$0.77
J2271	$11.07
J2275	$2.38
J2280	$10.39
J2300	$1.59
J2310	$2.49
J2320	$3.84
J2321	$7.67
J2322	$15.74
J2324	$151.62
J2352	$181.88
J2353	$92.68
J2354	$4.25
J2355	$267.86
J2360	$5.42
J2370	$1.28
J2400	$6.39
J2405	$6.09
J2410	$3.09
J2430	$265.87
J2440	$3.33
J2460	$1.01
J2501	$5.33
J2505	$2,802.50
J2510	$9.60
J2515	$1.46
J2540	$0.29
J2543	$4.90
J2545	$44.84
J2550	$2.85
J2560	$1.62
J2590	$1.28
J2597	$3.45
J2650	$0.31
J2670	$3.92
J2675	$3.62
J2680	$8.96
J2690	$1.43
J2700	$0.80
J2710	$0.67
J2720	$0.76
J2725	$24.40
J2730	$102.96
J2760	$31.92
J2765	$1.90

Code	2004 Payment Limit for FI Processed Drugs
J2770	$114.58
J2780	$1.43
J2783	$117.96
J2788	$34.77
J2790	$100.32
J2792	$20.55
J2795	$0.07
J2800	$3.80
J2820	$29.06
J2910	$17.31
J2912	$0.49
J2916	$8.17
J2920	$2.11
J2930	$3.24
J2940	$45.56
J2941	$45.92
J2950	$0.46
J2993	$1,364.44
J2995	$89.06
J2997	$36.70
J3000	$6.35
J3010	$0.93
J3030	$26.56
J3070	$5.23
J3100	$2,690.88
J3105	$29.39
J3120	$8.98
J3130	$17.96
J3140	$0.40
J3150	$0.94
J3230	$4.40
J3240	$617.50
J3245	$471.39
J3250	$1.55
J3260	$4.46
J3265	$1.56
J3280	$5.65
J3301	$1.60
J3302	$0.33
J3303	$1.01
J3305	$142.50
J3315	$398.62
J3320	$28.27
J3360	$0.85
J3364	$10.23
J3365	$511.50
J3370	$7.03
J3395	$1,603.13
J3410	$1.21
J3411	$0.90
J3415	$0.52
J3420	$0.17
J3430	$2.21
J3465	$4.99
J3475	$0.23
J3480	$0.08
J3485	$1.02
J3486	$20.79
J3487	$227.86
J7030	$11.31
J7040	$4.68
J7042	$9.44
J7050	$2.83
J7051	$0.76
J7060	$7.50
J7070	$10.97
J7100	$25.11
J7110	$14.21
J7120	$12.45
J7130	$0.52
J7190	$0.87
J7191	$2.04
J7192	$1.29
J7193	$1.12
J7194	$0.40
J7195	$0.95
J7197	$1.50
J7198	$1.43
J7308	$100.94
J7310	$4,750.00
J7317	$138.71
J7320	$233.14
J7330	$15,920.10
J7340	$29.30
J7342	$16.16
J7501	$59.84
J7504	$289.85
J7511	$357.58
J7513	$425.11
J7525	$118.80
J7619	$0.41
J7621	$1.90
J9000	$12.54
J9001	$416.69
J9010	$584.53
J9015	$734.46
J9017	$36.81
J9020	$62.61
J9031	$160.13
J9040	$182.40
J9045	$155.65
J9050	$142.49
J9060	$15.15
J9062	$75.76
J9065	$51.30
J9070	$5.73
J9080	$10.89
J9090	$22.86
J9091	$45.73
J9092	$91.45
J9093	$4.88
J9094	$9.77
J9095	$24.42
J9096	$48.86
J9097	$97.75
J9098	$371.45
J9100	$8.19
J9110	$8.55
J9120	$13.87
J9130	$11.22
J9140	$22.06
J9150	$74.23
J9151	$64.60
J9160	$1,330.95
J9165	$14.41
J9170	$357.90
J9178	$27.64
J9180	$711.71
J9181	$1.71
J9182	$17.10
J9185	$348.67
J9190	$2.07
J9200	$136.80
J9201	$129.49
J9202	$446.49
J9206	$152.88
J9208	$150.38
J9209	$35.15
J9211	$419.94
J9212	$4.09
J9213	$34.88
J9214	$14.88
J9215	$7.86
J9216	$209.22
J9217	$622.33
J9218	$25.10
J9219	$5,399.80
J9230	$12.01
J9245	$420.10
J9250	$0.39
J9260	$4.75
J9263	$9.45
J9265	$162.16
J9266	$1,543.75
J9268	$1,837.72
J9270	$93.80
J9280	$63.84
J9290	$207.48
J9291	$285.00
J9293	$359.35
J9300	$2,183.81
J9310	$501.13
J9320	$141.47
J9340	$93.58
J9350	$798.65
J9355	$58.13
J9357	$526.68
J9360	$3.15
J9370	$33.98
J9375	$67.96
J9380	$160.36
J9390	$89.36
J9395	$87.58
J9600	$2,603.67
P9041	$14.54
P9043	$14.54
P9045	$55.10
P9046	$14.54
P9047	$55.10
P9048	$29.10
Q0136	$12.69
Q0137	$4.74
Q0183	$16.16
Q0187	$1,681.50
Q2022	$0.95
Q3025	$85.21
Q4052	$83.03
Q4053	$467.09
Q4054	$4.74
Q4075	$0.47

***Note**: Tthe absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. These determinations shall be made by the local Medicare contractor processing the claim*

Source: CMS Pub. 100-04 Transmittal 75, CR 3105

HOSPITAL SERVICES

Coding and Billing Instructions for Velcade™

The Centers for Medicare & Medicaid Services (CMS) has approved transitional pass-through payment status under the Medicare hospital outpatient prospective payment system (OPPS) for Velcade™ (bortezomib) injections.

Payment for HCPCS code C9207 (Injection, bortezomib, per 3.5 mg) will be implemented in the Medicare systems in the January 1, 2004, release; however, pass-through payments for this drug are effective for services furnished **on or after October 1, 2003.**

Billing Instructions

Services Furnished Before October 1, 2003

Hospitals should use HCPCS code J3490 (Unclassified drugs) to bill for Velcade™ administered for injection prior to October 1, 2003. Although no separate payment is allowed under the OPPS for a drug billed with HCPCS J3490, charges associated with J3490 are split proportionally among all the other payable ambulatory payment classifications (APCs) on the claim and are added to the original charges for those other APCs. The resulting charges are converted to cost and used in determining whether the threshold for outlier payment is met. If the outlier threshold is met, claims will generate an outlier payment in addition to APC payments. Charges for J3490 also figure in the calculation of transitional corridor payments.

Services Furnished on or after October 1, 2003

Hospitals should use HCPCS code C9207, to bill for Velcade™ administered for injection on or after October 1, 2003, in order to receive the pass-through payment.

Action Required by Providers

For claims with dates of service **October 1, 2003, through December 31, 2003,** when additional services are furnished that would be reported on the same claim as C9207, hospitals may remove the charge for C9207 in order to receive payment for the other services on the claim. Hospitals that elect to bill in this manner can submit an adjustment bill after the January 1, 2004, release is installed to receive payment for C9207. Alternatively, hospitals may delay billing for all services furnished on the date that Velcade™ is administered until after the January 1, 2004, release is installed.

Hospitals that have submitted a claim using a code other than C9207 to bill for Velcade™ furnished **on or after October 1, 2003,** may submit an adjustment claim after January 1, 2004 in order to receive the pass-through payment for Velcade™.

Institutions that submit claims to fiscal intermediaries and that are not paid under the hospital OPPS should bill for Velcade™ the same way they bill for any other drug for which a national HCPCS code has not been assigned, that is, using an appropriate revenue code with or without a HCPCS code for an unclassified drug. ❖

Source: CMS Pub 100-20 Transmittal 26, CR 2982

Fiscal Year 2002 Supplemental Security Income Additional Payment

Under the inpatient rehabilitation facility prospective payment system (IRF PPS), facilities receive additional payment amounts to account for the cost of furnishing care to low-income patients. The supplemental security income (SSI) data is updated on an annual basis and these data are one of the components used to determine an appropriate low-income patient adjustment to the prospective payment rate for each IRF.

Fiscal intermediaries (FIs) use this data to determine an initial PPS amount and, if applicable, to determine a final outlier payment amount for IRFs with cost reporting periods beginning **on or after October 1, 2003, and before October 1, 2004.** Since the disproportionate share percentage is based on a facility's cost reporting period, FIs make a final determination of the amount of this percentage to compute the final low-income patient (LIP) adjustment at the year-end settlement of the facility's cost report. *Specifically, the FY 2002 SSI data is used for settlement purposes for facilities with cost reporting periods beginning on or after January 1, 2002 and before October 1, 2003.* The final LIP adjustment is used to retrospectively adjust the initial PPS amount.

The SSI file is also available at the following Web address: *http://www.cms.hhs.gov/providers/irfppsdata_ratios.asp*. ❖

Source: CMS Pub 100-04 Transmittal 39, CR 2978

Lung Volume Reduction Surgery and Claim Billing Instructions for Beneficiaries in a Risk M+C Plan

Lung volume reduction surgery (LVRS) (also known as reduction pneumoplasty, lung shaving, or lung contouring) is an invasive surgical procedure to reduce the volume of a hyperinflated lung in order to allow the underlying compressed lung to expand, and thus, establish improved respiratory function.

Effective for discharges **on or after January 1, 2004** (inpatient services), and for "from" dates of service **on or after January 1, 2004** (outpatient claims), Medicare will cover LVRS under certain conditions described in CMS Manual System Pub. 100-3, National Coverage Determinations (NCD), section 240.

Note: This new coverage of LVRS is separate from claims processing instructions currently in place for the National Emphysema Treatment Trial (NETT). There are no changes to billing in the NETT.

Billing Requirements

The Medicare code editor (MCE) software creates a limited coverage edit for ICD-9-CM procedure code 32.22. This procedure code has limited coverage due to the stringent conditions that must be met by hospitals. Where this procedure code is identified by MCE, the FI determines if coverage criteria is met and overrides the MCE edit if appropriate.

LVRS can only be performed in the facilities listed on the following Web site:
http://www.cms.hhs.gov/coverage/lvrsfacility.pdf

LVRS is an inpatient procedure. However pre- and post-operative services are performed on an outpatient basis and must be performed at one of the facilities certified to do so.

Inpatient Hospital Services

Inpatient hospital services for LVRS are submitted on a type of bill 11x with ICD-9-CM procedure code 32.22 (Lung volume reduction surgery).

Facilities certified to perform LVRSs are reimbursed under the inpatient prospective payment system methodology.

Outpatient Hospital Services

Outpatient pre- and post-operative pulmonary services for LVRS are submitted on a type of bill 13x using HCPCS codes G0302, G0303, G0304 and or G0305.

Facilities certified to performed services related to LVRS are reimbursed under the outpatient prospective payment system methodology, except for hospitals located in Maryland.

Medicare+Choice Claims

Medicare will pay fee-for-service for LVRS claims furnished to beneficiaries enrolled in risk Medicare+Choice (M+C) plans containing condition code 78 for discharges **on or after January 1, 2004,** (inpatient services) and for dates of service **on or after January 1, 2004** (outpatient claims), through **March 31, 2004.**

Claims for beneficiaries enrolled in a risk M+C plan that fall under the new coverage with condition code 78 for dates of service January 1, 2004, through March 31, 2004 will be placed on hold until changes to the Medicare systems, scheduled for April 5, 2004, can be made. However, claims will be released earlier if system changes are in place.

Part A or Part B deductible to inpatient and outpatient claims with condition code 78 for beneficiaries enrolled in a M+C plan do not apply. Applicable coinsurance will be applied for risk M+C beneficiaries who receive LVRS. ❖

Source: CMS Pub. 100-04 Transmittal 26, CR 2688

Reporting Discharge and or Transfer Patient Status Code

To ensure accurate coding and payments for discharge and or transfer policies under the inpatient prospective payment system (IPPS) new edits have been established to identify all same-day, same provider acute care readmissions where the claim is coded as being discharged to another provider or unit before being readmitted. In addition, new edits have been established to compare applicable inpatient claims with subsequent post-acute claims. Subsequent post-acute claims include transfers to a home health agency where the home health stay can begin within **three** days of an inpatient discharge, and transfer to a skilled nursing facility where the SNF stay can begin within **14** days of the inpatient discharge. Regulations regarding discharges and transfers for inpatient hospital paid under PPS are found at 42 CFR 412.4.

Based on these edits, the incoming admission claim will edit against an existing discharge or transfer claim where the patient status code submitted does not match the incoming admission claim. Fiscal intermediaries will cancel the discharge claim and return to the provider for correction of the appropriate patient status code. ❖

Source: CMS Transmittal A-03-065, CR 2716

Revenue Code 068x

Revenue code 068x (trauma response) was approved by the National Uniform Billing Committee (NUBC) to report in form locator (FL) 42 of Form CMS-1450 for types of bill 11x (inpatient hospital) and 13x (outpatient hospital), effective October 1, 2002.

The Centers for Medicare & Medicaid Services (CMS) has added revenue code 068x to the list of revenue codes that are packaged under the hospital outpatient prospective payment system (OPPS), effective for services furnished **on or after January 1, 2004.**

Reimbursement Methodology

- Revenue code 068x is a packaged revenue code under the hospital OPPS.
- Payment for revenue code 068x under the hospital inpatient prospective payment system is included in the diagnosis related group (DRG) payment.
- Institutions that report revenue codes and that submit claims to fiscal intermediaries but that are not paid under the hospital OPPS or the hospital inpatient PPS would be paid for revenue code 068x under existing applicable payment methodologies.

Packaged Revenue Codes

The following revenue codes when billed under OPPS without *CPT*/HCPCS codes are packaged services for which no separate payment is made. However, the cost of these services is included in the transitional outpatient payment (TOP) and outlier calculations.

The revenue codes for packaged services are:

0250	0251	0252	0254	0255	0257
0258	0259	0260	0262	0263	0264
0269	0270	0271	0272	0275	0276
0278	0279	0280	0289	0370	0371
0372	0379	0390	0399	0560	0569
0621	0622	0624	0630	0631	0632
0633	0637	*0681*	*0682*	*0683*	*0684*
0689	0700	0709	0710	0719	0720
0721	0762	0810	0819	0942.	

Any other revenue codes that are billable on a hospital outpatient claim must contain a CPT/HCPCS code in order to assure payment under OPPS. Claims containing revenue codes that require *CPT*/HCPCS that are received with no CPT/HCPCS shown on the claim detail line will be returned to the provider. ❖

Reference Resource: CMS Manual System, Pub. 100-04, Medicare Claim Processing, chapter 4, section 20.5.11

Source: CMS Pub 100-04 Transmittal 36, CR 2995

Intravenous Immune Globulin

The following is a provider education article issued by the Centers for Medicare & Medicaid Services (CMS).

Provider Types Affected

Physicians, hospitals, pharmacies, DME suppliers, and home health agencies.

Provider Action Needed

Please inform your staff and change your billing procedures as needed regarding reimbursement for the cost of the drug Intravenous (IV) Immune Globulin when administered in the home.

STOP – Impact to You

This is a new policy. Beginning January 1, 2004, Medicare pays for IV Immune Globulin administered in the beneficiary's home.

CAUTION – What You Need to Know

Only the cost of the drug is paid for, once prescribed. Services and items related to drug administration are not paid for when the drug is administered in the home. The drug must be deemed medically appropriate as a treatment for primary immune deficiency diseases.

GO – What You Need to Do

Please implement this new policy and inform your staff about the new billing procedures.

Background

A new section has been added to the Medicare Claims Processing Manual describing this new policy. The claims processing instructions regarding Intravenous immune globulin can be found in *Chapter 17 – Drugs and Biologicals*, *Section 80.6*. In addition, the coverage policy regarding IV Immune Globulin can be found in the *Medicare Benefit Policy Manual (pub 100-02), Chapter 15, Section 50.6*. Both of these manuals can be found at: *http://www.cms.hhs.gov/manuals/cmsindex.asp*.

This CR implements Section 642 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (DIMA). With this change, Medicare carriers, regional home health intermediaries (RHHIs), and DME regional carriers (DMERCs) will pay state licensed entities, which will receive the reimbursement.

Beneficiaries may not be reimbursed for the cost of the drug. Further reimbursement information is provided in the following table:

Intravenous Immune Globulin (continued)

Licensed Entity	Form of IV Immune Globulin (IVIG) Dispensed	Where To Bill
Pharmacies and Hospitals	IVIG	DMERC
Home Health Agencies	IVIG	RHHI
Physicians	IVIG for refilling implanted pump	Carriers
	IVIG for refilling external pump for home infusion	DMERC

Additional Information

The official instruction issued to your carrier regarding this change may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R74CP.pdf*.

To view the CR related to the coverage policy on this Medicare change, which was issued on January 23, 2004, as CR# 3059, please visit *http://www.cms.hhs.gov/manuals/pm_trans/R6BP.pdf*.

Should you have further questions, please contact your local carrier or RHHI at their toll free number. A list of these toll free numbers may be found at: *http://www.cms.hhs.gov/medlearn/tollnums*. ❖

Related Change Request (CR) #: 3060 (and 3059)
Related CR Release Date: January 30, 2004
Related CR Transmittal #: R74CP for CR 3060 and R6BP for 3059
Effective Date: January 1, 2004
Implementation Date: April 5, 2004

Source: Medlearn Matters Number MM3060

SKILLED NURSING FACILITY SERVICES

2004 Annual Update of HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes subject to the consolidated billing (CB) provision of the skilled nursing facility (SNF) prospective payment system (PPS). Services appearing on this list submitted on claims to both Medicare fiscal intermediaries (FIs) and carriers, including durable medical equipment regional carriers (DMERCs), will not be paid by Medicare to providers, other than a SNF, when **included** in SNF CB. For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay; however, SNF CB 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 SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. In order to assure proper payment in all settings, Medicare systems edit for services provided to SNF beneficiaries both included and excluded from SNF CB. **This notification provides a list of the exclusions, and some inclusions, to SNF CB, and only applies to codes affected by editing in Medicare FI claim processing systems.** A separate notification is issued for codes affecting Medicare carrier claim processing systems.

This notification is the first quarterly SNF consolidated billing update for fiscal year (FY) 2004. It incorporates a list of new temporary codes (such as K codes), as well as the annual update of all HCPCS codes. Since this is the only quarter in which new permanent HCPCS codes are produced, this notification is referred to as an annual update. Other quarterly updates will occur **as needed** due to the creation of new temporary codes prior to the next annual update. In lieu of any other update, editing based on these codes remains in effect.

SNF Consolidated Billing HCPCS Coding List

The following is a comprehensive list of HCPCS codes involved in editing claims submitted to FIs for services subject to SNF consolidated billing (CB) effective for services furnished **on or after January 1, 2004.**

New codes listed subsequent to prior publications appear in **bold** in the HCPCS code charts. Boldface is also used outside of the code charts in cases as noted when type of bill or revenue codes, rather than HCPCS codes, are used to perform editing. Bolding is also used to highlight titles, captions and other billing information for SNFs.

Codes from previous lists not appearing in this article have been deleted. Since there is a three-month grace period in which discontinued HCPCS codes for 2004 are still allowed to process, codes remain listed here if the three-month grace period overlaps with this update.

HCPCS codes subject to SNF CB have been classified into five major categories.

Major Category I

Exclusion of Services Beyond the Scope of a SNF

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

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

Computerized Axial Tomography Scans

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

Cardiac Catheterization

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

Magnetic Resonance Imaging (MRIs)

70336	*70540*	*70542*	*70543*	*70544*
70545	*70546*	*70547*	*70548*	*70549*
70551	*70552*	*70553*	***70557***	***70558***
70559	*71550*	*71551*	*71552*	*71555*
72141	*72142*	*72146*	*72147*	*72148*

2004 Annual Update of HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing (continued)

72149	*72156*	*72157*	*72158*	*72195*
72196	*72197*	*73218*	*73219*	*73220*
73221	*73222*	*73223*	*73718*	*73719*
73720	*73721*	*73722*	*73723*	*73725*
74181	*74182*	*74183*	*74185*	*75552*
75553	*75554*	*75555*	*75556****	*76093*
76094	*76390*	*76394*	*76400*	*76498*
C8900	C8901	C8902	C8903	C8904
C8905	C8906	C8907	C8908	C8909
C8910	C8911	C8912	C8913	C8914
C8918	**C8919**	**C8920**		

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

Radiation Therapy

77261	*77262*	*77263*	*77280*	*77285*
77290	*77295*	*77299*	*77300*	*77301*
77305	*77310*	*77315*	*77321*	*77326*
77327	*77328*	*77331*	*77332*	*77333*
77334	*77336*	*77370*	*77399*	*77401*
77402	*77403*	*77404*	*77406*	*77407*
77408	*77409*	*77411*	*77412*	*77413*
77414	*77416*	*77417*	*77418*	*77427*
77431	*77432*	*77470*	*77499*	*77520*
77522	*77523*	*77525*	*77600*	*77605*
77610	*77615*	*77620*	*77750*	*77761*
77762	*77763*	*77776*	*77777*	*77778*
77781	*77782*	*77783*	*77784*	*77789*
77790	*77799*	**C1716**	**C1718**	**C1719**
C1720	**C2616**	**C2632**	G0173	G0242
G0243	**G0251**	**G0256**	**G0338**	**G0339**
G0340				

Angiography, Lymphatic, Venous and Related Procedures

75600	*75605*	*75625*	*75630*	*75635*
75650	*75658*	*75660*	*75662*	*75665*
75671	*75676*	*75680*	*75685*	*75705*
75710	*75716*	*75722*	*75724*	*75726*
75731	*75733*	*75736*	*75741*	*75743*
75746	*75756*	*75774*	*75790*	*75801**
*75803**	*75805**	*75807**	*75809**	*75810**
*75820**	*75822**	*75825**	*75827**	*75831**
*75833**	*75840**	*75842**	*75860**	*75870**
*75872**	*75880**	*75885**	*75887**	*75889**
*75891**	*75893**	*75894*	*75896*	*75898*
75900	*75940*	*75960*	*75961*	*75962*
75964	*75966*	*75968*	*75970*	*75978*
75980	*75982*	*75992*	*75993*	*75994*
75995	*75996*	**G0278**		

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

Outpatient Surgery and Related Procedures – INCLUSION

Inclusions, rather than exclusions, are given in this one case, because of the great number of surgery procedures that are excluded and can only be safely performed in a hospital operating room setting. It is easier to automate edits around the much shorter list of inclusions under this category, representing **minor procedures that can be performed in the SNF itself**. Additionally, this was the approach originally taken in regulation to present this information. Procedures associated with splints and casts are included with minor surgical procedures and appear with an asterisk (*).

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

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

10040	*10060*	*10080*	*10120*	*11040*
11041	*11042*	*11043*	*11044*	*11055*
11056	*11057*	*11200*	*11300*	*11305*
11400	*11719*	*11720*	*11721*	*11740*
11900	*11901*	*11920*	*11921*	*11922*
11950	*11951*	*11952*	*11954*	*11975*
11976	*11977*	*15780*	*15781*	*15782*
15783	*15786*	*15787*	*15788*	*15789*
15792	*15793*	*15810*	*15811*	*16000*
16020	*17000*	*17003*	*17004*	*17110*
17111	*17250*	*17340*	*17360*	*17380*
17999	*20000*	*20526*	*20551*	*20552*
20553	*20974*	*21084*	*21085*	*21497*
26010	*29058*	*29065**	*29075**	*29085**
*29086**	*29105**	*29125**	*29126**	*29130**
*29131**	*29200**	*29220**	*29240**	*29260**
*29280**	*29345**	*29355*	*29358*	*29365**
*29405**	*29425*	*29435*	*29440*	*29445**
29450	*29505**	*29515*	***29520****	*29540**
*29550**	*29580**	*29590**	*29700*	*29705*
29710	*29715*	*29720*	*29730*	*29740*
29750	*29799*	*30300*	*30901*	*31720*
31725	*31730*	*36000*	*36002*	*36140*
36400	*36405*	*36406*	*36430*	*36468*
36469	*36470*	*36471*	*36489***	*36491***
36540	***36550***	***36589***	*36600*	*36620*
36680	*38220*	*38221*	*44500*	*51772*
51784	*51785*	*51792*	*51795*	*51797*
53601	*53660*	*53661*	*53670*	*53675*
54150	*54235*	*54240*	*54250*	*55870*
57160	*57170*	*58301*	*58321*	*58323*
59020	*59025*	*59425*	*59426*	*59430*
62367	*62368*	*64550**	*65205*	*69000*
69200	*69210*	***91123***	*95970*	*95971*
95972	*95973*	*95974*	*95975*	***95990***
99183	G0167	G0168		

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

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

Emergency Services

These services are identified on claims submitted to FIs by a hospital or CAH using **revenue code 045x** (Emergency Room services—"x" represents a varying third digit). Related services with the same line item date of service (LIDOS) are also excluded. Note that in order to get a match on the LIDOS there must **be** a LIDOS and HCPCS in revenue code 045x.

2004 Annual Update of HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing (continued)

Ambulance Trips – With Application to Major Category II

Note that ambulance trips associated with Major Category II services provided in renal dialysis facilities (RDFs) are also excluded from SNF consolidated billing.

A0425	A0426	A0427	A0428	A0429
A0430	A0431	A0432	A0433	A0434
A0435	A0436	Q3019	Q3020	

Major Category II

Additional Services Excluded when Rendered to Specific Beneficiaries

These services must be provided to specific beneficiaries, either:

A. End stage renal disease (ESRD) beneficiaries, or

B. Beneficiaries who have elected hospice, by specific licensed Medicare providers, and are excluded from SNF PPS and consolidated billing.

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

Dialysis, EPO, and Other Dialysis Related Services for ESRD Beneficiaries

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

1. When the services are provided in a RDF (including ambulance services listed under Major Category I. above),
2. Home dialysis when the SNF constitutes the home of the beneficiary, and
3. When the drugs EPO is used for ESRD beneficiaries. *Note that SNFs may not be paid for home dialysis supplies.*

Coding Applicable to Services Provided in a RDF

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

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

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

- **825** – Hemodialysis OPD/home support services
- **835** – Peritoneal OPD/home support services
- **845** – Continuous ambulatory peritoneal dialysis OPD/home support services
- **855** – Continuous cycling peritoneal dialysis OPD/home support services

HCPCS codes recognized for use with these revenue codes are:

Dialysis Supplies

A4651	A4652	A4653	A4656	A4657
A4660	A4663	A4670*****	**A4671**	**A4672**
A4673	**A4674**	A4680	A4690	A4706
A4707	A4708	A4709	A4712	A4714
A4719	A4720	A4721	A4722	A4723
A4724	A4725	A4726	**A4728**	A4730
A4736	A4737	A4740	A4750	A4755
A4760	A4765	A4766	A4770	A4771
A4772	A4773	A4774	A4802	A4860
A4870	A4890	A4911	A4913******	A4918
A4927	A4928	A4929	A4930	A4931

***** Not covered by Medicare

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

Dialysis Equipment

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

***** E1699 is a carrier priced code not billed by SNFs.

Hospice Care for A Beneficiary's Terminal Illness

Hospice services for terminal conditions are identified with **types of bill 81X or 82X.**

Major Category III

Additional Excluded Services Rendered by Certified Providers

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

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

Chemotherapy

J9000	J9001	J9010	J9015	J9017
J9020	J9040	J9045	J9050	J9060
J9062	J9065	J9070	J9080	J9090
J9091	**J9092**	J9093	J9094	J9095
J9096	J9097	J9100	J9110	J9120
J9130	J9140	J9150	J9151	J9160
J9170	**J9178**	J9180	J9181	J9182
J9185	J9200	J9201	J9206	J9208
J9211	J9230	J9245	**J9263**	J9265
J9266	J9268	J9270	J9280	J9290
J9291	J9293	J9300	J9310	J9320
J9340	J9350	J9355	J9357	J9360
J9370	J9375	J9380	J9390	J9600

Chemotherapy Administration

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

2004 Annual Update of HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing (continued)

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

Radioisotopes and their Administration

78804 *79030* *79035* *79100* *79200*
79300 *79400* *79403* *79420* *79440*
79440 **A9530** **C1080**** **C1081**** **C1082****
C1083** **G0273*** **G0274*** **G3001****

* These codes are discontinued effective December 31, 2003, but may be billed during the grace period (January 1, 2003 through March 31, 2004).

** These radiopharmaceutical and associated administration codes are used in cancer treatment and, in accordance with the SNF PPS final rule for FY 2004 (68 FR 46036, August 4, 2003), they are being added to the services excluded from consolidated billing, effective January 1, 2004. As explained in the final rule (68 FR 46060), a radiopharmaceutical is a radiotherapeutic substance linked to a radioisotope administered to deliver therapeutic radioactivity, and combines elements of both the chemotherapy and radioisotope categories excluded under the Balanced Budget Refinement Act of 1999.

Customized Prosthetic Devices

K0556 K0557 K0558 K0559 L5050
L5060 L5100 L5105 L5150 L5160
L5200 L5210 L5220 L5230 L5250
L5270 L5280 L5301 L5311 L5321
L5331 L5341 L5500 L5505 L5510
L5520 L5530 L5535 L5540 L5560
L5570 L5580 L5585 L5590 L5595
L5600 L5610 L5611 L5613 L5614
L5616 L5617 L5618 L5620 L5622
L5624 L5626 L5628 L5629 L5630
L5631 L5632 L5634 L5636 L5637
L5638 L5639 L5640 L5642 L5643
L5644 L5645 L5646 L5647 L5648
L5649 L5650 L5651 L5652 L5653
L5654 L5655 L5656 L5658 L5660
L5661 L5662 L5663 L5664 L5665
L5666 L5668 L5670 L5671 L5672
L5674 L5675 L5676 L5677 L5678
L5680 **L5681** L5682 **L5683** L5684
L5686 L5688 L5690 L5692 L5694
L5695 L5696 L5697 L5698 L5699
L5700 L5701 L5702 L5704 L5705
L5706 L5707 L5710 L5711 L5712
L5714 L5716 L5718 L5722 L5724
L5726 L5728 L5780 L5782 L5785
L5790 L5795 L5810 L5811 L5812
L5814 L5816 L5818 L5822 L5824
L5826 L5828 L5830 L5840 L5845
L5846 L5847 L5848 L5850 L5855
L5910 L5920 L5925 L5930 L5940
L5950 L5960 L5962 L5964 L5966
L5968 L5970 L5972 L5974 L5975
L5976 L5978 L5979 L5980 L5981
L5982 L5984 L5985 L5986 L5988
L5989 L5990 L5995 L6050 L6055
L6100 L6110 L6120 L6130 L6200
L6205 L6250 L6300 L6310 L6320
L6350 L6360 L6370 L6400 L6450
L6500 L6550 L6570 L6580 L6582
L6584 L6586 L6588 L6590 L6600
L6605 L6610 L6615 L6616 L6620
L6623 L6625 L6628 L6629 L6630
L6632 L6635 L6637 L6638 L6640
L6641 L6642 L6645 L6646 L6647
L6648 L6650 L6655 L6660 L6665
L6670 L6672 L6675 L6676 L6680
L6682 L6684 L6686 L6687 L6688
L6689 L6690 L6691 L6692 L6693
L6700 L6705 L6710 L6715 L6720
L6725 L6730 L6735 L6740 L6745
L6750 L6755 L6765 L6770 L6775
L6780 L6790 L6795 L6800 L6805
L6806 L6807 L6808 L6809 L6810
L6825 L6830 L6835 L6840 L6845
L6850 L6855 L6860 L6865 L6867
L6868 L6870 L6872 L6873 L6875
L6880 L6881 L6882 L6920 L6925
L6930 L6935 L6940 L6945 L6950
L6955 L6960 L6965 L6970 L6975
L7010 L7015 L7020 L7025 L7030
L7035 L7040 L7045 L7170 L7180
L7185 L7186 L7190 L7191 L7260
L7261 L7266 L7272 L7274 L7362
L7364 L7366

Major Category IV

Additional Excluded Preventive and Screening Services

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

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

Mammography

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

76083 *76090* *76091* *76092* G0202
G0203

Vaccines (Pneumococcal, Flu or Hepatitis B)

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

90657 *90658* *90659* *90732* *90740*
90743 *90744* *90746* *90747*

Vaccine Administration

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

G0008 G0009 G0010

2004 Annual Update of HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing (continued)

Screening Pap Smear and Pelvic Exams

Screening Pap smear and pelvic examination codes are billed with ICD-9-CM diagnosis codes V76.2 or V15.89.

G0101	G0123	G0143	G0144	G0145
G0147	G0148	P3000	Q0091	

Colorectal Screening Services

Colorectal screening services are billed with any of the following ICD-9-CM diagnosis codes:

555.0	555.1	555.2	555.9	556.0
556.1	556.2	556.3	556.8	556.9
558.2	558.9	V10.05	V10.06	G0104
G0106	G0107	G0120	G0122*****	**G0328**

*This service is not covered by Medicare.

Prostate Cancer Screening

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

G0102 G0103

Glaucoma Screening

G0117 G0118

Major Category V

Part B Services Included in SNF Consolidated Billing

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

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

11040	11041	11042	11043	11044

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

0029T	***29065****	***29075****	***29085****	***29086****
*29105****	*29125****	*29126****	*29130****	*29131****
29200*	*29220****	*29240****	*29260****	*29280****
29345*	***29365****	***29405****	***29445****	***29505****
29515*	*29520****	*29530*	*29540****	*29550****
*29580****	*29590****	*64550****	*90901*	*90911*
92506	*92507*	*92508*	*92510*	*92525*†
92526	*92601*	*92602*	*92603*	*92604*
92605	*92606*	*92607*	*92608*	*92609*
92610	*92611*	*92612*	*92613*	*92614*
92615	*92616*	*95831*	*95832*	*95833*
95834	*95851*	*95852*	*96000*	*96001*
96002	*96003*	*96105*	*96110*	*96111*
96115	*97001*	*97002*	*97003*	*97004*
97005†	*97006*†	*97010*******	*97012*	*97014*
97016	*97018*	*97020*	*97022*	*97024*
97026	*97028*	*97032*	*97033*	*97034*
97035	*97036*	*97039*	*97110*	*97112*
97113	*97116*	*97124*	*97139*	*97140*
97150	*97504*	*97520*	*97530*	*97532*
97533	*97535*	*97537*	*97542*	*97545*
97546	*97601*	*97602*•	*97703*	*97750*
97755	*97799*	G0192†	**G0237**	**G0238**
G0239	G0279	G0280	G0281	G0283
G0302	**G0303**	**G0304**	**G0305**	V5362†
V5363†	V5364†			

***** For Part B, these codes are defined as therapy when rendered by a therapist (revenue codes '042X' (physical therapy), '043X' (occupational therapy) and, '044X' (speech therapy)). When they are rendered by physicians (including nurse practitioners, clinical nurse specialists, or physician assistants) (any other revenue codes), they are defined as surgery and may be billed by the rendering provider.

****** Payment for code 97010 is bundled with other rehabilitation services. It may be bundled with any therapy code.

† Procedures not covered by Medicare.

• 97602 is bundled with other rehabilitation services. It may be bundled with any therapy code.

G0193 through G0201 were deleted but were not identified as terminated codes in the January 2003 update. ❖

Source: CMS Pub 100-4 Transmittal 19, CR 2926

Reminder of the Required Three-day Hospital Stay for SNF-Admissions

The following is a provider education article issued by the Centers for Medicare & Medicaid Services (CMS).

Provider Types Affected

Skilled nursing facilities (SNF) and hospitals that discharge Medicare patients to SNFs.

STOP – Impact to You

You need to remember that SNF admissions, not preceded by a hospital inpatient stay of at least three consecutive calendar days (not counting the day of discharge) within 30 days of the SNF admission, may ***not*** qualify for Medicare reimbursement.

CAUTION – What You Need to Know

To qualify for Medicare reimbursement, any SNF admission must be preceded by at least a three-day, inpatient hospital stay within 30 calendar days of the SNF admission. The length of this hospital stay cannot include the day of discharge, and moreover cannot count any emergency department or other outpatient observation care in the inpatient stay calculation. The required three-day inpatient stay begins on the day the patient is formally admitted to the hospital.

GO

Make certain that your billing offices, clinicians, and discharge planners are aware of this requirement, and consider establishing procedures to ensure that this requirement is met for any SNF admissions.

Background

A recent DHHS (Department of Human and Health Services) Inspector General report noted multiple instances in which SNF admissions could not document the requisite three-day hospital inpatient stay within 30 days of the SNF admission. These findings have prompted CMS to emphasize to hospitals and SNFs this mandatory hospital stay requirement prior to a SNF admission. **Please remember that the three-day stay may not include any time spent in observation or in the emergency room.**

Important Dates to Know

This is a reminder of existing policy and is an ongoing requirement.

Related Instructions

The legislative authority for coverage of SNF claims is contained in Section 1861 of the Social Security Act.

Relevant government regulations are found in Title 42 of the Code of Federal Regulations (CFR) and CMS coverage guidelines are found in both the intermediary and skilled nursing facility manuals. To see the entire report by the Inspector General, go to: *http://www.oig.hhs.gov/oas/reports/region5/50300063.htm.* ❖

Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A – This restates existing rules
Implementation Date: N/A

Source: Medlearn Matters Number: SE0402

Skilled Nursing Facility Prospective Payment System Non-Payable Services

As part of the implementing legislation for 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 medical and other health services for which payment may not be made to a SNF. Most of these are professional services performed by physicians and other practitioners. These services are always billed to the Medicare Part B carrier. Others are services that have been determined to require a hospital setting to assure beneficiary safety. The HCPCS codes for these services not payable to SNFs under PPS or consolidated billing are provided to FIs annually, with quarterly updates as necessary by the Centers for Medicare & Medicaid Services (CMS).

As a result of changes in HCPCS codes used for hepatitis B vaccination, new coverage for compression garments used in treating venous stasis ulcers, and changing the Medicare payable HCPCS code from A4232 to K0552 for an infusion pump for uninterrupted infusion of medication, epoprostenol or treprostinil, CMS has releasing a replacement file for claims processed October 1, 2003 and later.

Additional information related to updates to the SNF NO PAY file is available on CMS Web site *http://www.cms.hhs.gov/medlearn/2004snfannualupdate.asp.* ❖

Source: CMS Pub. 100-04 Transmittal 20, CR 2968

Skilled Nursing Facility Therapy Claim Processing Problem

As part of the implementing legislation for 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 updated annually, with quarterly updates as necessary.

As a result of changes to the HCPCS codes for services covered for SNFs for 2004, the Centers for Medicare & Medicaid Services (CMS) created a file to be integrated into our claim processing systems to comply with these changes effective January 1, 2004. Due to additional time we needed to test these and other system changes, we were holding claims impacted by these changes from January 1, 2004 through January 19, 2004.

Recently we discovered we needed to hold specific bill types with specific HCPCS codes longer than January 19, 2004 due to an error with the original file that CMS created for integration into our claims processing systems. The bill types are 22x and 23x, with the following five therapy *CPT* codes:

90901 90911 92506 92507 92508

Claims containing these bill types and associated *CPT* codes are being held until February 9, 2004. At that time we will release and process the claims being held.

We apologize for any inconvenience you may have experienced related to this problem. ❖

Source: CMS JSM-55, Dated January 21, 2004

Modifier CB Criteria for Tests Provided to ESRD Beneficiaries

Effective April 1, 2003, for services furnished on or after April 1, 2001, Medicare will not apply the skilled nursing facility (SNF) consolidated billing (CB) edits to line items that contain the modifier CB. A provider or supplier may use modifier CB only when it has determined that:

- The beneficiary has ESRD entitlement.
- The test is related to the dialysis treatment for ESRD.
- The test is ordered by a doctor providing care to patients in the dialysis facility.
- The test is not included in the dialysis facility's composite rate payment.

Those diagnostic tests that are presumptively considered to be dialysis-related and, therefore, appropriate for submission with modifier CB are identified below.

This list was not designed as an inclusive list of Medicare covered diagnostic services. Additional diagnostic services related to the beneficiary's ESRD treatment/care may be considered dialysis-related. However, if these services are not included in our listing, the contractor may require supporting medical documentation.

Beneficiaries in a SNF Part A stay are eligible for a broad range of diagnostic services as part of the SNF Part A benefit. Physicians ordering medically necessary diagnostic test that are not directly related to the beneficiary's ESRD are subject to the SNF consolidated billing requirements. Physicians may bill the carrier for the professional component of these diagnostic tests. In most cases, however, the technical component of diagnostic tests is included in the SNF PPS rate and is not separately billable to the carrier. Physicians should coordinate with the SNF in ordering such tests since the SNF will be responsible for bearing the cost of the technical component.

Diagnostic Test Considered ESRD Related

This list only applies to SNF consolidated billing

71010	Chest X-ray
71015	Chest X-ray
71020	Chest X-ray
71021	Chest X-ray
71022	Chest X-ray
71030	Chest X-ray
71035	Chest X-ray
73120	X-ray hand
75710	Artery X-rays, arm/leg
75716	Artery X-rays, arm/leg
75774	Artery X-rays, arms/legs
75790	Artery X-ray, each vessel
75820	Visualize A-V shunt
75822	Vein X-ray, arm/leg
75893	Vein X-ray, arms/legs
75894	Transcath therapy, embolization
75896	X-rays, transcath therapy
75898	X-rays, transcath therapy
75901	Mechanical removal of pericath obstructive material
75902	Mechanical removal of intraluminal obstructive material
75961	Transcath retrieval of intravascular foreign body
75962	Transcath balloon angioplasty
75964	Transcath balloon angioplasty, each additional
76070	Computed tomography, bone mineral density study, axial
76075	Dual energy DEXA, bonc density study, axial
76080	Radiologic exam, abscess, fistual or sinus tract study
76092	Screening mammography bilateral
76778	Ultrasound, transplanted kidney
78070	Parathyroid nuclear imaging
78351	Bone density, dual photon absorptionmetry
80048	Basic metabolic panel
80051	Electrolyte panel
80053	Comprehensive Metabolic Panel
80061	Lipid panel
80069	Renal function panel
80074	Acute hepatitis panel
80076	Hepatic function panel
80197	Tacrolimus
80410	Calcitonin stim panel
81000	Urinalysis with microscopy
81001	Urinalysis, auto w/scope
81002	Urinalysis nonauto w/o scope
81003	Urinalysis, auto, w/o scope
81005	Urinalysis, qual or semi-quant
81007	Urine screen for bacteria, except by culture or dipstick
81015	Microscopic exam of urine
82009	Test for acetone/ketones,qual
82010	Acetone assay, quant
82017	Acylcarnitines, quant
82040	Serum albumin
82042	Albumin, urine quant or other source
82108	Assay of aluminum

82232	Beta2microglobulin (monitor large molecular weigh solute clearance by dial
82247	Bilirubin, total
82248	Bilirubin, direct
82306	Assay of vitamin D-3 (calcifediol)
82307	Assay of vitamin D (calciferol)
82308	Assay of calcitonin
82310	Assay of calcium
82330	Assay of calcium, ionized
82374	Bicarbonate (CO2)
82379	Assay of carnitine
82435	Chloride blood (needed to determine acid/base status)
82465	Cholesterol, total serum
82550	CPK, total
82565	Assay of creatinine
82570	Assay of urine creatinine
82575	Urine creatinine clearance test
82607	Vit B12
82728	Ferritin
82746	Serum folate
82747	RBC folate
82800	Blood Gases, pH only
82803	Blood gases: pH, pO2 & pCO2
82805	Blood gases W/02 saturation
82810	Blood gases, O2 sat only
82945	Glucose other fluid
82947	Assay, glucose, blood quant
82948	Reagent strip/blood glucose
83540	Assay of iron
83550	Iron binding test
83735	Magnesium (monitored to avoid hypermagnesium)
83937	Osteocalcin
83970	Parathormone (PTH)
83986	Assay of body fluid acidity
84075	Alkaline phosphatase
84100	Assay of phosphorus, inorganic
84105	Urine phosphorus
84132	Assay of serum potassium
84133	Urine potassium
84134	Assay of prealbumin
84155	Assay of protein
84160	Serum protein by refractometry
84295	Assay of serum sodium
84315	Body fluid specific gravity
84450	Transferase (AST) (SGOT)
84460	Alanine amino (ALT) (SGPT)
84466	Transferrin
84520	Urea nitrogen, quantitative
84540	Assay of urine/urea-n
84545	Urea-N clearance test
84630	Zinc
85002	Bleeding time test
85004	Automated diff wbc count
85007	Bl smear w/diff wbc count
85008	Bl smear w/o diff wbc count
85009	Manual diff wbc count b-coat
85013	Spun microhematocrit
85014	Hematocrit
85018	Hemoglobin
85025	Complete CBC w/auto diff wbc
85027	Complete CBC, automated
85032	Manual cell count, each
85041	Automated RBC count
85044	Manual reticulocyte count
85045	Automated reticulocyte count
85046	Reticyte/hgb concentrate
85048	Automated leukocyte count
85049	Automated platelet count
85345	Coagulation time, Lee-White
85347	Coagulation time, activated
85348	Coagulation time, other methods
85520	Heparin assay
85610	Prothrombin time
85611	Prothrombin test,substitution
85651	Sed rate
85652	Automates sed rate
85730	Thromboplastin time, partial (PTT)
85732	Thromboplastin time, partial, substitution
86590	Streptokinase, antibody
86644	CMV screen
86645	Cytomegalovirus antibody dfa (IgM)
86687	HTLV-I antibody
86688	HTLV-II antibody
86689	HTLV/HIV confirmatory test
86692	Hepatitis, delta agent
86701	HIV-1
86702	HIV-2
86703	HIV-1/HIV2, single assay g y
86704	Hep B core antibody, total
86705	Hep b core antibody, IgM
86706	Hep B surface antibody
86707	Hep Be antibody
86709	Hep A, IgM antibody
86803	Hepatitis C ab test
86804	Hep C ab test, confirm
86812	HLA typing, A, B, or C
86813	HLA typing, A, B, or C, multiple antigens
86816	HLA typing, DR/DQ
86817	HLA typing, DR/DQ, multiple antigens yp g
86900	Blood typing, ABO
86901	Rh typing
86903	Blood typing, antigen screen
86904	Blood typing, patient serum
86905	Blood typing, RBC antigens
86906	Blood typing, Rh phenotype
87040	Culture, blood
87070	Culture, bacteria, other
87071	Culture bacteri aerobic other, quant
87073	Culture bacteria anaerobic, quant
87075	Culture bacteria anaerobic, any source w/ID
87076	Culture anaerobe ident, each
87077	Culture aerobic identify
87081	Culture screen only
87084	Culture w/ colony estimation
87086	Urine culture/quant colony count
87088	Urine bacteria culture, isolation & ID
87181	Microbe susceptible, diffuse
87184	Microbe susceptible, disk
87185	Microbe susceptible, enzyme
87186	Microbe susceptible, mic
87187	Microbe susceptible, mlc
87188	Microbe suscept, macrobroth
87190	Microbe suscept, mycobacteri
87197	Bactericidal level, serum
87205	Smear, gram stain
87271	CMV, DFA
87340	HepB surface antigen
87341	HepatitisB surface, ag, eia, neutralization
87350	HepatitisBe ag, eia
87380	Hepatitis delta ag, eia
87390	HIV-1 ag, eia
87391	HIV-2 ag, eia
87515	Hepatitis B, DNA, dir probe
87516	Hepatitis B, DNA, amp probe
87517	Hepatitis B, DNA, quant
87520	Hepatitis C, RNA, dir probe
87521	Hepatitis C, RNA, amp probe
87522	Hepatitis C, RN A, quant
87525	Hepatitis G, DNA, dir probe
87526	Hepatitis G, DNA, amp probe
87527	Hepatitis G, DNA, quant
89050	Cell count, peritoneal fluid (no diff)
89051	Cell count, peritoneal fluid with diff
93000	Echo exam of heart
93005	Electrocardiogram, tracing
93010	Electrocardiogram report
93040	Rhythm ECG with report
93041	Rhythm ECG, tracing
93042	Rhythm ECG with report
93307	Echo exam of heart
93308	Echo exam of heart, follow-up
93922	Extremity study
93923	Extremity study, multiple levels
93925	Lower extremity study - arterial
93926	Lower extremity study, limited- arterial
93930	Upper extremity study- arterial
93931	Upper extremity study, limited-arterial
93965	Extremity study-venous
93970	Extremity study-venous
93971	Extremity study, limited-venous
G0001	Routine venipuncture
G0202	Screening mammography, digital ❖

Source: CMS Pub 100-4 Transmittal 69, CR 2906

ESRD SERVICES

End-Stage Renal Disease Drug Pricing Update

On January 1, 2003, the Centers for Medicare & Medicaid Services (CMS) implemented a single drug pricer (SDP) for drugs and biologicals to standardize prices for some Medicare covered drugs. The Medicare Prescription Drug, Improvement, and Modernization Act (DIMA) of 2003 provides that payment limits for drugs and biologicals furnished in connection with dialysis services and billed by independent dialysis facilities are based on 95 percent of the average wholesale price (AWP) reflected in the published compemdium as of September 1, 2003. The 2004 new rates reflects this regulation. Fees for these ESRD services will be reimbursed based on the lower of the billed charges or 95 percent of the AWP effective for services furnished **on or after January 1, 2004.**

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

Note: The absence or presence of a HCPCS code and payment limit in this table does not indicate Medicare coverage of the drug.. Similary, the inclusion of a payment limit does not indicate Medicare coverage of the drug.

***CPT*/HCPCS CODE**	**NAME**	**FEE**
J0170	Adrenalin, epinephrine, 1 mg/1 cc ampule	$ 2.34
J0210*	Aldomet, methyldopate HCL, up to 250 mg	$11.88
J2997	Alteplase, recombinant, activase, 1 mg	$36.70
J3490	Amikin, Amikacin, 100 mg/2 cc	I. C.
J0280	Aminophylline, aminophyllin, 250 mg	$ 1.05
J0285	Amphotericin B, Fungizone, 50 mg	$10.39
J0290	Ampicillin sodium, 500 mg	$ 1.65
J0690	Ancef, cefazolin sodium, Kefzol, 500 mg	$ 2.25
J3430	Aquamephyton, phytonaidione (vitamin K), 1 mg	$ 2.21
J0380*	Aramine, metaraminol bitartrate, 10 mg	$ 1.27
J7504	Atgam, lymphocyte immune globine, 250 mg	$ 89.85
J2060	Ativan, lorazepam, 2 mg	$ 3.14
J0460	Atropine sulfate, 0.3 mg	$ 1.19
X0004	Azactam, aztreonam, 1 gm	I. C.
J3490	Bactrim, 80 mg/ml-16 mg/ml, 5 cc	I. C.
J0530	Bicillin C-R, penicillin-G, 600,000 units	$11.92
J0540	Bicillin C-R, penicillin-G, 1,200,000 units	$23.40
J0550	Bicillin C-R, penicillin-G, 2,400,000 units	$50.12
J0560	Bicillin L-A,penicillin-G, 600,000 units	$ 9.89
J0570	Bicillin L-A, penicillin-G, 1,200,000 units	$19.78

***CPT*/HCPCS CODE**	**NAME**	**FEE**
J0580	Bicillin L-A, penicillin-G, 2,400,000 units	$39.56
J0592	Buprenix, buprenorphine hydrochloride, 0.1 mg	$ 1.03
J0636	Calcijex, calcitriol, 0.1 mcg	$ 1.38
J0630	Calcitonin-salmon, up to 400 units	$38.41
J3490	Calcium chloride 10%, 10 cc	I. C.
J0610	Calcium gluconate, 10 ml	$ 1.44
J1955	Carnitine, levocarnitine, 1 gm	$34.20
J0710	Cefadyl, cephapirin sodium), 1 gm	$ 2.67
J0715	Ceftizoxime sodium, Cefizox, 500 mg	$ 4.96
00248	Cefobid, Cefoperazone sodium, 1 gm	$16.38
X0016	Cefotan, Cefotetan disodium gm	I. C.
J0698	Cefotaxime sodium, Claforan, 1 gm	$ 9.51
J0697	Cefuroxime sodium, 750 mg	$ 6.42
J0702	Celestone Soluspan, 3 mg-3mg/ml	$ 4.98
J0743	Cilastatin sodium imipenem, Primaxin I.V., 250 mg	$15.87
87000	Cipro, 200 mg	$13.69
X0017	Cleocin Phosphate, clindamycin phosphate, 300 mg	I. C.
J0745	Codeine phosphate, 30 mg	$ 0.87
J0800	Corticotropin Acthar Gel 40 Units	$92.94

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

End-Stage Renal Disease Drug Pricing Update (continued)

CPT/HCPCS CODE	NAME	PRICE
J0835	Cortrosyn, cosyntropin, 0.25 mg	$81.00
J9070	Cyclophosphamide, Cytoxan, 100 mg	$ 5.73
J9080	Cyclophosphamide, Cytoxan, 200 mg	$10.89
J9090	Cyclophosphamide, Cytoxan, 500 mg	$22.86
J9091	Cyclophosphamide, Cytoxan, 1 gm	$45.73
J9092	Cyclophosphamide, Cytoxan, 2 gm	$91.45
Q4054	Darbeepotin alfa, 1000 units	$ 4.74
J2597	DDAVP, desmopressin acetate), 1mcg	$ 3.45
J1100	Decadron, dexamethasone sodium phosphate, 1 mg	$ 0.10
J2175	Demerol, meperidine HCL, 100 mg	$ .53
J1070	Depo-Testosterone, up to 100 mg	$ 4.95
J1080	Depo-Testosterone, 1 cc, 200 mg	$ 9.43
J0895	Desferal, deferoxamine mesylate), 500 mg/5 cc	$15.63
J1100	Dexamethasone sodium phosphate, 1 mg/ml	$ 0.10
J7060	Dextrose 5%, 500 cc	$ 7.51
J1730*	Diazoxide, Hyperstat, 300 mg/20 ml	$122.95
J1450	Diflucan, Fluconazole, 200 mg	$97.61
J1160*	Digoxin, Lanoxin, up to 0.5 mg	$ 1.79
J1165	Dilantin, phenytoin sodium, 50 mg	$ 0.86
J1170	Dilaudid, hydromophone, 4 mg	$ 1.55
J1200*	Diphenhydramine HCL (Benadryl), up to 50 mg	$ 1.61
J1240	Dramamine, dimenhydrinate, 50 mg	$ 0.38
Q4055	Epoetin alfa, 1000 units	$ 11.62
J1364	Erythromycin lactobionate, 500 mg	$ 3.59
J0970	Estradiol valerate, Delestrogen, up to 40 mg	$ 1.62
J2916	Ferrlecit, sodium ferric gluconate complex in sucrose injection 12.5 mg	$ 8.17
00623	Flagyl, Metronidazole, 500 mg	$24.86
J9190	Fluorouracil, 500 mg	$ 2.07
J3490	Folic Acid, 5 mg/cc	I. C.
J0713	Fortaz, ceftazidime, 500 mg	$ 6.75
J1470	Gamma globulin, 2 cc	$24.35
J1550	Gamma globulin, 10 cc	$121.72
J1570	Ganciclovir sodium, Cytovene, 500 mg	$35.25

CPT/HCPCS CODE	NAME	PRICE
J1580	Garamycin, gentamicin, 80 mg	$ 2.07
J1630	Haldol, haloperidol, 5 mg	$ 6.83
J1644*	Heparin sodium 1000 units	$ 0.40
90371	*Hepatitis B immune globulin, 5 ml*	$649.80
90740	*Hepatitis B vaccine, dialysis or immunosupressed patient dosage (3 dose schedule), for intramuscular use*	$110.92
90747	*Hepatitis B vaccine, dialysis or immunosupressed patient dosage (4 dose schedule), for intramuscular use*	$110.92
J0360*	Hydralazine HCL, Apresoline, 20 mg	$16.04
J1720	Hydrocortisone sodium succinate (Solu-Cortef), 100 mg	$ 2.07
J3410	Hydroxyzine HCL, 25 mg	$ 1.21
J1564	Immune globulin, Gammimune N, 10 mg	$ 0.86
J1563	Immune globulin, intravenous, 1 gm	$78.38
J7501	Imuran, Azathioprine, 100 mg	$59.84
J1790	Inapsine, droperidol), 5 mg	$ 2.80
J1800*	Inderal, propranolol HCL, 1 mg/1 cc	$11.63
J1750	Infed, iron dextran), 50 mg	$17.91
90657	*Influenza virus vaccine, split virus, 6-35 months dosage*	$ 4.98
90658	*Influenza virus vaccine, split virus, 3 years and above dosage*	$ 9.95
90659	*Influenza virus vaccine, whole virus*	$ 9.95
J1815*	Insulin, per 5 units	$ 0.10
J1840	Kantrex, kanamycin sulfate, 500 mg	$3.30
J1890	Keflin, cephalothin sodium, 1 gm	$10.26
J3301	Kenalog, triamcinolone acetonide), 10 mg	$ 1.60
J1940	Lasix, furosemide, 20 mg	$0.93
J3490	Levophed bitartrate, Norepinephrine bitartrate 4 cc	I. C.
J 3490	Levothyroxine, 0.2 mg	I. C.
J1990	Librium, chlordiazepoxide hydrochloride, 100 mg	$24.99
J2001*	Lidocaine HCL, IV 10 mg	$ 0.98
J3490	Mandol, Cefamandole, 1 gm	I. C.
J2150*	Mannitol 25%, in 50 cc	$3.27

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

End-Stage Renal Disease Drug Pricing Update (continued)

CPT/HCPCS CODE	NAME	PRICE
J1051	Medroxyprogesterone acetate, Depo-Provera, 50 mg	$ 5.04
J0694	Mefoxin, cefoxitin sodium, 1 gm	$10.69
J3490	Mezlin, Mezlocillin, 1 gm	I. C.
J2270	Morphine sulfate, 10 mg	$0.77
J3490	Nafcil, nafcillin sodium, 500 mg	I. C.
J2320	Nandrolone decanoate, Deca-Durabolin, 50 mg	$ 3.84
J2321	Nandrolone decanoate, Deca-Durabolin, 100 mg	$ 7.67
J2322	Nandrolone decanoate, Deca-Durabolin, 200 mg	$15.74
J2310	Narcan, naloxone HCL, 1 mg	$ 2.49
J3260	Nebcin, tobramycin sulfate, 80 mg	$ 4.46
J2300	Nubain, nalbuphine HCL, 10 mg/1 cc	$ 1.59
J2700	Oxacillin sodium, 250 mg	$ 0.80
J2501	Paracalcitol, 1 mcg	$ 5.33
J2510	Penicillin G procaine, aqueous, 600,000 units	$ 9.60
J2545	Pentam, 300 mg	$44.84
J2550	Phenergan, promethazine HCL, 50 mg	$ 2.85
J2560	Phenobarbital sodium, 120 mg	$ 1.62
J3490	Pipracil, Piperacillin sodium, 1 gm	I. C.
90732	*Pneumovax, Pneumococcal vaccine 0.5 cc*	$18.62
J3480*	Potassium chloride, per 2 mEq/ml	$ 0.08
J1410	Premarin, estrogen congugated, 25 mg	$61.51
J0743	Primaxin-I.V., 250 mg	$15.87
J0780	Prochlorperazine, Compazine, up to 10 mg	$ 4.18
J0256	Prolastin, alpha 1-proteinase inhibitor 10 mg	$ 2.66
J2680	Prolixin Decanoate, fluphenazine, 25 mg	$ 8.96
J2690*	Pronestyl, procainamide HCL, 1 gm	$ 1.43
J2720*	Protamine sulfate, 10 mg	$0.76
J2765	Reglan, metoclorpramide HCL, 10 mg	$ 1.90
J0696	Rocephin, ceftriaxone sodium, 250 mg	$14.92
J1563	Sandoglobulin, immune globulin, 1g	$78.38
J3490	Septra, 80 mg/ml-16 mg/ml, 5 ml	I. C.
J3490	Sodium bicarbonate 8.4%, 50 cc	I. C.

CPT/HCPCS CODE	NAME	PRICE
J2912	Sodium chloride 0,9%, per 2 ml	$ 0.42
J1720	Solu Cortef, hydrocortisone sodium succinate 100 mg	$ 2.49
J2920	Solu-Medrol, methylprednisolone sodium succinate, up to 40 mg	$ 2.11
J2930	Solu-Medrol, methylprednisolone sodium succinate, up to 125 mg	$ 3.24
01478	Stadol, 1 mg	I. C.
01479	Stadol, 2 mg	I. C.
J3010	Sublimaze, fentanyl citrate, 2 cc	$ 0.93
J3070	Talwin Lactate, pentazocine HCL, 30 mg	$ 5.23
J3120	Testosterone enanthate, Delatestryl enanthate, up to 100 mg	$ 8.98
J3130	Testosterone enanthate, Delatestryl enanthate, up to 200 mg	$17.96
J3150	Testosterone propionate, up to 100 mg	$ 0.94
90703	*Tetanus toxoid, 1.ml*	$14.37
J3230	Thorazine, chlorpromazine HCL, up to 50 mg	$ 4.40
J3490	Ticar, Ticarcillin, 1 gm	I. C.
J3250	Tigan trimethobenzamide HCL, up to 200 mg	$ 1.55
X0042	Timentin, 100 mg-3 gm	I. C.
J3280	Torecan, thiethylprrazine maleate, up to 10 mg	$ 5.65
J3320	Trobicin, spectinomycin dihydrochloride, up to 2 g	$28.27
J0295	Unasyn, ampicillin sodium, per 1.5 g	$ 7.42
J3360	Valium, diazepam, 5 mg	$ 0.86
J3370	Vancocin, vancomycin HCL, 500 mg	$ 7.03
J1756	Venofer, iron sucrose, 1 mg	$ 0.66
J3490*	Verapamil, 5 mg	I. C.
J2250	Versed, midazolam HCL, 1 mg	$ 1.28
J3490	Vibramycin, Doxycycline, 100 mg	I.C
J3420	Vitamin B-12 cyanocobalamin, up to 1,000 mcg	$ 0.17
J3490	Water for injection, 30 cc	I. C.
J3490	Water for injection, 500 cc	I. C.
J2501	Zemplar, paricalcitol, 1 mcg	$ 5.23
J0697	Zinacef, cefuroxime sodium, 750 mg	$6.42
J2405	Zofran, ondansetron HCL per 1 mg	$ 6.09
Q4075	Zovirax, acyclovir, 5 mg	$ 0.47

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

Change in Coding for Darbepoetin Alfa (Aranesp®) and Epoetin Alfa (Epogen®) for Patients on Dialysis.

The Centers for Medicare & Medicaid Services (CMS) has established coding guidelines for billing for the administration of darbepoetin alfa (Aranesp®) and epoetin (EPO) alfa (Epoetin®) for treatment of anemia in end-stage renal disease patients on dialysis. Two new HCPCS codes have been assigned to report darbepoetin alfa and epoetin alfa effective for services furnished **on or after January 1, 2004:**

Q4054 Injection, darbepoetin alfa, 1 mcg (for ESRD on dialysis)

Q4055 Injection, epoetin alfa. 1,000 units (for ESRD on dialysis)

HCPCS code Q4055 **replaces** all current Q codes (Q9920 through Q9940) for billing EPO services to fiscal intermediaries by free standing, or hospital-based ESRD facilities.

In addition, effective January 1, 2004, HCPCS code J0880 (injection, darbepoetin alfa, 5 mcg) is **no** longer a valid code for billing darbepoetin alfa by free standing, or hospital-based ESRD facilities.

Coverage guidelines for darbepoetin alfa are the same as for epoetin alfa for ESRD related anemia.

The multiple Q-codes for epoetin alfa (Q9920 through Q9940), representing a single hematocrit level, have been discontinued and replaced with **Q4055**.

Since there is currently no payment rate for darbepoetin alfa, CMS has determined that HCPCS code Q4054 will be paid based on the single drug PRICER payment amount. This payment rate will be in effect until CMS has determined an appropriate conversion factor and corresponding payment rate for darbepoetin alfa.

Billing Guidelines for Q4054

Effective for services furnished **on or after January 1, 2004,** freestanding ESRD facilities (facilities that are not classified as hospital-based), and hospital-based ESRD facilities must bill for darbepoetin alfa, Q4054, on Form CMS-1450 (UB-92) or its electronic equivalent 837I.

The following billing guidelines apply to darbepoetin alfa:

- Type of bill 72x
- Revenue code 0636 *(2400 SV201 on the ANSI 837I HIPAA transaction)*
- HCPCS code Q4054 using value code 49 to record the hematocrit (HCT) values
- One line item per administration with the line item date of service and the number of mcgs in the units form locator (FL 46). For dosages that are more than a whole mcg, providers may round up to the next whole mcg.
- Reimbursement will be made as an add-on payment to the composite rate based on the single drug PRICER payment amount.

Billing Guidelines for Q4055

Effective for services furnished **on or after January 1, 2004,** freestanding ESRD facilities (facilities that are not classified as hospital-based), and hospital-based ESRD facilities must bill for epoetin alfa, Q4055, on Form CMS-1450 (UB-92) or its electronic equivalent 837I.

The following billing guidelines apply to epoetin alfa:

- Type of bill 72x
- Revenue code **0634** for administration of under 10,000 units of EPO, or revenue code **0635** for administration of over 10,000 units of EPO *(2400 SV201 on the ANSI 837I HIPAA transaction)*
- HCPCS code Q4055 using:
  - value codes 48 **or** 49 to record the hemoglobin (HGB) or hematocrit (HCT) values (2300 HI01-2 with the qualifier of BE in 2300 HI01-1 on the ANSI 837I HIPAA transaction),
    and
  - value code 68 to report the number of units of EPO administered during the billing period *(2300 HI01-2 with the qualifier of BE in 2300 HI01-1 on the ANSI 837I HIPAA transaction*)
- Reimbursement will continue to be the statutory rate for epoetin alfa (Q4055) at $10.00 per 1000 units.

Claims received for epoetin alfa, Q4055, and darbepoetin alfa, Q4054, with value code 49 and no hematocrit (HCT) reading taken prior to the last administration of epoetin alfa or darbepoetin alfa during the billing period will be returned to the provider.

Claims received for epoetin alfa, Q4055, with value code 48 and no hemoglobin (HGB) reading taken prior to the last administration of epoetin alfa during the billing period will be returned to provider.

Note: HCPCS code J0880 (injection, darbepoetin alfa, 5 mcg) cannot be billed on Form CMS-1450 (UB-92) or its electronic equivalent 837I.

Medicare Part B deductible and coinsurance requirements apply to payments for darbepoetin alfa (HCPCS code Q4054) and epoetin alfa (HCPCS code Q4055). ❖

Source: CMS Pub 100-20 Transmittal 39, CR 2963

Correction to the Allowance for Iron Sucrose – J1756

An article updating the end-stage renal disease drug-pricing list was published in the First Quarter 2004 *Medicare A Bulletin* (pages 45-48). In that article, the allowance for HCPCS code J1756 for iron sucrose (Venofer®), 1 mg was published incorrectly as $66.00. **The correct allowance for J1756 for iron sucrose, 1 mg is $0.66.** We apologize for any inconvenience this may have caused. ❖

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

January 2004 Update to Hospital Outpatient Prospective Payment System

The Centers for Medicare & Medicaid Services (CMS) has issued changes to the hospital outpatient prospective payment system (OPPS) for the January 2004 update. The January 2004 outpatient code editor (OCE) specifications and the PPS PRICER software systems reflects the Healthcare Common Procedure Coding System (HCPCS) codes and ambulatory payment classification (APC) additions and changes, and other revisions, identified in this notification. Unless otherwise noted, changes addressed in this notification are effective for services furnished **on or after January 1, 2004.**

The following issues are addressed:

1. **Limitations on Beneficiary Copayment**
   For calendar year (CY) 2004, the national unadjusted copayment amount for an APC group will be limited to 50 percent of the APC payment rate. In addition, the wage adjusted copayment amount for a procedure or service cannot exceed the inpatient hospital deductible amount of $876 for 2004.

2. **Outlier Payments for Hospitals**
   For CY 2004, the outlier threshold is reduced from 2.75 to 2.6 times the OPPS payment for the service, and the outlier payment percentage is increased from 45 to 50 percent. In 2004, an outlier payment will be made to a hospital if the cost of providing a service exceeds 2.6 times the OPPS payment for the service and the amount of the outlier payment will be 50 percent of the amount by which the provider's costs exceed 2.6 times the OPPS payments.

3. **Outlier Payments for Community Mental Health Centers (CMHCs)**
   For CY 2004, the outlier threshold for CMHCs (type of bill 76x) is increased from 2.75 to 3.65 times the OPPS payment, and the outlier payment percentage is increased from 45 to 50 percent. In 2004, an outlier payment will be made to a CMHC if the cost of providing a day of partial hospitalization exceeds 3.65 times the OPPS payment for the services and the amount of the outlier payment will be 50 percent of the amount by which the provider's costs exceed 3.65 times the OPPS payment.

4. **Billing for Stereotactic Radiosurgery**
   Stereotactic radiosurgery (SRS) is a form of radiation therapy for treating abnormalities, functional disorders, and tumors of the brain and neck; and most recently has expanded to treating tumors of the spine, lung, pancreas, prostate, bone, and liver. There are two basic methods in which SRS can be delivered to patients, linear accelerator-based treatment and multi-source photon-based treatment (often referred to as cobalt 60). Advances in technology have further distinguished linear accelerator-based SRS therapy into two types: gantry-based systems and image-guided robotic SRS systems. These two types of linear accelerator based SRS therapies may be delivered in a complete session or in a fractionated course of therapy up to a maximum of five sessions.

   Effective January 1, 2004, when SRS is furnished to beneficiaries in a hospital outpatient department that is paid under the hospital OPPS, hospitals are to bill using the following HCPCS codes:

   a. When billing for the planning and delivery of cobalt 60-based, multi-source SRS, hospitals are to use the following HCPCS codes:
      - Planning – HCPCS code G0242
      - Delivery – HCPCS code G0243

   b. When billing for the planning and delivery of non-robotic linear accelerator-based SRS (complete session), hospitals are to use the following HCPCS codes:
      - Planning – HCPCS code G0338 (Linear accelerator-based stereotactic radiosurgery plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment).
      - Delivery – HCPCS code G0173

   c. When billing for the planning and delivery of non-robotic linear accelerator-based SRS (fractionated sessions), hospitals are to use the following HCPCS codes:
      - Planning – HCPCS code G0338
      - Delivery – HCPCS code G0251

   d. When billing for the planning and delivery of image-guided robotic linear accelerator-based SRS (complete session), hospitals are to use the following HCPCS codes:
      - Planning – HCPCS code G0338
      - Delivery – HCPCS code G0339 (Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session, or first session of fractionated treatment).

      Code G0339 is reported for a complete course of therapy in one session, as well as the first session of a multi-session treatment.

January 2004 Update to Hospital Outpatient Prospective Payment System (continued)

e. When billing for the planning and delivery of image-guided robotic linear accelerator-based SRS (fractionated sessions), hospitals are to use the following HCPCS codes:

- Planning – HCPCS code G0338
- Delivery – HCPCS code G0340 (Image guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment).

Code G0340 is reported for additional sessions (second through fifth sessions) subsequent to the first session of a fractionated course of therapy. When providers perform multi-session image-guided robotic SRS therapy, they should bill using HCPCS code G0339 for the first session. For each additional session subsequent to the first session, providers are to bill using only HCPCS code G0340 up to a maximum of four additional sessions (total maximum of five sessions).

f. Payment for SRS planning does not include payment for *CPT* codes *77332 - 77334* when furnished on the same day. When provided, these services should be billed in addition to SRS planning code G0242.

5. Billing for Intensity Modulated Radiation Therapy

Intensity modulated radiation therapy (IMRT), also known as conformal radiation, delivers radiation with adjusted intensity to preserve adjoining normal tissue. IMRT has the ability to deliver a higher dose of radiation within the tumor and a lower dose of radiation to surrounding healthy tissue. Two types of IMRT are multi-leaf collimator-based IMRT and compensator-based IMRT. IMRT is provided in two treatment phases, planning and delivery. Effective January 1, 2004, when IMRT is furnished to beneficiaries in a hospital outpatient department that is paid under the hospital outpatient prospective payment system (OPPS), hospitals are to bill according to the following guidelines:

a. When billing for the planning of IMRT treatment services *CPT* codes *77280-77295*, *77300*, *77305-77321*, *77336*, and *77370* are **not** to be billed in addition to *77301*; however charges for those services should be included in the charge associated with *CPT* code *77301*.

b. Hospitals are not prohibited from using existing IMRT *CPT* codes *77301* and *77418* to bill for compensator-based IMRT technology in the hospital outpatient setting.

c. Payment for IMRT planning does not include payment for *CPT* codes *77332-77334* when furnished on the same day. When provided, these services are to be billed in addition to the IMRT planning code *77301*.

d. Providers billing for both *CPT* codes *77301* (IMRT treatment planning) and *77334* (design and construction of complex treatment devices) on the same day should append modifier 59 to indicate that the procedure represents a distinct service from others reported an the **same date** of services. A distinct service may be defined as a different session, different surgery, different site, different lesion, different injury or area of injury (in extensive injuries).

6. Payment for Single Indication Orphan Drugs

Medicare is discontinuing payment on a reasonable cost basis for single indication orphan drugs furnished in the outpatient department of a hospital subject to the OPPS. For CY 2004, the following single indication orphan drugs are assigned to APCs and paid under the OPPS:

J0205	Injection, alglucerase, per 10 units
J0256	Injection, alpha 1-proteinase inhibitor–human, 10 mg
J1785	Injection, imiglucerase, per unit
J2355	Injection, oprelvekin, 5 mg
J3240	Injection, thyrotropin alpha, 0.9 mg, provided in 1.1 mg vial
J7513	Daclizumab parenteral, 25 mg
J9015	Aldesleukin, per single use vial
J9160	Denileukin difitox, 300 mcg
J9216	Interferon, gamma 1-B, 3 million units
J9300	Gemtuzumab ozogamicin, 5 mg
Q2019	Injection, basiliximab, 20 mg

7. Payment for Prostate Brachytherapy

In 2003, Medicare paid a packaged amount for prostate brachytherapy. Hospitals were required to bill using HCPCS code G0256 (prostate brachytherapy with palladium sources), when palladium sources were implanted, and HCPCS code G0261 (prostate brachytherapy with iodine sources). These HCPCS codes were to be used in lieu of separate billing for *CPT* codes *77778* (*interstitial radiation source application; complex*) and *55859* (*transperiteneal placement of needles or catheters into prostate for interstitial radiation element application, with or without cystoscopy*) and HCPCS codes C1718 (iodine sources) and C1720 (palladium sources).

Under the OPPS for 2004, HCPCS codes G0256 and G0261 are deleted. For services furnished on or after January 1, 2004, hospitals are to use the *CPT* codes *77778* and *55859* to bill for the procedures and HCPCS codes C1718 and C1720 to bill for the brachytherapy sources. Separate payments will be made for the procedures and for the sources. Hospitals are to bill the brachytherapy sources showing the number of sources used in the units column. For example, if 100 brachytherapy sources are implanted in the prostate, the hospital will bill 100 units of the applicable code for the brachytherapy source.

8. Billing Injection/Infusion Codes

Effective January 1, 2004, code Q0085 (Chemotherapy administration by infusion technique and other technique, per visit) is no longer payable under the

January 2004 Update to Hospital Outpatient Prospective Payment System (continued)

OPPS. Hospitals must report both Q0083 (Chemotherapy administration by other than infusion technique only, per visit), and Q0084 (Chemotherapy administration by infusion technique only, per visit), when chemotherapy is administered by both infusion and another route of administration. Claims on which Q0085 is billed will be returned to the provider for correction.

Drug administration codes Q0081, Q0083 and Q0084 are defined on a per visit basis. Two units of the same code are billed on the same date only if two distinct and separate visits to the hospital occur on the same date.

Example: On March 12, two chemotherapy drugs are administered by intravenous injection and three chemotherapy drugs by infusion to a beneficiary during the same visit, between 7:30 a.m. and 10:30 a.m. The hospital bills one unit of Q0083 and one unit of Q0084, along with the HCPCS codes for the drugs, and date of service March 12. The patient leaves the outpatient department (OPD) at 11:00 a.m., following completion of the first chemotherapy visit, and returns later the same day suffering from dehydration and requiring infusion of fluids and infusion of anti-emetics. The hospital bills one unit of Q0081 for those services, with date of service March 12. Or, the patient leaves the OPD at 11:00 a.m., following completion of chemotherapy, and returns at 4:30 p.m. for a second infusion of one or more chemotherapy drugs that could not be administered for medical reasons during the earlier visit between 7:30 a.m. and 10:30 a.m. The hospital bills one unit of Q0084 on a separate line with date of service March 12.

Hospitals should not report cancer chemotherapy furnished to hospital outpatients using the *CPT* chemotherapy administration codes. Payment under OPPS for cancer chemotherapy is made only when cancer chemotherapy is billed using Q0083 and Q0084. *CPT* codes *90782-90788* each report an injection and as such, one unit of the code is billed each time there is a separate injection that meets the definition of the code. Note that code range *90782-90788* is used to report intradermal, subcutaneous, intramuscular, or routine intravenous drug injections. Hospitals may report and receive payment under the OPPS for both an injection and an infusion code when modifier 59 is also reported with the injection code to indicate that it is a separate and distinct service.

9. Billing for Oxaliplatin (Eloxatin™)

Hospitals are to report HCPCS code C9205, (Injection, oxaliplatin, per 5 mg), instead of J9263, (Injection, oxaliplatin, 0.5 mg), to allow transitional pass-through payment under the OPPS for oxaliplatin.

10. Billing for Bexxar® and Zevalin™

Zevalin™ (ibritumomab tiuxetan) and Bexxar® (tositumomab and Iodine I 131 tositumomab) are two types of radioimmunotherapies that are used to treat patients with certain forms of non-Hodgkin's lymphoma (NHL). Both Zevalin and Bexxar are therapeutic regimens administered in two separate steps: the first step is diagnostic to determine radiopharmaceutical biodistribution of radiolabeled antibodies; the second step is the therapeutic administration of targeted radiolabeled antibodies.

For services furnished **on or after January 1, 2004,** hospitals are to report the HCPCS codes listed below when billing for Zevalin or Bexxar for payment under the OPPS.

a. Zevalin:

- HCPCS code C1082, (Supply of radiopharmaceutical diagnostic imaging agent, indium-111 ibritumomab tiuxetan, per dose
- HCPCS code C1083, (Supply of radiopharmaceutical therapeutic imaging agent, Yttrium 90 ibritumomab tiuxetan, per dose

b. Bexxar:

- HCPCS code C1080 (Supply of radiopharmaceutical diagnostic imaging agent, I-131 tositumomab, per dose)
- HCPCS code C1081 (Supply of radiopharmaceutical therapeutic imaging agent, I-131 tositumomab, per dose)
- HCPCS code G3001 (Administration and supply of tositumomab, 450 mg)

  Use G3001 to bill for the infusion and supply of unlabeled tositumomab used during the dosimetric/diagnostic step and to bill for the infusion and supply of unlabeled tositumomab used during the therapeutic step. The OPPS payment for G3001 includes payment for both the supply of unlabeled tositumomab and administration of the unlabeled tositumomab.

- *CPT* code *77300* (*Basic radiation dosimetry calculation*)

c. For radionuclide scanning to determine the biodistribution of indium-111 ibritumomab tiuxetan (diagnostic Zevalin) or diagnostic I-131 tositumomab (Bexxar), use

- *CPT* code *78804* (*Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging*)
  The OPPS payment for *CPT* code *78804* includes payment for the administration of the diagnostic radiopharmaceutical as well as scans for determining biodistribution of the radiopharmaceutical.

d. For administration of Yttrium 90 ibritumomab tiuxetan (therapeutic Zevalin) or the therapeutic dose of I-131 tositumomab (Bexxar), use

- *CPT* code *79403* (*Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion*)

January 2004 Update to Hospital Outpatient Prospective Payment System (continued)

e. Hospitals are not to use the *CPT* codes *77750*, *78800-78803*, *78999*, *79100*, *79400*, or *77990* when billing for payment for Zevalin or Bexxar under the OPPS.

11. Reporting Implantable Devices

Effective January 1, 2004, in an effort to improve data that will be used to update APC payments, CMS reinstated the C codes for implantable devices for which payment is packaged into the APC payment for the procedure in which the device is used. These codes are for categories of devices for which device pass-through payments have expired. Under the OPPS for 2003, the codes were deleted because, when the devices ceased to be separately payable under the pass-through provisions, the payment for the devices was included in the payment for the procedure, thus, a device code was no longer needed for payment purposes.

In developing the 2004 OPPS CMS found that separate coding of devices results in improved accuracy in establishing the median costs used to set relative weights for the APCs for the procedures into which the costs of these devices are packaged. Claims that contain a separate line with a C code or other HCPCS code for the implantable device, along with a separate charge for the device, most completely and accurately account for the total cost of the procedure including the implanted device. This results in the most accurate median costs for those procedures that use implanted devices.

Hospitals are strongly encouraged to separately bill devices using a device category C code or other appropriate HCPCS code for implantable devices along with the charge for the device. Complete and accurate reporting of the codes and the charges for the devices is critical to ensuring that the relative weights for the services are accurate and thus for ensuring proper payment to hospitals for the procedures that use implanted devices.

All device category C codes for both current pass-through devices as well as packaged devices can be found on Addendum B on the CMS OPPS Web site: *http://www.cms.hhs.gov/regulations/hopps/2004f/*. Devices, whether packaged or paid as pass-through devices, are reported using revenue codes 272, 275, 276, 278, 279, 280, 289 or 624.

12. Billing for C9704

C9704 (Injection or insertion of inert substance for submucosal/intramuscular injection(s) into the upper gastrointestinal tract, under fluoroscopic guidance) is a new technology procedure under the hospital OPPS. This procedure involves the use of a solution made up of a polymer and a solvent that is implanted by injection into the wall of the lower esophagus.

This implantable device is used to help patients with symptoms of gastroesophageal reflux disease (GERD). This procedure involves a single endoscopy (*CPT* code *43234* or *43235*), fluoroscopy, and the use of the device. Under the hospital OPPS, the initial endoscopy is separately reportable, however, payment for C9704 includes the device and fluoroscopy. Therefore, hospitals are not to report C9704 with *CPT* code *76000* (fluoroscopy).

13. New Device Category Code Definition

Effective of January 1, 2004, C1819 (Surgical tissue localization and excision device implantable) will be reportable as a new pass-through device category code under the OPPS. The category is defined as follows:

- **Lesion Localization Device (C1819) –** An implantable radiofrequency guide device that captures and allows for appropriate stabilization, dissection, and excision of a lesion (may include radiofrequency, laser, or ultrasonic components). This device is used with ultrasound, stereotactic, and alphanumeric grid imaging techniques.

14. Updating Intermediary HCPCS File

The following HCPCS codes have been included in the fiscal intermediary processing system:

C1080	Supply of radiopharmaceutical diagnostic imaging agent, I-131 tositumomab, per dose
C1081	Supply of radiopharmaceuticaltherapeutic imaging agent, I-131tositumomab, per dose
C1082	Supply of radiopharmaceutical diagnostic imaging agent, indium-111 ibritumomab tiuxetan, per dose
C1083	Supply of radiopharmaceutical therapeutic imaging agent, Yttrium 90 ibritumomab tiuxetan, per dose
C1819	Surgical tissue localization and excision device (implantable)
C2633	Brachytherapy source, cesium-131
C9205**	Injection, oxaliplatin, per 5 mg
C9207*	Injection, bortezomib, per 3.5 mg
C9210	Injection, palonesetron hydrochloride, per 250 mcg
C9211	Injection, alefacept, for intravenous use, per 7.5 mg
C9212	Injection, alefacept, for intramuscular use, per 7.5 mg
C9704	Injection or insertion of inert substance for submucosal/intramuscular injection(s) into the upper gastrointestinal tract, under fluoroscopic guidance.

* This code has an effective date of October 1, 2003, with an implementation date of January 1, 2004, under the hospital OPPS.

** This code was slated for deletion effective December 31, 2003. This code will continue to be active and reportable under the hospital OPPS. The effective date of this code is July 1, 2003.

15. Changes to the OPPS PRICER Logic

The following list contains a description of all OPPS PRICER logic changes that are effective beginning January 1, 2004.

January 2004 Update to Hospital Outpatient Prospective Payment System (continued)

a. New OPPS wage indexes will be effective January 1, 2004. These are the same wage indexes that were implemented on October 1, 2003, for inpatient hospitals. Some corrections have been made since the publication of the inpatient rule and we are using the corrected wage indexes where applicable.

b. Inpatient hospitals considered reclassified on October 1, 2003, will be considered reclassified for OPPS on January 1, 2004.

c. Section 401 designations and floor MSA (metropolitan statistical area) designations will be considered effective for OPPS on January 1, 2004.

d. New payment rates and coinsurance amounts will be effective for OPPS on January 1, 2004. Some APCs have coinsurance amounts limited to 50 percent of the payment rate effective January 1, 2004. Some APCs have a coinsurance limit equal to the inpatient deductible of $876 effective January 1, 2004.

e. For outliers for hospitals, the factor multiplied times the total line item payments has been changed from 2.75 to 2.6 and the factor used to multiply the difference between line item payments and costs from 0.45 to 0.50.

f. For outliers for CMHCs (type of bill 76x), the factor multiplied times the total line item payments has been changed from 2.75 to 3.65 and the factor used to multiply the difference between line item payments and costs from 0.45 to 0.50.

g. There are no device offsets for 2004.

To review the final summary of data changes to the OCE (version 5.0) and APCs, effective January 1, 2004, access the CMS Web site at: *http://www.cms.hhs.gov/manuals/pm_trans/R32OTN.pdf*. ❖

Source: CMS Pub 100-20 Transmittal 32, CR 3007

January 2004 Outpatient Code Editor Specifications – Version 5.0

CMS has issued the January 2004 update to the outpatient code editor (OCE) specifications (version 5.0) that will be used to processed bills under the outpatient prospective payment system (PPS), effective January 1, 2004.

Instructions and specifications to the OCE software are available in the CMS Manual System, Pub. 100-4, Medicare Claim Processingl, chapter 4, section 40. Changes incorporated in the January 2004 revised OCE have been issued under CMS Pub. 100-4, transmittal 53, change request 3021. In addition to changes to the OCE, transmittal 53 also reflects the addition of section 40.2, *Non-OPPS OCE (Rejected Items and Processing Requirements)*, to the Medicare Claim Processing manual. To review this section or additional OCE information, access the CMS Web site at: *http://www.cms.hhs.gov/manuals/pm_trans/R53CP.pdf*.

This revised version of the OCE represents a significant change to the software in that it will process claims consisting of multiple days of services. Effective with unprocessed claims with dates of service on or after August 1, 2000, the following bills will be sent through the revised OCE:

- All outpatient hospital Part B – types of bill 12x, 13x, or 14x with the exception of critical access hospitals (CAHs)
- Community mental health center (CMHC) – TOB 76x
- Home health agency (HHA) and comprehensive outpatient rehabilitation facility (CORF) – TOBs 34x or 75x containing Healthcare Common Procedure Coding System (HCPCS) codes listed under the "HCPCS Codes for Reporting Antigens, Hepatitis B Vaccines, Splints, and Casts" section below.
- Any bill containing condition code 07, "treatment of non-terminal illness – hospice," with certain HCPCS codes listed under the "HCPCS Codes for Reporting Antigens, Hepatitis B Vaccines, Splints, and Casts" section below.

All other outpatient TOBs – 22x, 23x, 24x, 32x, 33x, 71x, 72x, 73x, 74x, 81x or 82x with dates of service April 1, 2002 and later will be processed through the revised OPPS OCE. In addition, outpatient TOBs 34x and 75x, which contain services other than those listed above with dates of service April 1, 2002 and later will be processed through the revised OPPS OCE.

HCPCS Codes for Reporting Antigens, Hepatitis B Vaccines, Splints, and Casts

Antigens

95144 95145 95146 95147 95148 95149 95165
95170 95180 95199

Hepatitis B Vaccines

G0010 *90740 90743 90744 90746 90747*

Splints

29105 29125 29126 29130 29131 29505 29515

Casts

29000 29010 29015 29020 29025 29035 29040
29044 29046 29049 29055 29058 29065 29075
29085 29305 29325 29345 29355 29358 93652
29405 29425 29435 29440 29445 29450 29700
29705 29710 29715 29720 29730 29740 29750
29799

Note: For TOB 34x, only hepatitis B vaccines and their administration, splints, casts, and antigens will be paid under OPPS. For TOB 75x, only hepatitis B vaccines and their administration are paid under OPPS. For bills containing condition code 07, only splints, casts and antigens will be paid under OPPS. ❖

Source: CMS Pub 100-4 Transmittal 53, CR 3021

Revenue Code Reporting Under Outpatient Prospective Payment System

The Centers for Medicare & Medicaid Services (CMS) has provided guidelines to identify proper revenue codes for the reporting of medical devices that have been granted pass-through status and for packaged services. It also removes revenue codes 0274 and 0290 from the list of revenue codes to be reported for these items. These guidelines are effective October 1, 2003.

Appropriate Revenue Codes to Report Medical Devices That Have Been Granted Pass-Through Status

Hospitals billing for implantable devices that have been granted pass-through status under the outpatient prospective payment system (OPPS) must use the appropriate HCPCS code and **one** of the following revenue codes:

0272	0275	0276	0278	0279
0280	0289	0624		

Hospital billing for implantable orthotic and prosthetic devices and implantable durable medical equipment (DME) must be reported under another revenue code such as 0278 – *other implants*.

Packaged Revenue Codes

The following revenue codes when billed under OPPS without HCPCS codes are packaged services for which no separate payment is made. However, the cost of these services is included in the transitional outpatient payment (TOP) and outlier calculations. The revenue codes for packaged services are:

0250	0251	0252	0254	0255	0257
0258	0259	0260	0262	0263	0264
0269	0270	0271	0272	0275	0276
0278	0279	0280	0289	0370	0371
0372	0379	0390	0399	0560	0569
0621	0622	0624	0630	0631	0632
0633	0637	0700	0709	0710	0719
0720	0721	0762	0810	0819	0942

Any other revenue codes that are billable on a hospital outpatient claim must contain a HCPCS code in order to assure payment under OPPS. Claim received with revenue codes that require a HCPCS code and no HCPCS code is shown on the line will be returned to the providers.

Clarification Regarding Revenue Codes 0274 and 0290

Revenue codes 0274 and 0290 are no longer acceptable revenue codes for reporting implantable orthotic and prosthetic devices and implantable DME furnished in the hospital outpatient setting by a hospital that is subject to the OPPS. When furnished by an OPPS hospital, implantable orthotic and prosthetic devices and implantable DME are subject to the OPPS and must be reported under another revenue code such as 0278 – *other implants.*

Non-implantable orthotic and prosthetic devices furnished by an OPPS hospital or any other hospital are billed to you and paid under the durable medical equipment, prosthetic orthotic and supply (DMEPOS) fee schedule, and reported under revenue code 0274 with the appropriate HCPCS code.

Non-implantable DME furnished by an OPPS hospital or any other hospital is billed to the DME regional carrier (DMERC) on Form CMS-1500 and paid under the DME-POS fee schedule.

Clarification of HCPCS Code to Revenue Code Reporting

Generally, CMS does not instruct hospitals on the assignment of HCPCS codes to revenue codes for services provided under OPPS since hospitals' assignment of cost vary. Where CMS does not provide explicit instructions, hospitals may report their charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report. ❖

Source: CMS Transmittal A-03-035, CR 2614

Payment Rate for Oxaliplatin (Eloxatin™) under the Hospital Outpatient Prospective Payment System

The Centers for Medicare & Medicaid Services (CMS) has notified fiscal intermediaries that the payment rate for HCPCS code C9205, (Injection, oxaliplatin, per 5 mg), published in the *Federal Register* of January 6, 2004, is incorrect. The correct payment rate for HCPCS code C9205 is $84.51, and the copayment amount is $14.12. Similarly, the payment rate for ambulatory payment classification (APC) 9205 – oxaliplatin, is $84.51; the copayment amount is also $14.12.

The OPPS PRICER system was installed with the correct payment rate of $84.51. Therefore, for services furnished on or after January 1, 2004, providers should continue to bill for oxaliplatin using HCPCS code C9205. Payment for oxaliplatin will be reimbursed at $84.51 per 5 mg. ❖

Source: CMS JSM 50, Dated January 20, 2004

PROVIDER AUDIT ISSUES

Changes to Fiscal Year 2004 Hospital Inpatient Prospective Payment System

An article addressing fiscal year 2004 prospective payment system rates for inpatient and long-term care hospitals and other bill processing changes was issued in the First Quarter 2004 *Medicare A Bulletin* (pages 42-45). Since then and as indicated in that article, the Centers for Medicare & Medicaid Services (CMS) has issued corrections to some wages indices and other items published incorrectly in the August 1, 2003, *Federal Register.* Certain corrections were published in the October 6, 2003, *Federal Register.* The relevant changes are:

- **Certain wage index values** – the wage index for hospitals and nursing homes located in rural Georgia was corrected, as well as that for hospitals reclassified to Columbus, GA-AL Metropolitan Statistical Area for discharges occurring on or after November 1, 2003.
- **Hospital geographic reclassifications** – a corrected listing was provided.
- **Assignment of cases to and payment for certain diagnosis-related groups (DRGs) –** this will require claims with DRGs 104, 105, or 525 for discharges occurring **on or after October 1, 2003,** that were processed prior to November 1, 2003, to be reprocessed.
- **Add-on payments for new technology** – the maximum add-on payment for the InFUSE™ bone graft technology was corrected in the October 6, 2003, *Federal Register*; the corrected amount is $4,450.

The updated PRICER also implements Public Las 108-89, which extended section 402(b) of Public Law 108-7. This provision requires that all hospitals paid on the basis of the national average standardized amounts are to receive the large urban standardized amount for **discharges through March 31, 2004**. This has the effect of increasing the operating standardized amounts for hospitals that are not located in large urban areas.

- The operating standardized amounts for large urban areas continue to be $3,145.06 for the labor portion and $1,278.78 for non-labor.
- The operating standardized amounts for hospitals located in other urban and rural areas increased to $3,146.32 for the labor portion and $1,278.89 for non-labor. These rates are slightly higher than those of the large urban hospitals due to the rates being prorated over the remaining five months ending March 31, 2004. ❖

Source: CMS Pub 100-20 Transmittal 16, CR 2971

Changes in Transitional Outpatient Payment for 2004

The Centers for Medicare & Medicaid Services has notified fiscal intermediaries (FIs) of changes to the hospital outpatient prospective payment system (OPPS) for services furnished during calendar years 2004 and 2005. This notification reflects changes resulting from enactment of the Medicare Prescription Drug, Improvement, and Modernization Act (DIMA) of 2003, on December 8, 2003.

As of January 1, 2004, transitional outpatient payments (TOPs) are being discontinued for all community mental health centers (CHMCs) and all hospitals except:

- rural hospitals having 100 or fewer beds,
- sole community hospitals (SCHs) (section 1886 (d) (5) (D)(iii) of the Social Security Act), which are located in rural areas, (although there will be a lag in TOPs after December 31, 2003, until the beginning of the provider's cost report period),
- cancer hospitals, and
- children's hospitals as described in sections 1886(d)(1)(B) (iii) and (v) of the Act.

The interim TOP payments 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 payment-to-cost ratio exceeds the provider's OPPS payments.) One last interim TOP will be paid for services furnished through December 31, 2003, for CMHCs and hospitals for which TOPs will be discontinued.

FIs are responsible for permanently continuing hold harmless TOP interim payments for cancer hospitals and children's hospitals in accordance with the provisions of the Statute. Hold harmless TOPs shall continue through December 31, 2005, for rural hospitals having 100 or fewer beds, in accordance with the provisions of DIMA.

In addition, hold harmless TOPs will apply to SCHs 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 DIMA. If a qualifying SCH has a cost reporting period that begins on a date other than January 1, 2004, TOPs and interim TOP payments 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 having 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 having 100 or fewer beds. ❖

Source: CMS Pub 100-20 Transmittal 30, CR 3015

LOCAL MEDICAL REVIEW POLICIES

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

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

Effective and Notice Dates

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

Electronic Notification

To receive quick, automatic notification when new and revised LMRPs are posted to the Web site, subscribe to the FCSO *eNews* mailing list. It is very easy to do; simply sign on to the provider education Web site, *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 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*.

ADDITIONS/REVISIONS TO EXISTING LMRPS

20974: Osteogenic Stimulation—Addition to Policy

The local medical review policy for osteogenic stimulation – *20974* was last updated October 17, 2002. Since then, diagnosis codes 738.4, 756.12, and 996.4 have been added to the "ICD-9 Codes that Support Medical Necessity" section of this policy for *CPT code 20975*.

Effective Date

This addition is effective for services furnished **on or after December 20, 2003**. ❖

33215: Implantation of Automatic Defibrillators—Revision to Policy

The local medical review policy for implantation of automatic defibrillators – *33215* was last revised on October 1, 2003. Since then, the policy has been revised to remove *CPT* codes *33240* and *33249*. HCPCS codes G0297, G0298, G0299 and G0300 have been added to the policy. Effective for services furnished on or after October 1, 2003, CPT codes *33240* and *33249* are not recognized under the outpatient prospective payment system and claims reporting these codes will be returned to the provider.

Effective Date

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

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

The local medical review policy for magnetic resonance imaging of the brain – *70551* has been revised. ICD-9-CM diagnosis code 676.60 (galactorrhea, unspecified as to episode of care or not applicable) has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy.

Effective Date

This addition is effective for services furnished **on or after December 20, 2003**. ❖

29540: Strapping—Addition to Policy

The local medical review policy for strapping – *29540* was last updated April 11, 2003. Since then, diagnosis code 959.7 (injury of ankle and foot) has been added to the "ICD-9 Codes that Support Medical Necessity" section of this policy for procedure codes *29540* and *29550*.

Effective Date

This addition is effective for services furnished **on or after December 20, 2003**. ❖

44388: Colonoscopy—Revision to Policy

The local medical review policy (LMRP) for colonoscopy – *44388* was last updated on January 1, 2003. Since then, the "Indications and Limitations of Coverage and/or Medical Necessity, Coding Guidelines, and Documentation Requirements" sections of the policy have been updated as a result of CMS Transmittal AB-03-114, change request 2822, dated August 1, 2003, for "Claim Processing and Payment of Incomplete Screening Colonoscopies." This transmittal applies to both screening and diagnostic colonoscopies.

In addition, the descriptors for ICD-9-CM codes 235.2, 564.4, 569.3, and 936 have been corrected. LMRP title was changed from "Colonoscopy" to "Diagnostic Colonoscopy".

Effective Date

This addition is effective for services furnished **on or after January 1, 2004**. ❖

76092: Screening Mammograms—Revision to Policy

The local medical review policy (LMRP) for screening mammograms – *76092* was last updated on January 1, 2003. Since then, CMS Manual System Pub. 100.4, Medicare Claim Processing, chapter 18, section 20.4 (formerly MIM 3660.10D), instructs providers billing for the technical component of the screening mammograms to use type of bill 14x, 22x, 23x or 85x, with revenue code 403 and *CPT* code *76092*. Therefore, the LMRP has been revised to reflect these billing guidelines when billing for a screening mammogram.

Effective Date

This revision is effective for services furnished **on or after January 1, 2002**. ❖

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

77750: Clinical Brachytherapy—Revision to Policy

The local medical review policy for clinical brachytherapy – *77750* was last revised on January 1, 2001. Since then, the policy has been updated to include additional coding guidelines as stated in Program Memorandum A-02-129. HCPCS codes G0256 and G0261 include payment for transperineal placement of needles and/or catheters into the prostate, cystourethroscopy, radioelement application implanted brachytherapy sources**.** Therefore the policy was revised to include these procedure codes.

HCPCS Descriptors

G0256	Prostate brachytherapy using permanently implanted Palladium seeds, including transperitoneal placement of needles or catheters into the prostate, cystoscopy and application of permanent interstitial radiation source
G0261	Prostate brachytherapy using permanently implanted iodine seeds, including transperineal placement of needles or catheters into the prostate, cystoscopy and application of permanent interstitial radiation source

Effective Date

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

In addition, type of bill 85x (critical access hospital) has been added to the policy, and types of bill 12x (hospital) and 71x (rural health clinic) have been removed from the policy. ❖

92235: Fluorescein Angiography—Revision to Policy

The original local medical review policy (LMRP) for fluorescein angiography – *92235* was effective August 1, 2000. Since then, the policy has been updated and revised accordingly. Changes include revisions to the Coding Guidelines and Utilization Guidelines sections of the policy.

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	130.2	135	250.52
250.53	361.2	368.11		

Effective Date

This revision is effective for services furnished **on or after March 15, 2004**. ❖

94799: Pulmonary Rehabilitation—Retirement of Policy

Per the Federal Register, December 31, 2002, (Vol. 67, No. 251) (pages 79965-80184), there is no pulmonary rehabilitation benefit category in the Medicare program. Therefore, the local medical review policy (LMRP) for pulmonary rehabilitation – *94799* is being retired. HCPCS codes G0237, G0238, and G0239 were developed to provide more specificity about the services being delivered by respiratory therapists. A policy has been developed to define these services.

Effective Date

The retirement of this LMRP is effective for services furnished **on or after January 5, 2004**. ❖

95805: Sleep Testing—Revision to Policy

The local medical review policy for sleep testing – *95805* was last updated on January 1, 2003. A revision to the policy has been made as a result of CMS Transmittal 150, CR 1949.

The following revisions were made to the LMRP under the "Indications and Limitations of Coverage and/or Medical Necessity" section for sleep apnea:

- The use of CPAP devices are covered under Medicare when ordered and prescribed by the licensed treating physician to be used in adult patients with OSA if either of the following criteria using the apnea-hypopnea index (AHI) are met:
  - AHI greater than or equal to 15 events per hour, or
  - AHI greater than or equal to 5, and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease or history of stroke.

The AHI is equal to the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of 2 hours of sleep recorded by polysomnography using actual recorded hours of sleep (i.e., the AHI may not be extrapolated or projected).

The following statement was added under the "Documentation Requirements":

- Initial claims for CPAP devices must be supported by information contained in the medical record indicating that the patient meets Medicare's stated coverage criteria.

Under "Other Comments" the definition of the following terms were revised as follows:

- Apnea is defined as a cessation of airflow for at least 10 seconds.
- Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 4% oxygen desaturation.

Effective Date

This addition is effective for services furnished **on or after April 1, 2002**. ❖

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

97001: Physical Medicine and Rehabilitation—Revision to Policy

The local medical review policy for physical medicine and rehabilitation – *97001* was last updated April 1, 2003. Since then, CMS has issued Transmittal 59, CR 2937, dated November 28, 2003, providing instructions regarding the type of signature submitted by physicians. Contractors are instructed to not deny claims on the basis of signature type submitted, with the exception of certificate of medical necessity for durable medical equipment. Therefore, the policy has been revised to remove instructions that restrict the type of signature submitted by the provider.

Effective Date

This revision is effective for services furnished **on or after January 1, 2004**. ❖

A4644: Low Osmolar Contrast Media—Retirement of Policy

The Centers for Medicare & Medicaid Services (CMS) has issued Program Memorandum A-03-019, (Change Request 2612, dated March 14, 2003) that removed all edits for HCPCS A4644, A4645, and A4646. Additionally, the transmittal stated that local edits could not be applied to the service. The outpatient prospective payment system (OPPS) does not provide separate payment for these HCPCS. Therefore, it was determined that the medical necessity criteria as outlined in the LMRP were unnecessary.

Effective Date

This policy has been retired effective for services furnished **on or after April 1, 2003**. ❖

A0425: Ground Ambulance Services—Revision to Policy

The local medical review policy for ground ambulance services – A0425 was last updated on June 30, 2003. Since then, Program Memorandum AB-03-106 (Change Request 2770, dated July 25, 2003) removed the requirement of a physician certification statement (PCS) if the transport is an emergency transport. This instruction applies to providers submitting ambulance claims to intermediaries as well as suppliers submitting ambulance claims to carriers.

The above revisions are effective for services processed **on or after August 8, 2003**.

In addition, skilled nursing facility – types of bill 22x and 23x have been removed form the policy.

Effective for claims processed **on or after October 2, 2003**, the ICD-9-CM codes are no longer used as examples to assume that the patient meets coverage requirements during routine claim processing. Therefore, the diagnoses have been removed from the "ICD-9 Codes that Support Medical Necessity" section of the policy. ❖

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

The latest revision for the local medical review policy for hyperbaric oxygen therapy (HBO therapy) – C1300 was last updated April 1, 2003. Since then, ICD-9-CM 909.2 (Late effect of radiation) has been added to the "ICD-9 Codes that Support Medical Necessity" and to the "Coding Guidelines" sections of the policy. Also, clarification has been provided in the "Indications and Limitations" and the "Coding Guidelines' sections of policy regarding acute peripheral arterial insufficiency as follows: "….and acute peripheral arterial insufficiency associated with arterial embolism and thrombosis."

Effective Date

Implementation of this policy is effective for services furnished **on or after January 1, 2004**. ❖

EPO: Epoetin alfa—Revision to Policy

The local medical review policy (LMRP) for epoetin alfa – EPO was last updated on January 5, 2004.

The following revisions have been made to HCPCS code Q0136:

- Dual diagnosis requirements for HCPCS code Q0136 have been removed from the LMRP. The ICD-9-CM code for the appropriate anemia diagnosis is no longer required.
- ICD-9-CM codes 285.22, 285.8 and 285.9 have been removed from the LMRP.

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

In addition, the following revision has been made to HCPCS code Q4055 based on CMS Transmittal 18, CR 2963:

- ICD-9-CM range 280.0-285.9 has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy for HCPCS code Q4055. ICD-9-CM code 585 must be coded as secondary to the appropriate anemia diagnosis.

This revision is effective for services furnished **on or after January 1, 2004**. ❖

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

G0104: Colorectal Cancer Screening—Revision to Policy

The local medical review policy for colorectal cancer screening – G0104 was last updated on January 1, 2003. Since then, the "Indications and Limitations of Coverage and/or Medical Necessity, Coding Guidelines, and Documentation Requirements" sections of the policy have been updated as a result of CMS Transmittal AB-03-114, change request 2822, dated August 1, 2003, for "Claim Processing and Payment of Incomplete Screening Colonoscopies."

Effective Date

This addition is effective for services furnished **on or after January 1, 2004**. ❖

J0585: Botulinum Toxin Type A (Botox®)—Addition to Policy

The local medical review policy (LMRP) for botulinum toxin type A (Botox®) – J0585 was last updated on March 14, 2003. Since then, ICD-9-CM code 478.79 (Other disease of larynx, not elsewhere classified [spasmodic dysphonia]) has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy for HCPCS code J0585. Spasmodic dysphonia is included in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy; however, there was no corresponding ICD-9-CM code in the LMRP.

Effective Date

These revisions are effective for claims processed **on or after January 15, 2004**. ❖

J1955: Levocarnitine (Carnitor®, L-carnitine®)—Revision to Policy

The local medical review policy (LMRP) for levocarnitine (Carnitor®, L-carnitine®) – J1955 was effective September 29, 2003. Since then, dual diagnosis requirements for end-stage renal disease (ESRD) patients for HCPCS code J1955 have been removed from the LMRP. Therefore, ICD-9-CM codes 280.0-280.9, 285.21, 458.2, and 791.3 have been removed from the LMRP for ESRD patients.

Effective Date

This revision is effective for claims processed **on or after November 21, 2003**. ❖

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

The local medical review policy for diabetes outpatient self-management training –AG0108 was last updated April 1, 2003. Since then, CMS Transmittal 1895 (Change Request 2793, dated August 1, 2003) expands the payment for diabetic outpatient self-management training to include home health agencies, renal dialysis facilities and durable medical equipment suppliers if certified by one of the appropriate accreditation organizations. The outpatient diabetes self-management training program must be accredited as meeting approved quality standards. In addition to the American Diabetes Association (ADA), the Centers for Medicare & Medicaid Services (CMS) has approved the Indian Health Service as an accreditation organization. Facilities are instructed to forward a copy of their Certificate of Recognition received from one of the accredited organizations to the following address:

Medicare Registration – ADA
P. O. Box 2078
Jacksonville, FL 32231-2078

Effective Date

This revision is effective for services furnished **on or after January 1, 2004**.

Additionally, type of bill 12x (hospital) has been removed from the policy. ❖

Local Medical Review Policy—Correction to Policies

The following local medical review policies were published in the First Quarter 2004 *Medicare A Bulletin*. The effective date for these policies was published as claims *processed* on or after January 5, 2004. **The correct effective date is for services furnished on or after January 5, 2004.**

- B-Type Natriuretic Peptide [BNP] – A83880
- Biofeedback – A90901
- Epogen alfa – AEPO
- Magnetic Resonance Angiography [MRA] – A70544
- Respiratory Therapeutic Services – AG0237. ❖

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

NESP: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) (formerly J0880)—Revision to Policy

The local medical review policy (LMRP) for darbepoetin alfa (Aranesp®) – NESP was last updated on September 29, 2003.

The following revisions have been made to HCPCS code Q0137 (formerly J0880):

- Dual diagnosis requirements for HCPCS code Q0137 have been removed from the LMRP. The ICD-9-CM code for the appropriate anemia diagnosis is no longer required.
- ICD-9-CM codes 285.21, 285.22, 285.8 and 285.9 have been removed from the LMRP.

In addition, the following revision has been made to HCPCS code Q4054 based on CMS Transmittal 18, Change Request 2963:

- ICD-9-CM range 280.0-285.9 has been added to the "ICD-9-CM Codes that Support Medical Necessity" section of the policy for HCPCS code Q4054. ICD-9-CM code 585 must be coded as secondary to the appropriate anemia diagnosis.

Effective Date

This revision is effective for services furnished **on or after January 1, 2004**. ❖

Correct Billing of Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])

A local medical review policy (LMRP) was developed for darbepoetin alfa, which became effective September 29, 2003. This LMRP contains *incorrect* instructions for billing darbepoetin alfa. The LMRP is being corrected to include HCPCS code C1774 and will include the correct billing instructions.

The following instructions must be used when billing darbepoetin alfa for dates of service prior to 01/01/2004:

- HCPCS code C1774 (darbepoetin alfa, 1 mcg) must be billed for types of bill 13x, 21x, 23x, and 85x.
- HCPCS code J0880 (darbepoetin alfa, 5 mcg) must be billed for type of bill 72x.

Providers who have billed HCPCS code J0880 and received a return to provider error message should correct the procedure to C1774 or submit corrected claims for processing. ❖

PHPPROG: Psychiatric Partial Hospitalization Program—Revision to Policy

The local medical review policy (LMRP) for psychiatric partial hospitalization program – APHPPROG was last updated on August 2, 2001. Since then, CMS has issued Transmittal 59, CR 2937, dated November 28, 2003, providing instructions regarding the type of signature submitted by physicians. Contractors are instructed to not deny claims on the basis of signature type submitted, with the exception of certificate of medical necessity for durable medical equipment. Therefore, the policy has been revised to remove instructions that restrict the type of signature submitted by the provider.

Effective Date

This revision is effective for services furnished **on or after January 1, 2004**. ❖

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

2004 HCPCS Local Medical Review Policy Changes

Florida Medicare has revised local medical review policies (LMRPs) impacted by the 2004 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and removed accordingly.

LMRP Title	2004 Changes
A43235 – Diagnostic and Therapeutic Esophagogastroduodenoscopy	• Added procedure codes *43237* and *43238* • Deleted type of bill code 71x
A70551 – Magnetic Resonance Imaging of the Brain	• Added procedure codes *70557, 70558,* and *70559* • Added language in the "Coding Guidelines" section
A76090 – Diagnostic Mammography	• Deleted procedure code G0236 • Added procedure code *76082* • Added language in the "Coding Guidelines" section
A76092 – Screening Mammograms	• Deleted procedure code *76085* • Added procedure code *76083* • Added language in the "Coding Guidelines" section
A84155 – Serum Protein	• Descriptor change for procedure codes *84155* and *84160* • Deleted type of bill codes 12x, 71x and 72x • Added type of bill code 85x
A97001 – Physical Medicine and Rehabilitation	• Descriptor change for procedure code *97537*
AC1300 – Hyperbaric Oxygen Therapy (HBO Therapy)	• Deleted procedure code G0167 • Removed language related to G0167 from the "Reasons for Denials" section
AG0030 – Positron Emission Tomography (PET) Scan	• Deleted procedure code Q4078 • Added procedure code A9526 • Added language in the "Coding Guidelines" section
AG0245 – Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes	• Descriptor change for procedure code G0247
AG0262 – Wireless Capsule Endoscopy	• Deleted procedure code G0262 • Added procedure code *91110* • Changed policy identification number to A91110
AJ0151 – Adenosine (Adenocard®, Adenoscan®)	• Deleted procedure code J0151 • Added procedure codes J0150 and J0152 • Removed language from the "Coding Guidelines" section • Changed policy identification number to AJ0150
AJ0880 – Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])	• Deleted procedure codes C1774 and J0880 • Added procedure codes Q0137 and Q4054 • Added language in the "Coding Guidelines" section • Changed policy identification number to ANESP
AJ9999 – Antineoplastic Drugs	• Deleted procedure codes C1167, C9120 and J9180 • Removed procedure code J9999 • Deleted procedure code C9110 (not related to HCPCS update) • Added procedure codes J9178, J9263, and J9395 to LMRP • Changed policy identification number to AJ9000
AQ4053 – Pegfilgrastim (Neulasta™)	• Deleted procedure code Q4053 • Added procedure code J2505 • Changed policy identification number to AJ2505
AZEVALIN – Ibritumomab tiuxetan (Zevalin™) Therapy	• Deleted procedure codes G0273 and G0274 • Revised language in the "Coding Guidelines" section • Added procedure codes *78804*, C1082, *79403* and C1083
AQ9920 – Chronic Renal Failure Erythropoietin (EPOGEN)/AQ0136 Epoetin (PROCRIT™)	• Deleted procedure codes Q9920-Q9940 • Added procedure code Q4055 • Added language in the "Coding Guidelines" section • Changed policy identification number to AEPO • Changed policy name to Epoetin alfa

Full-text for these local medical review policies are available on the provider education Web site *http://www.floridamedicare.com*.

ADDITIONAL INFORMATION ON LMRPS

Billing for Internet Surveillance of an Implanted Cardioverter Defibrillator Without Face-to-Face Contact

Traditional follow up of an implanted cardioverter defibrillator (ICD) is done by way of a compatible programmer in a face-to-face encounter. Intervening symptoms, event markers and device responses are evaluated and if necessary reprogramming of the device is initiated.

The Internet now provides a medium through which a physician can acquire device information from a patient's ICD without face-to-face contact. The patient may use a manufacturer's specific transmitter to send data to a central server. The physician, in turn, retrieves the data with an office computer. This information is identical to a face-to-face ICD interrogation without reprogramming.

Unless otherwise instructed in the future and until a unique *CPT* code(s) is established and issued for this surveillance of an ICD without face-to-face contact, Florida Medicare will reimburse for the Internet-based ICD device evaluation using one of the following *CPT* codes:

93741 *Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); single chamber, without reprogramming*

or

93743 *Electronic analysis of pacing cardioverter-defibrillator (includes interrogation, evaluation of pulse generator status, evaluation of programmable parameters at rest and during activity where applicable, using electrocardiographic recording and interpretation of recordings at rest and during exercise, analysis of event markers and device response); dual chamber, without reprogramming*

The date of the retrieval of the data from the central server by the physician will be considered the date of service for the Internet-based modality. When a physician practice purchases the Internet server based service and performs the professional service, it is appropriate to bill a global charge as the practice is incurring a practice expense. All such purchasing arrangements are subject to applicable federal self referral regulations and antitrust guidelines. In cases where a hospital purchases the Internet server based service, the hospital would bill the technical component using modifier TC and the physician would bill the professional component by using modifier 26. ❖

Skin Graft Coding/Billing Issues

Recent billing issues have been identified with the billing of procedure codes *15000* and *15400*. Some providers are billing both the *15000* and *15400* procedure codes for each wound on both the initial xenograft application and each subsequent weekly treatments where the wound is debrided and the xenograft is reapplied.

Procedure code *15000* is intended for reporting the surgical preparation or creation of a graft recipient site by excision of open wounds, burn eschar, or scar, including subcutaneous tissue, for the first 100 sq. cm. or one percent of body area of infants and children. The American Medical Association *Current Procedural Terminology (CPT)* clearly states "Use this code for initial wound preparation." It was intended that this code be used to report the "initial" creation/preparation of the graft site by excision and not for reporting subsequent debridement procedures. Subsequent procedures must be reported with the appropriate level skin debridement code(s) (*11040-11042*). If multiple sites are debrided, the *11040-11044* codes can be billed by appending modifier 59. In addition, *cpt Assistant* April 1999, page 10, and May 1999, page 10, clearly indicates that procedure code *15000* is for the first 100 sq. cm. (or for infants and children one percent of body area) and should be reported for the total body surface area involved not per wound site. Procedure code *15001* should be reported for each additional 100 sq. cm., if applicable. As these codes represent total body surface area, and, are therefore not dependent upon anatomical site, it would not be appropriate to use the modifiers RT or LT.

Procedure code *15400* is intended for reporting the application of xenograft, skin; 100 sq. cm. or less. Again, the *cpt Assistant* April 2001, page 10, clearly states *15400* should be reported for the total body surface area involved and not per wound site. In addition, for the purposes of billing Medicare for the physician service, this procedure code has a 90-day global period and the provision for payment of these services has been provided for in the Medicare physician fee schedule allowance of $326.95. As stated above, the physician may bill for the appropriate level debridement code for these weekly debridements, if applicable. However, as the outpatient hospital is providing the facility and overhead to perform this service, it would be appropriate for the facility to bill procedure code *15400* for these weekly services. ❖

WIDESPREAD MEDICAL REVIEW PROBES

Inpatient Rehabilitation Facility Services—Widespread Probe Review Referral

The Statistical and Medical Data Analysis department conducted an analysis of inpatient rehabilitation facility services. First Coast Service Options, Inc. (FCSO) has reimbursed its three stand-alone rehabilitation hospitals and twenty-six distinct part units (DPUs) approximately $180 million during calendar year 2002. This payment exceeds the national average. While FCSO's average length of stay (LOS) per discharge was 12.75 days compared to the nation's 14 days, half of our providers have exceeded the national average LOS. In February 2002, the Centers for Medicare & Medicaid Services (CMS) clarified that fiscal intermediaries are responsible for performing medical review functions relative to inpatient rehabilitation services effective April 1, 2002. Based on all these findings, a widespread probe review has been recommended.

The Hospital Manual, Chapter 2, Section 211 contains CMS's interpretation of the inpatient rehabilitation regulation. Effective October 1, 2003, CMS moved this information to the new on-line CMS manual system, Pub 100-2, Medicare Benefit Policy, Chapter One, Section 110. The medical review staff will apply these coverage criteria when performing the recommended widespread probe. This service-specific probe review generally will not exceed evaluating a total of 100 claims amassed by requesting three to four records from each billing provider. The purpose of the review is to determine:

- If the services billed to Medicare were documented as having been performed;
- If the services were reasonable and necessary for the patient's condition; and
- If it was reasonable and necessary to furnish the care on an inpatient basis rather than in a less intensive setting.

The information obtained from the widespread probe will be evaluated in terms of the need to develop local medical review policy to further define national coverage. ❖

CRITICAL ACCESS HOSPITAL SERVICES

January 2004 Update to the Medicare Outpatient Code Editor for Non-OPPS Hospitals

The Medicare outpatient code editor (OCE) specifications (version 19.1) have been updated with the January 2004 new additions, changes, and deletions to the *Current Procedural Terminology, Fourth Edition*/Healthcare Common Procedure Coding System (*CPT-4*/HCPCS) codes.

This OCE (version 19.1) update is used to process bills from hospitals that are not paid under the hospital outpatient prospective payment system (OPPS). Below are the specifications to the January 2004 update to the Medicare OCE.

- The new *CPT*/HCPCS codes as described in Appendix A have been added to the list of valid codes for the non-OPPS OCE. Appendix A is available at: *http://www.cms.hhs.gov/manuals/pm_trans/R51CP.pdf* (pages 6-19).
- The *CPT*/HCPCS codes listed in Appendices B and C have been deleted from the non- OPPS OCE. Appendices B and C are available at: *http://www.cms.hhs.gov/manuals/pm_trans/R51CP.pdf* (pages 20-25).
- The codes listed in Appendix D have been added to the list of nonreportable procedures. Appendix D is available at: *http://www.cms.hhs.gov/manuals/pm_trans/R51CP.pdf* (pages 26-31).
- The codes listed in Appendix E, which are billable only to the DMERC (durable medical equipment regional carrier), have been added to the list of nonreportable procedures. Appendix E is available at: *http://www.cms.hhs.gov/manuals/pm_trans/R51CP.pdf* (pages 32-45).
- The following *CPT* codes have been added to the list of ambulatory surgical centers procedures and payment groups, **effective January 1, 2004:**

***CPT* Code**	**Payment Group**	***CPT* Code**	**Payment Group**	***CPT* Code**	**Payment Group**	***CPT* Code**	**Payment Group**
36555	1	*36556*	1	*36557*	2	*36558*	2
36560	3	*36561*	3	*36563*	3	*36565*	3
36566	3	*36568*	1	*36569*	1	*36570*	3
36571	3	*36575*	2	*36576*	2	*36578*	2
36580	1	*36581*	2	*36582*	3	*36583*	3
36584	1	*36585*	3	*36589*	1	*36590*	1

- The following new *CPT* codes have been added to the list of procedures for females only, **effective January 1, 2004:**

  57425 59070 59072 59074 59076 59897

- The following HCPCS codes have been added to the list of noncovered procedures, **effective January 1, 2004:**

  A9280 J7303 V5362 V5363 V5364

- HCPCS codes E0740 and E0760 have been removed from the list of noncovered procedures, **effective January 1, 2001.**
- HCPCS code G0282 has been removed from the list of noncovered procedures, **effective January 1, 2004.**
- HCPCS code G0257 has been removed from the list of nonreportable procedures, **effective January 1, 2003.** ❖

Source: CMS Pub 100-4 Transmittal 51, CR 3027

Health Professional Shortage Area Incentive Payments for Physicians

Health Professional Shortage Area (HPSA) incentive payment initiative has been expanded to include professional services rendered in an optional method critical access hospital located in a rural or urban HPSA county.

In accordance with section 1833(m) of the Social Security Act, physicians who provide covered professional services in any rural or urban HPSA are entitled to an incentive payment. Physicians providing services in either rural or urban HPSAs are eligible for a ten percent incentive payment. It is not enough for the physician merely to have his/her office or primary service location in a HPSA, nor must the beneficiary reside in a HPSA, although frequently this will be the case. The key to eligibility is where the service is actually provided (place of service). For example, a physician providing a service in his/her office, the patient's home, or in a hospital, qualifies for the incentive payment as long as the specific location of the service provision is within an area designed as a HPSA. On the other hand, a physician may have an office in a HPSA but go outside the office (and the designated HPSA area) to provide the service. In this case, the physician would not be eligible for the incentive payment.

If the critical access hospital (CAH) electing the optional method (method II) is located within a HPSA, the physicians providing (outpatient) professional services in the CAH are eligible for HPSA physician incentive payments. An approved method II CAH, which is located in a HPSA county, must notify First Coast Service Options, Inc. (FCSO) **in writing,** of the HPSA **designation date**. This documentation must be sent to:

First Coast Service Options, Inc.
Medicare Registration – HPSA
P.O. Box 2078
Jacksonville, FL 32231-2078

Once the fiscal intermediary receives the HPSA documentation, an indicator will be placed on the provider file showing the effective date of the CAH's HPSA status.

CAHs selecting method II payment need to keep adequate records to pay physicians the appropriate incentive amounts for those *CPT*/HCPCS procedures the physicians have performed in these facilities. In addition to keeping records of which physicians perform what procedures, CAHs will have to track procedures subject to the HPSA bonus, to assure the quarterly HPSA bonus is also properly distributed.

Billing Requirements

Rural and urban HPSA incentive payment is effective for services furnished **on or after January 1, 2004.**

One of the following modifiers must be on the claim along with the physician service and revenue code 96x, 97x, or 98x:

QB physician providing a service in a rural HPSA

QU physician providing a service in an urban HPSA

The HPSA modifier can only be used with the **professional component** codes. The HPSA incentive payment will not be paid unless the professional component can be separately identified. If the professional component is not separately identified, the service will be returned as unprocessable and providers will need to re-bill the service as separate professional and technical component revenue codes.

HPSA Incentive Reimbursement for Optional Method CAHs

- The HPSA incentive payment is ten percent of the amount actually paid, not the approved amount.
- The HPSA incentive payment will not be included with each claim.
- The fiscal intermediary will create a utility file to run the paid claims for a quarterly log. From this log, providers will receive a quarterly report for each physician payment, along with the HPSA quarterly incentive payment, one month following the end of each quarter.
- The sum of the "10% of Line Reimbursement Amount" column in the report should equal the payment sent along with the report to the CAH.
- If any of the claims included on the report are adjusted, the adjustment will also be included on the report.
- If an adjustment is received after the end of the quarter, it will be included in the next quarterly report.

Billing for Anesthesia Services

When a medically necessary anesthesia service is furnished within any rural or urban HPSA by a physician, a HPSA bonus is payable at ten percent of the amount paid when *CPT* codes *00100 through 01999* are billed with an anesthesia modifier in revenue code 963.

Anesthesiology modifiers:

AA anesthesia services performed personally by anesthesiologist.

GC service performed, in part, by a resident under the direction of a teaching physician.

QK medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals

QY medical direction of one CRNA by an anesthesiologist.

Modifiers AA and GC result in physician payment of 80 percent of the allowed amount.

Modifiers QK and QY result in physician payment of 50 percent of the allowed amount.

Modifiers QB **or** QU are required when billing revenue code 963 for the FI to issue the additional ten percent payment per line item for physician anesthesia services furnished in a method II CAH located in a rural or urban HPSA. ❖

Source: CMS Pub 100-4 Transmittal 41, CR 2990
CMS MIM Transmittal 1898, CR 2817

New Requirements for Critical Access Hospital

The Medicare Drug Improvement and Modernization Act of 2003 was signed into law on December 8, 2003, and amended the following rules and regulations affecting critical access hospitals (CAHs).

Change in Reporting Election Method

Effective January 1, 2004, a CAH must notify the fiscal intermediary of an election, or change of a previous election, at least **30 days** prior to the affected cost reporting period instead of 60 days. If a CAH chooses payment under the elective method (cost-based facility payment plus fee schedule for professional services) for a cost reporting period, that election is effective for the entire cost-reporting period to which it applies. If the CAH wishes to make a new election or change a previous election, that election must be made in writing by the CAH, to the appropriate FI, **at least 30 days** in advance of the beginning of the affected cost reporting period. Election method requests, or a change of a previous election may be sent to:

Provider Audit and Reimbursement Department
Attention: Rita Boccio
P. O. Box 4568
Jacksonville, FL 32232-5268

Increase in Bed Limitations

Effective January 1, 2004, bed limitations for state certified CAHs has been increased from 15 to **25 beds,** and may include any mix of acute or swing beds.

The states continue to certify facilities as necessary. The facility must be located in a rural area of a state that has established a Medicare rural hospital flexibility program, or must be located in a metropolitan statistical area (MSA) of such a state and be treated as being located in a rural area based on a law or regulation of the state, as described in 42 CFR 412.103. It also must be located more than a 35-mile drive from any other hospital or critical access hospital unless it is designated by the state, prior to January 1, 2006, to be a "necessary provider." In mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles. In addition, the facility must make available 24-hour emergency care services, provide not more than 25 beds for acute (hospital-level) inpatient care or in the case of a CAH with a swing bed agreement, swing beds used for SNF-level care. The CAH maintains a length of stay, as determined on an annual average basis, of no longer than 96 hours.

Change in Payment Methodology

Effective for cost reporting periods **beginning on or after January 1, 2004**, payment for inpatient services (types of bill 11x or 18x) of a CAH is 101 percent of the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement.

Effective for cost reporting periods **beginning on or after January 1, 2004,** payment for outpatient CAH services under the standard method will be made for the lesser of 1) 80 percent of the **101 percent** reasonable cost of the CAH in furnishing those services, or 2) **101 percent** of the reasonable cost of the CAH in furnishing those services less applicable Part B deductible and coinsurance amounts.

Payment for Skilled Nursing Facility Level

Skilled nursing facility level services provided by a CAH are paid at 101 percent of the reasonable cost if the facility meets the following requirements:

1. The facility has been certified as a CAH by CMS.
2. The facility operates up to 25 beds for either acute (CAH) care or SNF swing bed care.
3. The facility has been granted swing-bed approval by CMS.

Clinical Diagnostic Laboratory Tests Furnished by CAHs

Payment for clinical diagnostic laboratory tests furnished by a CAH is made on a reasonable cost basis only if the patient is an outpatient of the CAH and is physically present in the CAH at the time the specimen is collected (TOB 85x). A CAH cannot seek reasonable cost reimbursement for tests provided to individuals in locations such as rural health clinic, the individual's home or a SNF. Individuals in these locations are non-patients of a CAH and their lab test would be categorized as "reference lab tests" for nonpatients (TOB 14x), and **are** paid under the clinical laboratory fee schedule. ❖

Source: CMS Pub 100-4 Transmittal 63, CR 3051
CMS Pub 100-4 Transmittal 68, CR 3052

2004 HCPCS ANNUAL UPDATE

Annual Procedure Code Update

Effective for Services Furnished on or After January 1, 2004

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

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

Description of HCPCS Coding Levels

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

Level I – Numeric Codes (*CPT*)

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

Level II – Alpha Numeric (HCFA-Assigned)

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

Category III Codes – New Emerging Technology Codes

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

The 2004 HCPCS Update

The 2004 HCPCS update is divided into the following major sections:

Additions

The procedure/modifier codes listed under "Modifiers and Procedure Codes Added for 2004" section are newly identified *CPT*/HCPCS codes and modifiers that must be used only for services furnished **on or after January 1, 2004.**

Revisions

The procedure/modifier codes listed under "Modifiers and Procedure Codes Revised for 2004" section include *CPT*/HCPCS codes in which the descriptor or administrative instructions have changed from 2003. When using these codes, refer to the *2004 CPT* or HCPCS coding books to ensure the correct code is billed for the service furnished.

Reinstated Codes

The procedure/modifier codes listed under "Modifiers and Procedure Codes Reinstated for 2004" section include *CPT*/HCPCS codes that were discontinued during 2003 or for 2004; however after some reconsideration CMS has reinstated theses codes for 2004.

Discontinued Procedures

The procedure codes listed under "Modifiers and Procedure Codes Discontinued for 2004" section should not be used for service dates **after December 31, 2003.** However, Medicare contractors will continue to accept claims with discontinued *CPT*/HCPCS codes with 2004 service dates received prior to April 1, 2004. Services provided in 2004 that are billed with discontinued *CPT*/HCPCS codes, will be allowed at 2003 payment rates when received between January 1, 2004, and March 31, 2004.

Effective for claims received **on or after April 1, 2004,** services furnished in 2004 billed to Medicare Part A using discontinued codes will be denied payment. Providers will be notified that a discontinued *CPT*/HCPCS code was submitted and a valid *CPT*/HCPCS code must be used.

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

The 2003 HCPCS Update (continued)

A Word About Coverage

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

Jurisdiction

The lists of added, revised, or discontinued *CPT*/HCPCS codes for 2004 are complete with no regard to contractor jurisdiction. The majority of procedure codes in the HCPCS are processed in Florida by the local Medicare Part A fiscal intermediary, First Coast Service Options, Inc. (FCSO). However, some *CPT*/HCPCS codes listed represent services processed by the durable medical equipment regional carrier (DMERC). The DMERC that serves Florida is Palmetto Government Benefits Administratrors (*http://www.palmettogba.com*). It is the responsibility of the billing provider to submit claims to the appropriate Medicare contractor.

Use of Unlisted *CPT*/HCPCS Codes

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

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

Reminder for EMC Billers

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

Questions or Concerns?

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

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

Grace Period Established for 2004 HCPCS Annual Update

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

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

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

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

Modifiers and Procedure Codes Added for 2004

MODIFIERS

UN
UP
UQ
UR
US

CPT-4 Codes

0001F
0002F
0003F
0004F
0005F
0006F
0007F
0008F
0009F
0010F
0011F
0045T
0046T
0047T
0048T
0049T
0050T
0051T
0052T
0053T
0054T
0055T
0056T
0057T
0058T
0059T
0060T
0061T

00529
01173
01958
20982
21685
22532
22533
22534
31632
31633
34805
35510
35512
35522
35525
35697
36555
36556
36557
36558
36560
36561
36563
36565
36566
36568
36569
36570
36571
36575
36576
36578
36580
36581
36582
36583
36584
36585
36589
36590
36595
36596
36597
36838
37765
37766
43237
43238
47140
47141
47142
53500
57425
59070
59072
59074
59076
59897
61537
61540
61566
61567
61863
61864
61867
61868
63101
63102
63103
64449
64517
64681
65780
65781
65782
67912
68371
70557
70558
70559
75998
76082
76083
76514
76937
76940
78804
79403
84156
84157
85055
85396
87269
87329
87660
88112
88361
89220
89225
89230
89235
89240
89268
89272
89280
89281
89290
89291
89335
89342
89343
89344
89346
89352
89353
89354
89356
90655
90698
90715
90734
91110
95991
97755
99601
99602

CMS Assigned Codes

A0800
A4216
A4217
A4248
A4366
A4416
A4417
A4418
A4419
A4420
A4423
A4424
A4425
A4426
A4427
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A4430
A4431
A4432
A4433
A4434
A4638
A4671
A4672
A4673
A4674
A4728
A6407
A6441
A6442
A6443
A6444
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A6456
A6550
A6551
A7046
A7520
A7521
A7522
A7523
A7524
A7525
A7526
A9280
A9525
A9526
A9528
A9529
A9530
A9531
A9532
A9533
A9534
A9999
C1080
C1081
C1082
C1083
C1819
C2633
C9210
C9211
C9212
C9704
E0118
E0140
E0190
E0240
E0247
E0248
E0300
E0301
E0302
E0303
E0304
E0470
E0471
E0472
E0561
E0562
E0637
E0638
E0675
E0955
E0956
E0957
E0960
E0981
E0982
E0983
E0984
E0985
E0986
E1002
E1003
E1004
E1005
E1006
E1007
E1008
E1009
E1010
E1019
E1021
E1028
E1029
E1030
E1391
E1634
E2120
E2201
E2202
E2203
E2204
E2300
E2301
E2310
E2311
E2320
E2321
E2322
E2323
E2324
E2325
E2326
E2327
E2328

Modifiers and Procedure Codes Added for 2004 (continued)

E2329	E2599	G0327	J9263	P9057
E2330	G0302	G0328	J9395	P9058
E2331	G0303	G0338	L0112	P9059
E2340	G0304	G0339	L0861	P9060
E2341	G0305	G0340	L1831	Q0137
E2342	G0306	J0152	L1907	Q0182
E2343	G0307	J0215	L1951	Q4054
E2351	G0308	J0583	L1971	Q4055
E2360	G0309	J0595	L3031	T2101
E2361	G0310	J1335	L3917	T5001
E2362	G0311	J1595	L5673	T5999
E2363	G0312	J2001	L5679	V2121
E2364	G0313	J2185	L5681	V2221
E2365	G0314	J2280	L5683	V2321
E2366	G0315	J2353	L8511	V2745
E2367	G0316	J2354	L8512	V2756
E2399	G0317	J2505	L8513	V2761
E2402	G0318	J2783	L8514	V2762
E2500	G0319	J3411	L8631	V2782
E2502	G0320	J3415	L8659	V2783
E2504	G0321	J3465	P9051	V2784
E2506	G0322	J3486	P9052	V2786
E2508	G0323	J7303	P9053	V2797
E2510	G0324	J7621	P9054	
E2511	G0325	J9098	P9055	
E2512	G0326	J9178	P9056	

Modifiers and Procedure Codes Revised for 2004

MODIFIERS

CB

CPT-4 Codes

0001T	*0036T*	*26356*	*67916*	*76831*
0003T	*0037T*	*26357*	*67917*	*76872*
0005T	*0038T*	*31622*	*67923*	*78290*
0006T	*0039T*	*31625*	*67924*	*78601*
0007T	*0040T*	*31628*	*70250*	*78800*
0008T	*0041T*	*31629*	*70260*	*78802*
0009T	*0042T*	*33310*	*70470*	*80055*
0010T	*0043T*	*34826*	*70543*	*83716*
0012T	*0044T*	*36400*	*70552*	*84155*
0013T	*00220*	*36410*	*70553*	*84160*
0016T	*00320*	*37785*	*71270*	*84165*
0017T	*00528*	*38208*	*71552*	*84378*
0018T	*00580*	*38209*	*72127*	*86146*
0019T	*00942*	*43242*	*72130*	*86294*
0020T	*01214*	*43259*	*72133*	*86300*
0021T	*01382*	*43752*	*72156*	*86301*
0023T	*01402*	*44388*	*72157*	*87040*
0024T	*01464*	*44799*	*72158*	*87045*
0026T	*01622*	*45335*	*72194*	*87070*
0027T	*01732*	*45338*	*72198*	*87075*
0028T	*01916*	*45381*	*72270*	*87271*
0029T	*01995*	*45386*	*74170*	*87272*
0030T	*01996*	*50548*	*74175*	*87328*
0031T	*11100*	*58340*	*74183*	*88045*
0032T	*15852*	*61538*	*74185*	*88312*
0033T	*16036*	*61539*	*75860*	*88342*
0034T	*20240*	*61543*	*76355*	*88358*
0035T	*20550*	*63043*	*76360*	*89055*
	20551	*63044*	*76362*	*89250*
	20552	*63173*	*76370*	*89251*
	22522	*64680*	*76394*	*89258*
	25025	*64821*	*76775*	*90657*
		67221	*76802*	*90658*

Modifiers and Procedure Codes Revised for 2003 (continued)

90693
90703
90704
90705
90706
90707
90708
90718
90727
90733
90871
90918
90919
90920
90921
90922
90923
90924
90925
92597
93736
93788
95967
96155
97537
99024
99026
99027
99050
99292
99293
99294
99295
99296
99512

CMS Assigned Codes

A4326
A4538
A4623
A6025
A9517
E0141
E0143
E0144
E0147
E0149
E0950
E0951
E0952
E0958
E0959
E0961
E0966
E0967
E0972
E0973
E0974
E0978
E0990
E0992
E0995
E1225
E1226
E1390
G0279
G0280
J0880
J1650
J7308
J9130
L0480
L1843
L1844
L1950
L2405
L3902
L4350
L4360
L4386
L5646
L5648
L5848
L5984
L6620
L6675
L6676
L8658
M0100
M0301
P9017
V5362
V5363
V5364

Procedure Codes Reinstated for 2004

CMS Assigned Codes

C1713
C1714
C1715
C1717
C1721
C1722
C1724
C1725
C1726
C1727
C1728
C1729
C1730
C1731
C1732
C1733
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C1895
C1896
C1897
C1898
C1899
C2615
C2617
C2619
C2620
C2621
C2622
C2625
C2626
C2627
C2628
C2629
C2630
C2631

Procedure Codes Discontinued for 2004

CPT-4 Codes

0002T	*To Report, Use 34805*
0025T	*To Report, Use 76514*
00544	*To Report, Use 00542*
47134	*To Report, Use 47140*
36493	*To Report, Use 36597*
36533	*To Report, See 36557-36561, 36565-36566, 36570-36571*
36530	*To Report, Use 36563*
36531	*To Report, See 36575-36576, 36578, 36581-36582, 36584-36585*
36534	*To Report, See 36575-36578, 36581-36583, 36585*
36532	*To Report, Use 36590*
36535	*To Report, Use 36589*
36536	*To Report, Use 36595*
36537	*To Report, Use 36596*
47134	*To Report, Use 47140*
61862	*To Report, See 61867, 61868*
76085	*To Report, See 76082, 76083*
76490	*To Report, Use 76940*
89252	*To Report, Use 89280-89281*
89256	*To Report, Use 89352*
89256	*To Report, Use 89352*
89350	*To Report, Use 89220*
89355	*To Report, Use 89225*
89360	*To Report, Use 89230*
89365	*To Report, Use 89235*
89399	*To Report, Use 89240*
90659	*To Report Influenza Virus Vaccine, Split Virus, See 90657 or 90658*
99025	
99551	*To Report, See 99601-99602*
99552	*To Report, See 99601-99602*
99553	*To Report, See 99601-99602*
99554	*To Report, See 99601-99602*
99555	*To Report, See 99601-99602*
99556	*To Report, See 99601-99602*
99557	*To Report, See 99601-99602*
99558	*To Report, See 99601-99602*
99559	*To Report, See 99601-99602*
99560	*To Report, See 99601-99602*
99561	*To Report, See 99601-99602*
99562	*To Report, See 99601-99602*
99563	*To Report, See 99601-99602*
99564	*To Report, See 99601-99602*
99565	*To Report, See 99601-99602*
99566	*To Report, See 99601-99602*
99567	*To Report, See 99601-99602*
99568	*To Report, See 99601-99602*
99569	*To Report, See 99601-99602*

CMS Assigned Codes

A4214	
A4319	
A4323	
A4621	
A4622	
A4631	
A4644	
A4645	
A4646	
A4712	
A6421	
A6422	
A6424	
A6426	
A6428	
A6430	
A6432	
A6434	
A6436	
A6438	
A6440	
A7019	
A7020	
A9518	X-Ref A9530
C1010	
C1011	
C1015	
C1016	
C1017	
C1018	
C1020	
C1021	
C1022	
C1166	
C1167	
C1774	
C9010	
C9111	
C9116	
C9120	
C9204	
C9503	
C9711	
E0142	
E0145	
E0146	
E0943	
E0975	
E0976	
E0979	
E0991	
E0993	
E1065	
E1066	
E1069	
G0110	
G0111	
G0112	
G0113	
G0114	
G0115	
G0116	
G0167	
G0236	
G0256	
G0261	
G0262	
G0272	
G0273	
G0274	
J0151	
J1910	
J2000	
J2352	
J7508	
J9180	
K0016	X-Ref E0973
K0022	X-Ref E0982
K0025	X-Ref E0966
K0026	
K0027	
K0028	X-Ref E1226
K0029	
K0030	X-Ref E0992
K0031	
K0032	
K0033	
K0035	X-Ref E0951
K0036	X-Ref E0952
K0048	X-Ref E0990
K0049	X-Ref E0995
K0054	
K0055	
K0057	
K0058	
K0062	X-Ref E0967
K0063	X-Ref E0967
K0079	X-Ref E0961
K0080	X-Ref E0974
K0082	X-Ref E2360
K0083	X-Ref E2361
K0084	X-Ref E2362
K0085	X-Ref E2363
K0086	X-Ref E2364
K0087	X-Ref E2365
K0088	X-Ref E2366
K0089	X-Ref E2367
K0100	X-Ref E0959
K0103	X-Ref E0972
K0107	X-Ref E0950
K0112	
K0113	
K0268	X-Ref E0561
K0460	X-Ref E0983
K0461	X-Ref E0984
K0531	X-Ref E0562
K0532	X-Ref E0470
K0533	X-Ref E0471
K0534	X-Ref E0472
K0538	X-Ref E2402
K0539	X-Ref A6550
K0540	X-Ref A6551
K0541	X-Ref E2500
K0542	
K0543	X-Ref E2508
K0544	X-Ref E2510
K0545	X-Ref E2511

Procedure Codes Discontinued for 2004 (continued)

K0546	X-Ref E2512	K0611	X-Ref A4671	Q9924	
K0547	X-Ref E2599	K0612	X-Ref A4672	Q9925	
K0549	X-Ref E0303	K0613	X-Ref A4673	Q9926	
K0550	X-Ref E0304	K0614	X-Ref A4674	Q9927	
K0556	X-Ref L5673	K0615	X-Ref E2502	Q9928	
K0557	X-Ref L5679	K0616	X-Ref E2504	Q9929	
K0558	X-Ref L5681	K0617	X-Ref E2506	Q9930	
K0559	X-Ref L5683	K0621		Q9931	
K0560	X-Ref L8631	K0622		Q9932	
K0581	X-Ref A4416	K0623		Q9933	
K0582	X-Ref A4417	K0624		Q9934	
K0583	X-Ref A4418	K0625		Q9935	
K0584	X-Ref A4419	K0626		Q9936	
K0585	X-Ref A4420	L1885	X-Ref E1810	Q9937	
K0586	X-Ref A4423	L2102		Q9938	
K0587	X-Ref A4424	L2104		Q9939	
K0588	X-Ref A4425	L2122		Q9940	
K0589	X-Ref A4426	L2124		V2116	
K0590	X-Ref A4427	Q0086		V2117	
K0591	X-Ref A4428	Q2010		V2216	
K0592	X-Ref A4429	Q4052	X-Ref J2353	V2217	
K0593	X-Ref A4430	Q4053	X-Ref J2505	V2316	
K0594	X-Ref A4431	Q4078	X-Ref A9526	V2317	
K0595	X-Ref A4432	Q9920		V2740	
K0596	X-Ref A4433	Q9921		V2741	
K0597	X-Ref A4434	Q9922		V2742	
K0610	X-Ref E1634	Q9923		V2743	

AMBULANCE SERVICE FEE SCHEDULE

2004 Ambulance Fee Schedule and Inflation Factor

Section 1834(l)(3)(A) of the Act provides the basis for updating payment limits for ambulance services. Specifically, this section provides for an update in payments for 2004 that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the ambulance inflation factor (AIF). The AIF for CY 2004 is **2.1 percent**.

2004 Ambulance Fee Schedule Transition/Reasonable Cost Blend

During the transition period, the AIF is applied to both the fee schedule portion of the blended payment amount (incorporated in the ambulance fee schedule file), and to the reasonable cost portion of the blended payment amount separately for each ambulance provider. Then, these two amounts are added together to determine the total payment amount for each provider. The blending percentages used to combine these two components of the payment amounts for ambulance services for calendar year (CY) 2004 are **40 percent** of the reasonable cost and **60 percent** of the ambulance fee schedule (AFS).

The AFS rates for 2004 for Florida based on localities are provided below. Providers may calculate their payment by combining 60 percent of the appropriate fee schedule with 40 percent of their 2004 reasonable cost for the same service.

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

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

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

Part B coinsurance and deductible requirements apply to these services. ❖

2004 Ambulance Fee Schedule Rates

HCPCS Code	Locality 01/02	Locality 03	Locality 04	Type
A0425	5.65	5.65	5.65	
A0426	203.26	213.81	218.94	
A0427	321.83	338.69	346.65	
A0428	169.39	178.26	182.45	
A0429	271.02	285.21	291.92	
A0430	2,324.60	2,410.61	2,451.23	Urban
	3,486.91	3,615.92	3,676.84	Rural
A0431	2,702.69	2,802.69	2,849.91	Urban
	4,054.04	4,204.03	4,274.86	Rural
A0432	296.42	311.95	319.28	
A0433	465.81	490.21	501.73	
A0434	550.50	579.34	592.96	
A0435	6.78	6.78	6.78	Urban
	10.17	10.17	10.17	Rural
A0436	18.07	18.07	18.07	Urban
	27.11	27.11	27.11	Rural
Q3019	271.02	285.21	291.92	
Q3020	169.39	178.26	182.45	

Source: CMS Pub 100-4 Transmittal 56, CR 3000

OUPATIENT REHABILITATION SERVICES

The following fee schedules are effective for outpatient rehabilitation services furnished **on or after January 1, 2004.** Inclusion or exclusion of a specific fee schedule does not represent a determination that the Medicare program either covers or does not cover that service.

CODE/MD	FEE 01/02	FEE 03	FEE 04	O/P
G0101	35.64	37.24	38.37	1
G0102	20.60	21.84	22.66	1
G0128	4.52	4.80	5.11	1
G0281	11.08	11.57	12.04	0
G0283	11.08	11.57	12.04	0
29065	83.62	89.73	95.00	1
29075	77.29	83.05	87.96	1
29085	82.08	87.92	92.93	1
29105	80.32	86.02	90.96	1
29125	60.31	64.34	67.52	1
29126	74.10	78.66	82.19	1
29130	37.40	39.78	42.00	1
29131	48.21	50.96	53.10	0
29200	53.13	56.12	58.57	1
29220	53.11	56.61	59.70	1
29240	59.73	63.21	66.06	1
29260	49.39	52.38	54.78	0
29280	50.02	53.17	55.62	0
29345	122.85	131.88	140.04	1
29365	109.81	118.15	125.59	1
29405	80.06	85.94	91.09	1
29445	142.00	152.36	162.17	1
29505	69.70	74.15	77.59	1
29515	61.07	64.91	68.22	1
29520	51.84	54.57	56.43	1
29530	51.91	55.03	57.50	1
29540	35.89	37.97	39.91	1
29550	34.87	37.14	39.29	1
29580	47.08	50.00	52.51	1
29590	49.35	52.06	54.71	1
64550	17.79	18.79	19.50	0
90804	64.38	66.48	68.69	1
90805	70.71	72.83	75.14	1
90806	96.54	99.40	102.46	1
90807	102.99	106.04	109.42	1
90808	144.34	148.67	153.36	1
90809	149.25	153.50	158.24	1
90810	68.84	70.96	73.25	1
90811	77.29	79.60	82.06	1
90812	104.30	107.59	111.06	1
90813	109.57	112.81	116.34	1
90814	151.27	155.82	160.67	1
90815	155.13	159.51	164.37	1
90845	89.69	92.22	95.10	1
90846	93.65	96.38	99.36	1
90847	114.32	117.69	121.34	1
90849	32.04	32.96	33.86	1
90853	31.33	32.20	33.07	1
90857	35.07	36.26	37.45	1
90901	39.57	41.73	43.25	0
90911	92.46	97.77	101.45	0
92506	126.67	134.66	139.59	0
92507	60.28	63.70	65.88	0
92508	28.55	30.14	31.17	0
92526	80.12	84.97	87.84	0
92552	17.44	19.40	20.87	1
92553	26.15	29.10	31.30	1
92555	14.96	16.74	18.12	1
92556	22.97	25.68	27.76	1
92557	47.71	53.25	57.49	1
92561	28.27	31.38	33.66	1
92562	16.02	17.88	19.29	0
92563	14.96	16.74	18.12	1
92564	18.97	21.21	22.94	1
92565	15.67	17.50	18.90	1
92567	21.21	23.77	25.80	1
92568	14.96	16.74	18.12	1
92569	16.02	17.88	19.29	1
92571	15.32	17.12	18.51	1
92572	3.65	4.09	4.43	1
92573	14.26	15.98	17.33	1
92575	11.54	12.74	13.58	1
92576	17.91	20.07	21.76	1
92577	28.75	32.05	34.55	1
92579	28.63	31.76	34.05	1
92582	28.63	31.76	34.05	1
92583	35.22	39.18	42.12	1
92584	97.89	108.68	116.61	1
92587	59.28	65.33	69.88	1
92587TC	51.48	57.14	61.31	1
9258726	7.80	8.18	8.57	1
92588	78.00	85.13	90.60	1
92588TC	58.08	64.56	69.38	1
9258826	19.92	20.57	21.22	1
92589	21.56	24.16	26.19	1
92596	23.68	26.44	28.55	1
92597	94.17	99.69	103.45	0
92601	123.76	134.29	140.21	0
92602	86.67	94.38	98.97	0
92603	82.08	89.44	93.86	0
92604	55.24	60.55	64.01	0
92607	116.10	125.73	130.96	0
92608	26.03	28.81	30.80	0
92609	58.41	63.49	66.43	0
92610	125.29	136.10	142.29	0
92611	125.29	136.10	142.29	0
92612	146.93	155.77	161.74	0
92613	42.65	44.67	46.70	0
92614	136.33	144.37	149.96	0
92616	190.19	200.59	207.64	0
94664	13.20	14.84	16.15	1
94667	21.44	23.87	25.69	1
94668	17.19	18.82	19.86	1
95831	22.94	24.05	24.86	0
95832	20.13	21.00	21.71	0
95833	33.92	35.32	36.38	0

Outpatient Rehabilitation Services (continued)

CODE/MD	LOC 01/02	LOC 03	LOC 04	O/P
95834	41.01	42.74	44.17	0
95851	19.52	20.71	21.49	0
95852	13.76	14.66	15.28	0
96000	87.58	89.45	91.61	1
96001	104.53	106.70	109.20	1
96002	21.55	22.35	23.22	1
96003	20.65	21.81	23.10	1
96105	71.04	79.31	85.65	0
96110	15.23	19.25	23.59	0
96111	143.39	149.78	156.68	0
96115	71.04	79.31	85.65	0
97001	73.43	76.56	79.52	0
97002	38.54	40.08	41.42	0
97003	78.02	81.50	84.63	0
97004	44.54	46.54	48.10	0
97012	14.75	15.32	15.87	0
97016	13.91	14.61	15.18	0
97018	6.60	7.09	7.49	0
97020	4.83	5.19	5.53	0
97022	14.59	15.38	15.98	0
97024	5.89	6.33	6.70	0
97026	4.83	5.19	5.53	0
97028	5.93	6.32	6.68	0
97032	15.46	16.08	16.65	0
97033	20.54	21.69	22.64	0
97034	13.97	14.59	15.14	0
97035	12.20	12.69	13.17	0
97036	22.58	23.67	24.47	0
97039	11.47	11.94	12.40	0
97110	28.59	30.12	31.63	0
97112	28.35	29.54	30.63	0
97113	32.45	34.31	35.97	0
97116	24.36	25.39	26.38	0
97124	21.67	22.48	23.19	0
97139	15.38	16.11	16.71	0
97140	26.19	27.27	28.30	0
97150	17.39	18.26	19.09	0
97504	30.35	32.02	33.60	0
97520	27.64	28.78	29.84	0
97530	28.68	29.93	31.04	0
97532	24.32	25.08	25.82	0
97533	25.38	26.22	27.00	0
97535	29.40	30.68	31.81	0
97537	26.81	27.73	28.55	0
97542	27.17	28.11	28.95	0
97601	38.34	40.64	42.67	0
97703	24.76	26.25	27.37	0
97750	28.35	29.54	30.63	0
97755	34.34	35.51	36.68	1

O/P Indicator
0 = Fee applicable in hospital outpatient setting
1 = Fee not applicable in hospital outpatient setting

SURGICAL DRESSING SERVICES

The following fee schedules are effective for surgical dressing items furnished **on or after January 1, 2004.** Inclusion or exclusion of a specific fee schedule does not represent a determination that the Medicare program either covers or does not that cover that service.

CODE	FEE	CODE	FEE	CODE	FEE	CODE	FEE	CODE	FEE
A4462	3.29	A6216	0.05	A6246	9.92	A6430	8.76	A6501	0.00
A6010	30.96	A6217	0.00	A6247	23.78	A6432	0.00	A6502	0.00
A6011	2.28	A6219	0.95	A6248	16.24	A6434	0.00	A6503	0.00
A6021	21.02	A6220	2.58	A6251	1.99	A6436	19.08	A6504	0.00
A6022	21.02	A6222	2.13	A6252	3.25	A6438	0.00	A6505	0.00
A6023	190.30	A6223	2.42	A6253	6.34	A6440	12.69	A6506	0.00
A6024	6.19	A6224	3.61	A6254	1.21	A6441	0.67	A6507	0.00
A6154	13.93	A6229	3.61	A6255	3.03	A6442	0.17	A6508	0.00
A6196	7.35	A6231	4.66	A6257	1.53	A6443	0.29	A6509	0.00
A6197	16.44	A6232	6.88	A6258	4.30	A6444	0.56	A6510	0.00
A6199	5.29	A6233	19.19	A6259	10.94	A6445	0.32	A6511	0.00
A6200	9.50	A6234	6.54	A6266	1.92	A6446	0.41	K0620	1.14
A6201	20.80	A6235	16.82	A6402	0.12	A6447	0.67	K0621	1.88
A6202	34.88	A6236	27.25	A6403	0.43	A6448	1.16	K0622	0.67
A6203	3.35	A6237	7.91	A6407	1.88	A6449	1.75	K0623	1.40
A6204	6.23	A6238	22.79	A6410	0.39	A6450	0.00	K0624	5.82
A6207	7.34	A6240	12.24	A6411	0.00	A6451	0.00	K0625	2.93
A6209	7.48	A6241	2.57	A6421	2.09	A6452	5.91	K0626	7.13
A6210	19.92	A6242	6.07	A6422	1.17	A6453	0.61	L8110AW	43.27
A6211	29.37	A6243	12.31	A6424	2.05	A6454	0.77	L8120AW	60.96
A6212	9.70	A6244	39.28	A6426	1.88	A6455	1.39		
A6214	10.29	A6245	7.27	A6428	3.04	A6456	1.28		

ORTHOTIC/PROSTHETIC DEVICES

The following fee schedules are effective for orthotic and prosthetic devices furnished **on or after January 1, 2004.** Inclusion or exclusion of a specific fee schedule does not represent a determination that the Medicare program either covers or does not cover that service.

CODE/MD	FEES	CODE/MD	FEES	CODE/MD	FEES	CODE/MD	FEES	CODE/MD	FEES
A4214	1.75	A4373	6.28	A4433	3.34	A7524	77.40	K0590	2.78
A4216	0.00	A4375	17.18	A4434	3.76	A7525	2.07	K0591	6.51
A4217AU	0.00	A4376	47.58	A4450	0.09	A7526	3.37	K0592	8.25
A4280	4.98	A4377	4.29	A4452	0.36	E0752	372.52	K0593	8.52
A4290	139.81	A4378	30.75	A4455	1.22	E0754	916.00	K0594	6.22
A4310	6.56	A4379	15.02	A4481	0.37	E0756	6767.01	K0595	3.59
A4311	12.61	A4380	37.33	A4483	0.00	E0757	4834.90	K0596	3.34
A4312	18.04	A4381	4.61	A4561	19.22	E0758	4255.80	K0597	3.76
A4313	15.74	A4382	24.62	A4562	47.78	E0759	558.88	K0618	621.62
A4314	21.50	A4383	28.19	A4622	57.27	K0112	240.86	K0619	402.87
A4315	22.43	A4384	9.62	A4623	6.55	K0113	146.91	L0100	457.97
A4316	24.14	A4385	5.10	A4625	6.93	K0137	2.42	L0110	135.11
A4319	6.33	A4387	0.00	A4626	2.71	K0138	3.43	L0112	1,132.88
A4320	5.33	A4388	4.36	A4629	4.63	K0139	3.65	L0120	22.65
A4321	0.00	A4389	6.22	A5051	2.07	K0277	4.18	L0130	163.75
A4322	2.82	A4390	9.61	A5052	1.49	K0278	6.28	L0140	56.50
A4323	8.05	A4391	7.07	A5053	1.68	K0279	8.44	L0150	94.23
A4324	2.17	A4392	8.18	A5054	1.79	K0400	4.98	L0160	134.15
A4325	1.80	A4393	9.04	A5055	1.44	K0419	17.18	L0170	567.71
A4326	10.79	A4394	2.58	A5061	3.52	K0420	47.58	L0172	115.11
A4327	42.27	A4395	0.05	A5062	2.09	K0421	4.29	L0174	206.79
A4328	9.86	A4396	40.48	A5063	2.70	K0422	30.75	L0180	281.24
A4330	7.15	A4397	4.13	A5071	6.01	K0423	15.02	L0190	423.35
A4331	3.18	A4398	13.81	A5072	2.99	K0424	37.33	L0200	388.73
A4332	0.12	A4399	12.26	A5073	2.74	K0425	4.61	L0210	40.35
A4333	2.20	A4400	41.54	A5081	3.30	K0426	24.62	L0220	92.19
A4334	4.93	A4402	1.42	A5082	10.11	K0427	28.19	L0450	152.20
A4338	12.26	A4404	1.69	A5093	1.95	K0428	9.62	L0452	0.00
A4340	31.75	A4405	3.40	A5102	22.58	K0429	5.10	L0454	280.72
A4344	16.02	A4406	5.74	A5105	34.65	K0430	6.72	L0456	805.03
A4346	19.59	A4407	8.76	A5112	34.62	K0431	4.01	L0458	721.87
A4347	17.30	A4408	9.87	A5113	4.70	K0432	4.36	L0460	812.52
A4348	27.83	A4409	6.22	A5114	8.06	K0433	6.22	L0462	1,010.64
A4351	1.81	A4410	9.04	A5119	10.85	K0434	9.61	L0464	1,203.15
A4352	5.46	A4413	5.50	A5121	6.34	K0435	7.07	L0466	309.38
A4353	6.99	A4414	4.93	A5122	12.85	K0436	6.64	L0468	387.88
A4354	10.03	A4415	6.00	A5126	1.12	K0437	9.17	L0470	552.24
A4355	7.57	A4416	2.75	A5131	13.48	K0438	2.58	L0472	346.63
A4356	45.63	A4417	3.72	A5200	11.29	K0439	0.05	L0474	486.47
A4357	9.70	A4418	1.81	A7042	169.52	K0556	570.24	L0476	860.71
A4358	6.63	A4419	1.74	A7043	23.31	K0557	475.19	L0478	1,270.02
A4359	29.01	A4420	0.00	A7501	105.03	K0558	1,066.79	L0480	1,071.88
A4361	18.37	A4422	0.12	A7502	49.91	K0559	1,066.79	L0482	1,228.76
A4362	3.39	A4423	1.86	A7503	11.33	K0560	1,813.25	L0484	1,432.71
A4363	3.93	A4424	4.75	A7504	0.67	K0581	2.75	L0486	1,419.28
A4364	2.62	A4425	3.58	A7505	4.68	K0582	3.72	L0488	812.52
A4365	11.32	A4426	2.73	A7506	0.33	K0583	1.81	L0490	228.96
A4366	12.91	A4427	2.78	A7507	2.49	K0584	1.74	L0500	113.44
A4367	7.35	A4428	6.51	A7508	2.87	K0585	0.00	L0510	230.94
A4368	0.26	A4429	8.25	A7509	1.41	K0586	1.86	L0515	246.62
A4369	2.42	A4430	8.52	A7520	47.48	K0587	4.75	L0520	338.83
A4371	3.65	A4431	6.22	A7521	47.05	K0588	3.58	L0530	311.86
A4372	4.18	A4432	3.59	A7522	45.16	K0589	2.73	L0540	336.55

Orthotic/Prosthetic Devices (continued)

CODE/MD	FEES	CODE/MD	FEES	CODE/MD	FEES	CODE/MD	FEES	CODE/MD	FEES
L0550	1,009.92	L1652	288.53	L2038	1,076.24	L2525	1,189.73	L3845	59.80
L0560	1,105.02	L1660	128.82	L2039	1,798.84	L2526	641.27	L3850	85.41
L0561	279.41	L1680	1,059.12	L2040	137.47	L2530	176.87	L3855	92.31
L0565	1,101.92	L1685	1,117.55	L2050	366.11	L2540	318.25	L3860	125.52
L0600	72.17	L1686	749.73	L2060	469.88	L2550	216.19	L3900	1,150.76
L0610	195.70	L1690	1,565.22	L2070	134.98	L2570	478.06	L3901	1,290.31
L0620	326.31	L1700	1,302.16	L2080	287.84	L2580	453.17	L3904	2,626.71
L0700	1,742.69	L1710	1,530.61	L2090	354.81	L2600	154.60	L3906	310.76
L0710	1,902.27	L1720	1,130.66	L2106	511.81	L2610	182.81	L3907	418.21
L0810	2,020.87	L1730	853.07	L2108	804.29	L2620	201.27	L3908	44.14
L0820	1,634.80	L1750	148.10	L2112	381.89	L2622	230.84	L3909	10.42
L0830	2,360.48	L1755	1,241.64	L2114	436.92	L2624	313.82	L3910	326.05
L0860	917.03	L1800	66.77	L2116	575.67	L2627	1,292.91	L3911	0.00
L0861	174.47	L1810	98.00	L2126	1,024.24	L2628	1,518.77	L3912	70.81
L0960	69.33	L1815	89.81	L2128	1,290.77	L2630	186.40	L3914	71.31
L0970	86.03	L1820	97.60	L2132	607.23	L2640	252.97	L3916	93.55
L0972	87.94	L1825	43.51	L2134	728.05	L2650	90.34	L3917	77.81
L0974	179.70	L1830	81.65	L2136	890.21	L2660	140.30	L3918	63.26
L0976	160.48	L1831	238.22	L2180	88.15	L2670	128.41	L3920	75.43
L0978	144.90	L1832	610.20	L2182	68.99	L2680	117.80	L3922	86.52
L0980	13.14	L1834	717.88	L2184	124.33	L2750	62.92	L3923	28.67
L0982	14.32	L1836	108.00	L2186	137.77	L2755	105.78	L3924	92.48
L0984	45.70	L1840	754.62	L2188	300.59	L2760	45.73	L3926	76.04
L1000	1,528.27	L1843	726.26	L2190	78.07	L2768	105.48	L3928	44.91
L1005	2,590.66	L1844	1,258.44	L2192	268.40	L2770	46.48	L3930	46.37
L1010	61.54	L1845	758.15	L2200	35.79	L2780	54.10	L3932	40.22
L1020	84.08	L1846	950.22	L2210	58.08	L2785	31.81	L3934	35.49
L1025	95.57	L1847	465.56	L2220	66.68	L2795	63.96	L3936	65.61
L1030	63.85	L1850	216.67	L2230	57.76	L2800	80.29	L3938	69.02
L1040	76.86	L1855	927.17	L2240	62.95	L2810	58.79	L3940	79.19
L1050	66.55	L1858	1,018.98	L2250	267.48	L2820	65.37	L3942	54.77
L1060	75.06	L1860	840.39	L2260	150.90	L2830	73.51	L3944	90.19
L1070	76.73	L1870	863.68	L2265	88.65	L2840	41.02	L3946	74.02
L1080	53.17	L1880	532.80	L2270	40.43	L2850	46.61	L3948	49.56
L1085	147.72	L1885	837.57	L2275	98.36	L3224	44.26	L3950	116.69
L1090	69.00	L1900	227.67	L2280	365.43	L3225	50.92	L3952	129.33
L1100	121.81	L1901	14.32	L2300	206.27	L3650	44.09	L3954	81.35
L1110	206.31	L1902	61.83	L2310	92.60	L3651	48.49	L3956	0.00
L1120	32.87	L1904	353.98	L2320	154.88	L3652	146.18	L3960	607.20
L1200	1,308.20	L1906	103.44	L2330	295.58	L3660	75.71	L3962	632.23
L1210	196.97	L1907	455.46	L2335	173.88	L3670	105.53	L3963	1,599.38
L1220	166.77	L1910	201.30	L2340	410.32	L3675	129.28	L3980	227.72
L1230	427.91	L1920	263.16	L2350	670.74	L3700	51.42	L3982	281.35
L1240	73.64	L1930	178.08	L2360	38.95	L3701	15.00	L3984	300.32
L1250	72.51	L1940	402.43	L2370	193.24	L3710	106.80	L3985	445.69
L1260	74.51	L1945	739.02	L2375	85.05	L3720	532.84	L3986	515.46
L1270	74.41	L1950	560.69	L2380	92.67	L3730	701.43	L3995	25.21
L1280	66.34	L1951	679.77	L2385	100.83	L3740	788.28	L4000	982.00
L1290	75.22	L1960	417.24	L2390	82.40	L3760	368.39	L4010	552.61
L1300	1,257.43	L1970	617.12	L2395	125.81	L3762	79.21	L4020	690.26
L1310	1,293.90	L1971	379.40	L2397	88.23	L3800	147.29	L4030	380.05
L1500	1,429.84	L1980	276.27	L2405	70.58	L3805	235.67	L4040	307.27
L1510	904.58	L1990	354.96	L2415	98.32	L3807	184.19	L4045	246.93
L1520	2,148.52	L2000	763.51	L2425	116.01	L3810	47.74	L4050	310.77
L1600	97.00	L2010	696.01	L2430	116.01	L3815	44.32	L4055	201.23
L1610	33.05	L2020	878.96	L2435	136.84	L3820	76.12	L4060	239.23
L1620	108.83	L2030	762.57	L2492	76.76	L3825	54.05	L4070	228.25
L1630	129.86	L2035	140.22	L2500	237.47	L3830	62.36	L4080	80.46
L1640	347.34	L2036	1,396.61	L2510	635.82	L3835	67.60	L4090	71.22
L1650	184.19	L2037	1,287.06	L2520	346.78	L3840	46.30	L4100	80.33

Orthotic/Prosthetic Devices (continued)

CODE/MD	FEES	CODE/MD	FEES	CODE/MD	FEES	CODE/MD	FEES	CODE/MD	FEES
L4110	63.84	L5622	290.73	L5701	2,759.47	L5982	463.63	L6641	128.65
L4130	439.35	L5624	291.56	L5702	3,491.15	L5984	456.86	L6642	174.38
L4350	79.16	L5626	382.37	L5704	429.86	L5985	229.00	L6645	321.89
L4360	221.45	L5628	408.85	L5705	768.08	L5986	508.19	L6646	2,557.88
L4370	142.11	L5629	254.87	L5706	752.93	L5987	5,834.12	L6647	421.09
L4380	87.13	L5630	359.92	L5707	992.63	L5988	1,620.12	L6648	2638.08
L4386	128.34	L5631	352.37	L5710	299.92	L5989	2,512.10	L6650	334.20
L4392	19.06	L5632	196.66	L5711	419.18	L5990	1,471.32	L6655	65.69
L4394	13.91	L5634	243.95	L5712	351.24	L5995	0.00	L6660	73.61
L4396	135.85	L5636	204.34	L5714	360.78	L6000	1,065.57	L6665	36.94
L4398	62.51	L5637	231.68	L5716	584.51	L6010	1,185.80	L6670	40.83
L5000	424.42	L5638	403.58	L5718	730.57	L6020	1,105.57	L6672	162.06
L5010	1,025.05	L5639	899.15	L5722	771.82	L6025	6,489.90	L6675	96.31
L5020	1,740.81	L5640	512.81	L5724	1,210.50	L6050	1,523.44	L6676	111.33
L5050	1,925.65	L5642	496.87	L5726	1,395.08	L6055	2,123.28	L6680	186.07
L5060	2,215.04	L5643	1,248.22	L5728	1,908.28	L6100	1,543.47	L6682	205.72
L5100	1,929.89	L5644	473.68	L5780	918.18	L6110	1,637.12	L6684	279.54
L5105	2,786.00	L5645	639.88	L5781	3,244.95	L6120	1,907.82	L6686	631.27
L5150	2,816.26	L5646	439.41	L5782	0.00	L6130	2,076.07	L6687	462.58
L5160	3,063.19	L5647	637.93	L5785	516.13	L6200	2,187.84	L6688	459.80
L5200	2,933.44	L5648	528.00	L5790	576.63	L6205	2,920.42	L6689	550.89
L5210	1,946.04	L5649	1,913.22	L5795	1,148.09	L6250	2,292.35	L6690	600.31
L5220	2,212.03	L5650	391.51	L5810	390.45	L6300	2,987.83	L6691	277.86
L5230	3,050.83	L5651	963.10	L5811	584.89	L6310	2,579.86	L6692	448.49
L5250	4,161.05	L5652	349.64	L5812	453.35	L6320	1,409.33	L6693	2,302.41
L5270	4,142.59	L5653	466.74	L5814	3,011.95	L6350	3,141.25	L6700	416.01
L5280	4,110.86	L5654	265.96	L5816	686.13	L6360	2,825.06	L6705	244.23
L5301	2,205.98	L5655	225.39	L5818	770.15	L6370	1,690.43	L6710	276.79
L5311	3,157.72	L5656	302.37	L5822	1,365.67	L6380	979.56	L6715	274.93
L5321	3,197.63	L5658	291.59	L5824	1,229.87	L6382	1,473.72	L6720	684.17
L5331	4,074.43	L5661	488.03	L5826	2,532.66	L6384	2,038.72	L6725	331.23
L5341	4,241.50	L5665	410.63	L5828	2,264.70	L6386	322.06	L6730	545.67
L5400	1,092.15	L5666	56.14	L5830	1,521.76	L6388	352.56	L6735	238.97
L5410	335.08	L5668	90.55	L5840	2,813.74	L6400	1,860.88	L6740	339.57
L5420	1,338.40	L5670	217.61	L5845	1,453.61	L6450	2,486.10	L6745	298.10
L5430	403.56	L5671	461.14	L5846	4,396.14	L6500	2,600.97	L6750	298.99
L5450	328.31	L5672	239.14	L5847	2,560.45	L6550	3,126.41	L6755	299.75
L5460	437.40	L5673	570.24	L5848	872.06	L6570	3,510.11	L6765	316.72
L5500	1,029.99	L5674	52.97	L5850	102.59	L6580	1,340.09	L6770	300.46
L5505	1,424.51	L5675	76.82	L5855	275.68	L6582	1,213.76	L6775	335.81
L5510	1,167.56	L5676	290.61	L5910	290.45	L6584	1,903.48	L6780	375.74
L5520	1,153.27	L5677	395.42	L5920	425.51	L6586	1,781.35	L6790	362.38
L5530	1,385.19	L5678	31.84	L5925	359.29	L6588	2,340.66	L6795	1,011.61
L5535	1,359.98	L5679	475.19	L5930	2,729.72	L6590	2,223.28	L6800	812.57
L5540	1,451.53	L5680	265.80	L5940	402.27	L6600	150.43	L6805	272.86
L5560	1,558.69	L5681	1,066.79	L5950	628.99	L6605	148.53	L6806	1,311.64
L5570	1,620.49	L5682	501.55	L5960	773.13	L6610	142.64	L6807	1,056.79
L5580	1,891.80	L5683	1,066.79	L5962	508.80	L6615	153.70	L6808	902.39
L5585	2,328.18	L5684	38.60	L5964	751.06	L6616	56.95	L6809	316.73
L5590	1,927.88	L5686	40.97	L5966	957.03	L6620	245.91	L6810	154.66
L5595	3,405.87	L5688	48.99	L5968	2,947.11	L6623	685.91	L6825	911.11
L5600	3,661.14	L5690	78.47	L5970	162.88	L6625	487.36	L6830	1,086.02
L5610	1,660.39	L5692	106.56	L5972	304.23	L6628	384.18	L6835	946.03
L5611	1,292.11	L5694	145.49	L5974	186.88	L6629	117.33	L6840	690.23
L5613	2,020.16	L5695	134.31	L5975	375.98	L6630	172.84	L6845	656.02
L5614	1,368.52	L5696	148.38	L5976	449.12	L6632	60.03	L6850	595.18
L5616	1,091.69	L5697	64.38	L5978	234.04	L6635	141.25	L6855	702.79
L5617	453.76	L5698	105.28	L5979	1,829.90	L6637	301.29	L6860	534.93
L5618	240.05	L5699	189.65	L5980	2,973.47	L6638	2,028.09	L6865	292.24
L5620	222.96	L5700	2,297.79	L5981	2,402.15	L6640	267.65	L6867	781.30

Orthotic/Prosthetic Devices (continued)

CODE/MD	FEES	CODE/MD	FEES	CODE/MD	FEES	CODE/MD	FEES	CODE/MD	FEES
L6868	192.27	L7364	319.57	L8440	42.05	V2115	59.33	V2320	42.02
L6870	190.62	L7366	430.47	L8460	58.51	V2116	53.18	V2321	125.76
L6872	755.30	L7367	315.73	L8465	52.16	V2117	61.31	V2410	71.91
L6873	375.16	L7368	409.30	L8470	5.35	V2118	58.81	V2430	93.62
L6875	623.33	L7900	438.92	L8480	7.38	V2121	60.72	V2500	65.18
L6880	404.39	L8000	35.28	L8485	8.92	V2200	41.11	V2501	99.29
L6881	3,315.54	L8001	101.72	L8490	106.56	V2201	44.81	V2502	122.31
L6882	2,515.01	L8002	133.81	L8500	529.27	V2202	52.73	V2503	117.02
L6890	136.40	L8015	48.61	L8501	117.55	V2203	41.48	V2510	88.98
L6895	501.79	L8020	182.84	L8507	33.97	V2204	44.98	V2511	127.85
L6900	1,431.99	L8030	264.47	L8509	88.58	V2205	49.35	V2512	151.08
L6905	1,423.85	L8035	2,971.19	L8510	204.94	V2206	60.08	V2513	126.84
L6910	1,217.55	L8040	1,960.33	L8511	0.00	V2207	50.15	V2520	83.64
L6915	613.86	L8040KM	1,862.31	L8512	0.00	V2208	50.76	V2521	145.61
L6920	5,352.12	L8040KN	784.13	L8513	0.00	V2209	55.84	V2522	141.71
L6925	7,204.87	L8041	2,362.79	L8514	0.00	V2210	71.84	V2523	120.76
L6930	5,385.31	L8041KM	2,244.64	L8600	500.79	V2211	61.26	V2530	178.86
L6935	7,316.68	L8041KN	945.11	L8603	351.71	V2212	66.66	V2531	439.11
L6940	7,036.26	L8042	2,654.81	L8606	184.62	V2213	68.36	V2623	719.88
L6945	8,597.47	L8042KM	2,522.08	L8610	513.68	V2214	73.28	V2624	48.82
L6950	7,997.69	L8042KN	1,061.92	L8612	541.78	V2215	79.29	V2625	316.22
L6955	9,578.33	L8043	2,973.40	L8613	242.57	V2216	82.23	V2626	200.62
L6960	849.86	L8043KM	2,824.71	L8614	5,353.47	V2217	75.63	V2627	1,148.63
L6965	1,571.76	L8043KN	1,189.36	L8619	6,586.07	V2218	81.12	V2628	262.62
L6970	2,057.98	L8044	3,291.97	L8630	270.19	V2219	35.71	V2700	35.13
L6975	3,187.55	L8044KM	3,127.38	L8631	1,813.25	V2220	28.96	V2710	51.42
L7010	2,929.07	L8044KN	1,316.80	L8641	293.24	V2221	77.37	V2715	9.32
L7015	4,654.51	L8045	2,061.52	L8642	240.71	V2300	53.39	V2718	22.90
L7020	2,729.03	L8045KM	1,958.44	L8658	251.57	V2301	61.92	V2730	16.91
L7025	2,753.99	L8045KN	824.61	L8659	1,564.96	V2302	67.84	V2740	11.22
L7030	4,211.28	L8046	2,123.85	L8670	446.41	V2303	56.19	V2741	8.14
L7035	2,820.41	L8046KM	2,017.66	V2020	64.64	V2304	58.81	V2742	9.23
L7040	2,260.89	L8046KN	849.53	V2100	31.41	V2305	72.12	V2743	10.27
L7045	1,296.25	L8047	1,088.47	V2101	33.10	V2306	67.26	V2744	17.54
L7170	5,968.39	L8047KM	1,034.05	V2102	46.95	V2307	66.68	V2745	9.95
L7180	6,197.98	L8047KN	435.39	V2103	27.28	V2308	71.16	V2750	20.41
L7185	5,893.87	L8300	78.10	V2104	30.21	V2309	83.24	V2755	14.75
L7186	7,093.85	L8310	120.10	V2105	36.98	V2310	91.56	V2760	12.85
L7190	6,190.58	L8320	52.46	V2106	37.53	V2311	87.20	V2762	48.35
L7191	7,412.66	L8330	52.00	V2107	39.45	V2312	76.87	V2770	16.59
L7260	1,578.30	L8400	15.20	V2108	38.26	V2313	104.92	V2780	13.40
L7261	2,873.10	L8410	17.29	V2109	43.98	V2314	114.92	V2782	52.20
L7266	1,058.68	L8415	17.19	V2110	51.33	V2315	127.59	V2783	58.88
L7272	1,833.33	L8417	60.98	V2111	45.25	V2316	119.62	V2784	38.28
L7274	4,606.18	L8420	20.10	V2112	44.65	V2317	128.74	V2786	0.00
L7360	191.36	L8430	22.10	V2113	61.69	V2318	117.64		
L7362	200.93	L8435	19.84	V2114	54.56	V2319	39.82		

CLINICAL LABORATORY SERVICES

The following fee schedules are effective for clinical laboratory services furnished **on or after January 1, 2004.** Inclusion or exclusion of a specific fee schedule does not represent a determination that the Medicare program either covers or does not cover that service.

CODE/MD	60%	62%
G0001	3.00	3.00
G0027	9.09	9.39
G0103	25.70	26.56
G0107	4.54	4.69
G0123	28.21	29.15
G0143	28.21	29.15
G0144	29.39	30.37
G0145	34.70	35.86
G0147	14.76	14.76
G0148	14.76	14.76
G0265	14.11	14.58
G0266	14.11	14.58
G0306	10.86	11.22
G0307	9.04	9.34
G0328	18.09	18.69
G0328QW	18.09	18.69
P2038	7.02	7.25
P3000	14.76	14.76
P9612	3.00	3.00
P9615	3.00	3.00
Q0111	5.96	6.16
Q0112	5.96	6.16
Q0113	7.56	7.81
Q0114	9.99	10.32
Q0115	13.83	14.29
78267	10.98	11.35
78268	94.11	97.25
80048	11.83	12.22
80051	9.80	10.13
80053	14.77	15.26
80061	18.72	19.34
80061QW	18.72	19.34
80069	12.13	12.53
80074	66.54	68.76
80076	11.42	11.80
80100	20.32	21.00
80101	19.24	19.88
80101QW	19.24	19.88
80102	18.51	19.13
80150	21.06	21.76
80152	25.01	25.84
80154	25.84	26.70
80156	20.34	21.02
80157	18.52	19.14
80158	24.31	25.12
80160	24.05	24.85
80162	18.55	19.17
80164	18.93	19.56
80166	21.66	22.38
80168	22.83	23.59
80170	22.90	23.66
80172	22.76	23.52
80173	20.34	21.02
80174	24.05	24.85
80176	16.26	16.80
80178	9.24	9.55
80182	18.93	19.56
80184	16.01	16.54
80185	18.52	19.14
80186	19.23	19.87
80188	23.18	23.95
80190	23.41	24.19
80192	23.41	24.19
80194	20.39	21.07
80196	9.92	10.25
80197	19.17	19.81
80198	19.77	20.43
80200	22.52	23.27
80201	16.66	17.22
80202	18.93	19.56
80299	19.13	19.77
80400	45.56	47.08
80402	121.46	125.51
80406	109.34	112.98
80408	175.34	181.18
80410	112.23	115.97
80412	460.50	475.85
80414	72.16	74.57
80415	78.08	80.68
80416	184.38	190.53
80417	61.46	63.51
80418	809.76	836.75
80420	100.64	103.99
80422	64.38	66.53
80424	66.56	68.78
80426	207.40	214.31
80428	93.16	96.27
80430	109.60	113.25
80432	177.43	183.34
80434	141.30	146.01
80435	143.85	148.65
80436	127.36	131.61
80438	70.41	72.76
80439	93.88	97.01
80440	81.24	83.95
81000	4.43	4.58
81001	4.43	4.58
81002	3.57	3.69
81003	3.14	3.24
81003QW	3.14	3.24
81005	3.03	3.13
81007	3.59	3.71
81007QW	3.59	3.71
81015	4.02	4.15
81020	5.15	5.32
81025	8.84	9.13
81050	4.19	4.33
82000	17.31	17.89
82003	28.28	29.22
82009	6.31	6.52
82010	9.99	10.32
82010QW	9.99	10.32
82013	15.61	16.13
82016	19.37	20.02
82017	23.57	24.36
82024	53.97	55.77
82030	18.08	18.68
82040	5.73	5.92
82042	2.46	2.54
82043	2.46	2.54
82044	6.39	6.60
82044QW	6.39	6.60
82055	15.10	15.60
82055QW	15.10	15.60
82075	16.84	17.40
82085	13.56	14.01
82088	56.94	58.84
82101	41.94	43.34
82103	18.77	19.40
82104	20.20	20.87
82105	23.44	24.22
82106	23.44	24.22
82108	35.60	36.79
82120	4.02	4.15
82120QW	4.02	4.15
82127	19.37	20.02
82128	19.37	20.02
82131	23.57	24.36
82135	23.00	23.77
82136	23.57	24.36
82139	23.57	24.36
82140	20.36	21.04
82143	9.61	9.93
82145	21.72	22.44
82150	9.06	9.36
82154	40.29	41.63
82157	40.90	42.26
82160	34.94	36.10
82163	28.68	29.64
82164	20.39	21.07
82172	19.80	20.46
82175	26.51	27.39
82180	13.81	14.27
82190	17.08	17.65
82205	16.01	16.54
82232	22.61	23.36
82239	23.94	24.74
82240	24.31	25.12
82247	7.02	7.25

Clinical Laboratory Services Fee Schedule (continued)

CODE/MD	60%	62%
82248	7.02	7.25
82252	2.73	2.82
82261	23.57	24.36
82270	4.54	4.69
82273	4.54	4.69
82273QW	4.54	4.69
82274	18.09	18.69
82274QW	18.09	18.69
82286	9.62	9.94
82300	13.25	13.69
82306	41.36	42.74
82307	45.02	46.52
82308	37.41	38.66
82310	7.20	7.44
82330	19.09	19.73
82331	7.23	7.47
82340	8.43	8.71
82355	16.17	16.71
82360	12.22	12.63
82365	17.30	17.88
82370	17.51	18.09
82373	24.35	25.16
82374	6.83	7.06
82375	17.22	17.79
82376	7.94	8.20
82378	26.51	27.39
82379	23.57	24.36
82380	12.89	13.32
82382	24.02	24.82
82383	35.01	36.18
82384	33.28	34.39
82387	29.07	30.04
82390	15.01	15.51
82397	19.74	20.40
82415	17.70	18.29
82435	6.42	6.63
82436	4.55	4.70
82438	6.83	7.06
82441	8.38	8.66
82465	6.08	6.28
82465QW	6.08	6.28
82480	9.93	10.26
82482	8.31	8.59
82485	20.02	20.69
82486	24.35	25.16
82487	20.02	20.69
82488	20.02	20.69
82489	20.02	20.69
82491	24.35	25.16
82492	24.35	25.16
82495	28.34	29.28
82507	38.85	40.15
82520	21.17	21.88
82523	26.11	26.98
82523QW	26.11	26.98
82525	17.34	17.92
82528	31.45	32.50
82530	23.35	24.13
82533	22.78	23.54
82540	6.48	6.70
82541	24.35	25.16
82542	24.35	25.16
82543	24.35	25.16
82544	24.35	25.16
82550	9.10	9.40
82552	18.71	19.33
82553	13.00	13.43
82554	13.00	13.43
82565	7.16	7.40
82570	7.23	7.47
82570QW	7.23	7.47
82575	13.20	13.64
82585	11.98	12.38
82595	9.04	9.34
82600	27.11	28.01
82607	21.06	21.76
82608	20.01	20.68
82615	11.41	11.79
82626	35.31	36.49
82627	31.07	32.11
82633	43.28	44.72
82634	40.90	42.26
82638	17.11	17.68
82646	27.81	28.74
82649	35.91	37.11
82651	36.07	37.27
82652	53.78	55.57
82654	19.11	19.75
82657	24.35	25.16
82658	24.35	25.16
82664	48.00	49.60
82666	30.01	31.01
82668	26.26	27.14
82670	39.04	40.34
82671	45.13	46.63
82672	30.30	31.31
82677	33.79	34.92
82679	34.88	36.04
82679QW	34.88	36.04
82690	21.99	22.72
82693	13.75	14.21
82696	32.95	34.05
82705	7.11	7.35
82710	22.12	22.86
82715	24.05	24.85
82725	12.08	12.48
82726	24.35	25.16
82728	19.03	19.66
82731	89.99	92.99
82735	12.62	13.04
82742	27.66	28.58
82746	20.54	21.22
82747	4.30	4.44
82757	16.89	17.45
82759	30.01	31.01
82760	15.64	16.16
82775	29.43	30.41
82776	11.71	12.10
82784	12.99	13.42
82785	23.01	23.78
82787	4.36	4.51
82800	4.88	5.04
82803	27.04	27.94
82805	39.65	40.97
82810	12.20	12.61
82820	13.96	14.43
82926	7.61	7.86
82928	7.32	7.56
82938	24.72	25.54
82941	24.64	25.46
82943	19.97	20.64
82945	5.48	5.66
82946	21.06	21.76
82947	5.48	5.66
82947QW	5.48	5.66
82948	4.43	4.58
82950	6.64	6.86
82950QW	6.64	6.86
82951	17.99	18.59
82951QW	17.99	18.59
82952	5.48	5.66
82952QW	5.48	5.66
82953	6.63	6.85
82955	13.55	14.00
82960	8.12	8.39
82962	3.27	3.38
82963	30.01	31.01
82965	7.28	7.52
82975	22.13	22.87
82977	10.06	10.40
82978	19.91	20.57
82979	9.62	9.94
82980	24.31	25.12
82985	21.06	21.76
82985QW	21.06	21.76
83001	25.97	26.84
83001QW	25.97	26.84
83002	25.88	26.74
83002QW	25.88	26.74
83003	23.29	24.07
83008	23.45	24.23
83010	17.58	18.17
83012	24.02	24.82
83013	94.11	97.25
83014	10.98	11.35
83015	26.31	27.19
83018	30.68	31.70
83020	17.99	18.59
83021	24.35	25.16
83026	3.30	3.41
83030	11.56	11.95
83033	6.50	6.72
83036	13.56	14.01
83036QW	13.56	14.01
83045	4.88	5.04
83050	5.86	6.06
83051	10.21	10.55
83055	6.87	7.10
83060	8.12	8.39
83065	6.00	6.20

Clinical Laboratory Services Fee Schedule (continued)

CODE/MD	60%	62%
83068	11.83	12.22
83069	5.51	5.69
83070	6.64	6.86
83071	9.61	9.93
83080	23.57	24.36
83088	41.26	42.64
83090	23.57	24.36
83150	17.30	17.88
83491	24.47	25.29
83497	18.01	18.61
83498	37.95	39.22
83499	35.22	36.39
83500	31.65	32.71
83505	33.96	35.09
83516	16.12	16.66
83518	11.85	12.25
83518QW	11.85	12.25
83519	18.88	19.51
83520	18.09	18.69
83525	15.98	16.51
83527	18.09	18.69
83528	22.22	22.96
83540	9.05	9.35
83550	12.21	12.62
83570	12.36	12.77
83582	19.80	20.46
83586	17.89	18.49
83593	36.75	37.98
83605	14.92	15.42
83605QW	14.92	15.42
83615	8.44	8.72
83625	17.88	18.48
83632	28.24	29.18
83633	7.69	7.95
83634	11.17	11.54
83655	16.91	17.47
83661	27.56	28.48
83662	26.43	27.31
83663	26.43	27.31
83664	26.43	27.31
83670	12.80	13.23
83690	9.62	9.94
83715	15.73	16.25
83716	17.30	17.88
83718	11.44	11.82
83718QW	11.44	11.82
83719	16.26	16.80
83721	13.33	13.77
83727	24.02	24.82
83735	9.36	9.67
83775	10.30	10.64
83785	34.36	35.51
83788	24.35	25.16
83789	24.35	25.16
83805	24.63	25.45
83825	22.72	23.48
83835	23.67	24.46
83840	22.81	23.57
83857	15.01	15.51
83858	18.72	19.34
83864	27.82	28.75
83866	13.76	14.22
83872	8.19	8.46
83873	24.04	24.84
83874	18.04	18.64
83880	47.43	49.01
83883	19.00	19.63
83885	7.94	8.20
83887	33.09	34.19
83890	3.56	3.68
83891	3.56	3.68
83892	3.56	3.68
83893	3.56	3.68
83894	3.56	3.68
83896	3.56	3.68
83897	3.56	3.68
83898	23.42	24.20
83901	23.42	24.20
83902	15.17	15.68
83903	23.42	24.20
83904	23.42	24.20
83905	23.42	24.20
83906	23.42	24.20
83912	3.56	3.68
83915	15.58	16.10
83916	27.42	28.33
83918	21.19	21.90
83919	21.19	21.90
83921	21.19	21.90
83925	27.19	28.10
83930	9.24	9.55
83935	9.52	9.84
83937	28.73	29.69
83945	17.99	18.59
83950	89.99	92.99
83970	57.67	59.59
83986	5.00	5.17
83986QW	5.00	5.17
83992	20.54	21.22
84022	21.76	22.49
84030	7.69	7.95
84035	5.11	5.28
84060	10.32	10.66
84061	11.06	11.43
84066	13.50	13.95
84075	7.23	7.47
84078	10.20	10.54
84080	20.66	21.35
84081	23.09	23.86
84085	9.42	9.73
84087	11.31	11.69
84100	6.63	6.85
84105	6.50	6.72
84106	5.99	6.19
84110	11.80	12.19
84119	12.03	12.43
84120	20.55	21.24
84126	35.59	36.78
84127	16.28	16.82
84132	6.42	6.63
84133	6.01	6.21
84134	20.38	21.06
84135	26.73	27.62
84138	26.46	27.34
84140	23.53	24.31
84143	31.89	32.95
84144	29.15	30.12
84146	27.08	27.98
84150	34.88	36.04
84152	25.70	26.56
84153	25.70	26.56
84154	25.70	26.56
84155	5.12	5.29
84156	5.12	5.29
84157	5.12	5.29
84160	7.23	7.47
84165	15.01	15.51
84181	23.80	24.59
84182	25.15	25.99
84202	10.67	11.03
84203	10.67	11.03
84206	18.72	19.34
84207	26.00	26.87
84210	15.17	15.68
84220	7.28	7.52
84228	7.94	8.20
84233	89.99	92.99
84234	90.64	93.66
84235	73.12	75.56
84238	51.09	52.79
84244	30.73	31.75
84252	17.81	18.40
84255	35.67	36.86
84260	21.19	21.90
84270	11.17	11.54
84275	10.28	10.62
84285	32.90	34.00
84295	6.72	6.94
84300	6.79	7.02
84302	6.79	7.02
84305	27.55	28.47
84307	21.61	22.33
84311	9.77	10.10
84315	3.50	3.62
84375	12.22	12.63
84376	7.69	7.95
84377	7.69	7.95
84378	11.17	11.54
84379	11.17	11.54
84392	6.64	6.86
84402	35.57	36.76
84403	36.08	37.28
84425	12.22	12.63
84430	16.26	16.80
84432	22.44	23.19
84436	9.61	9.93
84437	7.94	8.20
84439	12.60	13.02
84442	20.66	21.35
84443	23.47	24.25

Clinical Laboratory Services Fee Schedule (continued)

CODE/MD	60%	62%
84445	24.31	25.12
84446	19.81	20.47
84449	21.05	21.75
84450	7.22	7.46
84460	7.40	7.65
84460QW	7.40	7.65
84466	17.84	18.43
84478	8.04	8.31
84478QW	8.04	8.31
84479	9.04	9.34
84480	19.81	20.47
84481	21.97	22.70
84482	21.97	22.70
84484	13.75	14.21
84485	10.01	10.34
84488	10.01	10.34
84490	10.01	10.34
84510	12.22	12.63
84512	7.58	7.83
84520	5.51	5.69
84525	4.02	4.15
84540	6.64	6.86
84545	9.23	9.54
84550	6.31	6.52
84560	6.64	6.86
84577	17.43	18.01
84578	4.54	4.69
84580	9.92	10.25
84583	7.02	7.25
84585	21.66	22.38
84586	26.81	27.70
84588	47.43	49.01
84590	16.20	16.74
84591	16.20	16.74
84597	9.77	10.10
84600	22.45	23.20
84620	16.55	17.10
84630	15.91	16.44
84681	26.81	27.70
84702	21.03	21.73
84703	10.49	10.84
84703QW	10.49	10.84
84830	14.02	14.49
85002	6.29	6.50
85004	9.04	9.34
85007	4.81	4.97
85008	4.81	4.97
85009	5.19	5.36
85013	3.31	3.42
85014	3.31	3.42
85014QW	3.31	3.42
85018	3.31	3.42
85018QW	3.31	3.42
85025	10.86	11.22
85027	9.04	9.34
85032	6.01	6.21
85041	4.20	4.34
85044	6.01	6.21
85045	5.59	5.78
85046	7.80	8.06
85048	3.55	3.67
85049	6.25	6.46
85055	5.86	6.06
85130	16.62	17.17
85170	5.05	5.22
85175	6.35	6.56
85210	8.12	8.39
85220	24.66	25.48
85230	25.02	25.85
85240	25.02	25.85
85244	28.53	29.48
85245	32.06	33.13
85246	32.06	33.13
85247	32.06	33.13
85250	26.60	27.49
85260	25.02	25.85
85270	25.02	25.85
85280	27.04	27.94
85290	22.83	23.59
85291	12.42	12.83
85292	7.28	7.52
85293	7.28	7.52
85300	8.12	8.39
85301	15.11	15.61
85302	16.80	17.36
85303	19.32	19.96
85305	16.20	16.74
85306	21.41	22.12
85307	21.41	22.12
85335	17.99	18.59
85337	14.56	15.05
85345	6.01	6.21
85347	5.95	6.15
85348	5.20	5.37
85360	11.17	11.54
85362	9.62	9.94
85366	12.03	12.43
85370	14.83	15.32
85378	9.97	10.30
85379	14.22	14.69
85380	14.22	14.69
85384	11.87	12.27
85385	11.87	12.27
85390	6.63	6.85
85400	12.36	12.77
85410	10.77	11.13
85415	13.25	13.69
85420	9.13	9.43
85421	14.23	14.70
85441	5.88	6.08
85445	9.52	9.84
85460	10.81	11.17
85461	9.26	9.57
85475	12.40	12.81
85520	13.25	13.69
85525	13.25	13.69
85530	13.25	13.69
85536	9.04	9.34
85540	12.02	12.42
85547	12.02	12.42
85549	26.21	27.08
85555	9.34	9.65
85557	18.66	19.28
85576	30.01	31.01
85597	25.12	25.96
85610	5.49	5.67
85610QW	5.49	5.67
85611	5.51	5.69
85612	13.37	13.82
85613	13.37	13.82
85635	13.76	14.22
85651	4.96	5.13
85652	3.77	3.90
85660	7.71	7.97
85670	8.07	8.34
85675	6.50	6.72
85705	11.17	11.54
85730	8.38	8.66
85732	9.04	9.34
85810	16.32	16.86
86000	9.75	10.08
86001	7.30	7.54
86003	7.30	7.54
86005	11.14	11.51
86021	21.03	21.73
86022	25.66	26.52
86023	17.40	17.98
86038	16.89	17.45
86039	15.60	16.12
86060	10.20	10.54
86063	8.07	8.34
86140	7.23	7.47
86141	18.09	18.69
86146	23.12	23.89
86147	23.12	23.89
86148	22.44	23.19
86155	22.33	23.07
86156	9.36	9.67
86157	11.27	11.65
86160	16.78	17.34
86161	16.78	17.34
86162	28.39	29.34
86171	14.00	14.47
86185	12.50	12.92
86215	18.51	19.13
86225	19.20	19.84
86226	16.92	17.48
86235	25.06	25.90
86243	28.68	29.64
86255	16.84	17.40
86256	16.84	17.40
86277	21.99	22.72
86280	11.44	11.82
86294	27.41	28.32
86294QW	27.41	28.32
86300	28.50	29.45
86301	28.50	29.45
86304	28.50	29.45
86308	7.23	7.47
86308QW	7.23	7.47

Clinical Laboratory Services Fee Schedule (continued)

CODE/MD	60%	62%
86309	9.04	9.34
86310	10.30	10.64
86316	28.50	29.45
86317	20.95	21.65
86318	18.09	18.69
86318QW	18.09	18.69
86320	31.32	32.36
86325	31.24	32.28
86327	31.70	32.76
86329	19.62	20.27
86331	16.75	17.31
86332	34.05	35.19
86334	31.21	32.25
86336	21.77	22.50
86337	29.92	30.92
86340	21.06	21.76
86341	27.65	28.57
86343	17.41	17.99
86344	11.16	11.53
86353	68.49	70.77
86359	4.47	4.62
86360	9.77	10.10
86361	5.86	6.06
86376	20.33	21.01
86378	27.51	28.43
86382	23.62	24.41
86384	15.91	16.44
86403	14.24	14.71
86406	14.87	15.37
86430	7.93	8.19
86431	7.93	8.19
86590	12.22	12.63
86592	5.96	6.16
86593	6.16	6.37
86602	8.11	8.38
86603	17.98	18.58
86606	21.03	21.73
86609	18.00	18.60
86611	8.11	8.38
86612	18.03	18.63
86615	18.43	19.04
86617	21.64	22.36
86618	21.05	21.75
86618QW	21.05	21.75
86619	18.69	19.31
86622	12.48	12.90
86625	18.33	18.94
86628	11.31	11.69
86631	16.52	17.07
86632	17.74	18.33
86635	16.03	16.56
86638	16.94	17.50
86641	15.86	16.39
86644	20.11	20.78
86645	23.54	24.32
86648	21.25	21.96
86651	18.43	19.04
86652	18.43	19.04
86653	18.43	19.04
86654	18.43	19.04
86658	18.20	18.81
86663	18.33	18.94
86664	21.38	22.09
86665	25.35	26.20
86666	8.11	8.38
86668	14.53	15.01
86671	17.13	17.70
86674	19.64	20.29
86677	20.28	20.96
86682	18.17	18.78
86684	22.14	22.88
86687	11.72	12.11
86688	19.57	20.22
86689	27.05	27.95
86692	23.98	24.78
86694	20.11	20.78
86695	18.43	19.04
86696	27.05	27.95
86698	17.46	18.04
86701	12.41	12.82
86701QW	12.41	12.82
86702	18.88	19.51
86703	19.17	19.81
86704	16.84	17.40
86705	16.44	16.99
86706	15.01	15.51
86707	16.16	16.70
86708	17.31	17.89
86709	15.73	16.25
86710	18.94	19.57
86713	21.39	22.10
86717	17.12	17.69
86720	18.43	19.04
86723	18.43	19.04
86727	17.98	18.58
86729	16.69	17.25
86732	18.43	19.04
86735	18.23	18.84
86738	18.51	19.13
86741	18.43	19.04
86744	18.43	19.04
86747	21.00	21.70
86750	13.00	13.43
86753	17.32	17.90
86756	18.01	18.61
86757	27.05	27.95
86759	18.43	19.04
86762	20.11	20.78
86765	18.00	18.60
86768	16.26	16.80
86771	18.33	18.94
86774	20.68	21.37
86777	20.11	20.78
86778	20.12	20.79
86781	18.50	19.12
86784	11.31	11.69
86787	18.00	18.60
86790	18.00	18.60
86793	18.33	18.94
86800	22.22	22.96
86803	19.94	20.60
86804	21.64	22.36
86805	73.05	75.49
86806	66.49	68.71
86807	55.29	57.13
86808	41.47	42.85
86812	36.06	37.26
86813	81.02	83.72
86816	38.92	40.22
86817	89.95	92.95
86821	78.88	81.51
86822	51.07	52.77
86880	7.50	7.75
86885	7.99	8.26
86886	7.23	7.47
86900	4.17	4.31
86903	8.46	8.74
86904	13.28	13.72
86905	5.34	5.52
86906	10.83	11.19
86940	11.46	11.84
86941	13.27	13.71
87001	18.47	19.09
87003	23.52	24.30
87015	9.33	9.64
87040	14.42	14.90
87045	13.18	13.62
87046	13.18	13.62
87070	12.03	12.43
87071	13.18	13.62
87073	13.18	13.62
87075	13.22	13.66
87076	11.29	11.67
87077	11.29	11.67
87077QW	11.29	11.67
87081	9.26	9.57
87084	12.03	12.43
87086	11.28	11.66
87088	11.31	11.69
87101	10.77	11.13
87102	11.74	12.13
87103	12.60	13.02
87106	14.42	14.90
87107	14.42	14.90
87109	21.50	22.22
87110	23.73	24.52
87116	15.10	15.60
87118	15.29	15.80
87140	7.79	8.05
87143	17.51	18.09
87147	7.23	7.47
87149	17.79	18.38
87152	7.31	7.55
87158	7.31	7.55
87164	15.01	15.51
87166	15.78	16.31
87168	5.96	6.16
87169	5.96	6.16
87172	5.96	6.16
87176	8.22	8.49

Clinical Laboratory Services Fee Schedule (continued)

CODE/MD	60%	62%
87177	12.43	12.84
87181	1.17	1.21
87184	9.63	9.95
87185	1.17	1.21
87186	12.08	12.48
87187	14.48	14.96
87188	8.12	8.39
87190	7.90	8.16
87197	20.99	21.69
87205	5.96	6.16
87206	7.50	7.75
87207	8.37	8.65
87210	5.96	6.16
87210QW	5.96	6.16
87220	5.96	6.16
87230	27.59	28.51
87250	27.32	28.23
87252	36.42	37.63
87253	28.22	29.16
87254	27.32	28.23
87255	47.31	48.89
87260	16.76	17.32
87265	16.76	17.32
87267	16.76	17.32
87269	16.76	17.32
87270	16.76	17.32
87271	16.76	17.32
87272	16.76	17.32
87273	16.76	17.32
87274	16.76	17.32
87275	16.76	17.32
87276	16.76	17.32
87277	16.76	17.32
87278	16.76	17.32
87279	16.76	17.32
87280	16.76	17.32
87281	16.76	17.32
87283	16.76	17.32
87285	16.76	17.32
87290	16.76	17.32
87299	16.76	17.32
87300	16.76	17.32
87301	16.76	17.32
87320	16.76	17.32
87324	16.76	17.32
87327	16.76	17.32
87328	16.76	17.32
87329	16.76	17.32
87332	16.76	17.32
87335	16.76	17.32
87336	16.76	17.32
87337	16.76	17.32
87338	17.19	17.76
87339	16.76	17.32
87340	14.43	14.91
87341	14.43	14.91
87350	16.10	16.64
87380	22.94	23.70
87385	16.76	17.32
87390	15.61	16.13
87391	15.61	16.13
87400	16.76	17.32
87420	16.76	17.32
87425	16.76	17.32
87427	16.76	17.32
87430	16.76	17.32
87449	16.76	17.32
87449QW	16.76	17.32
87450	13.39	13.84
87451	13.39	13.84
87470	17.79	18.38
87471	41.65	43.04
87472	59.85	61.85
87475	17.79	18.38
87476	41.65	43.04
87477	59.85	61.85
87480	17.79	18.38
87481	41.65	43.04
87482	58.33	60.27
87485	17.79	18.38
87486	41.65	43.04
87487	59.85	61.85
87490	17.79	18.38
87491	41.65	43.04
87492	48.84	50.47
87495	17.79	18.38
87496	41.65	43.04
87497	59.85	61.85
87510	17.79	18.38
87511	41.65	43.04
87512	58.33	60.27
87515	17.79	18.38
87516	41.65	43.04
87517	59.85	61.85
87520	17.79	18.38
87521	41.65	43.04
87522	59.85	61.85
87525	17.79	18.38
87526	41.65	43.04
87527	58.33	60.27
87528	17.79	18.38
87529	41.65	43.04
87530	59.85	61.85
87531	17.79	18.38
87532	41.65	43.04
87533	58.33	60.27
87534	17.79	18.38
87535	41.65	43.04
87536	98.47	101.75
87537	17.79	18.38
87538	41.65	43.04
87539	59.85	61.85
87540	17.79	18.38
87541	41.65	43.04
87542	58.33	60.27
87550	17.79	18.38
87551	41.65	43.04
87552	59.85	61.85
87555	17.79	18.38
87556	41.65	43.04
87557	59.85	61.85
87560	17.79	18.38
87561	41.65	43.04
87562	59.85	61.85
87580	17.79	18.38
87581	41.65	43.04
87582	58.33	60.27
87590	17.79	18.38
87591	41.65	43.04
87592	59.85	61.85
87620	17.79	18.38
87621	41.65	43.04
87622	58.33	60.27
87650	17.79	18.38
87651	41.65	43.04
87652	58.33	60.27
87660	17.79	18.38
87797	17.79	18.38
87798	41.65	43.04
87799	59.85	61.85
87800	35.58	36.77
87801	83.30	86.08
87802	16.76	17.32
87803	16.76	17.32
87804	16.76	17.32
87804QW	16.76	17.32
87810	16.76	17.32
87850	16.76	17.32
87880	16.76	17.32
87880QW	16.76	17.32
87899	16.76	17.32
87899QW	16.76	17.32
87901	359.69	371.68
87902	359.69	371.68
87903	682.72	705.48
87904	36.42	37.63
88130	21.02	21.72
88140	11.17	11.54
88142	28.21	29.15
88143	28.21	29.15
88147	14.76	14.76
88148	14.76	14.76
88150	14.76	14.76
88152	14.76	14.76
88153	14.76	14.76
88154	14.76	14.76
88155	8.37	8.65
88164	14.76	14.76
88165	14.76	14.76
88166	14.76	14.76
88167	14.76	14.76
88174	29.39	30.37
88175	34.70	35.86
88230	162.77	168.20
88233	196.63	203.18
88235	205.74	212.60
88237	176.47	182.35
88239	206.12	212.99
88240	14.11	14.58
88241	14.11	14.58

Clinical Laboratory Services Fee Schedule (continued)

CODE/MD	60%	62%
88245	190.23	196.57
88248	241.96	250.03
88249	241.96	250.03
88261	246.93	255.16
88262	174.14	179.94
88263	190.23	196.57
88264	174.14	179.94
88267	251.17	259.54
88269	190.23	196.57
88271	20.22	20.89
88272	35.39	36.57
88273	44.89	46.39
88274	48.63	50.25
88275	56.11	57.98
88280	35.07	36.24
88283	95.84	99.03
88285	26.54	27.42
88289	40.56	41.91
88371	31.05	32.09
88372	31.79	32.85
88400	7.02	7.25
89050	6.61	6.83
89051	7.70	7.96
89055	5.96	6.16
89060	9.99	10.32
89125	6.03	6.23
89160	5.15	5.32
89190	6.64	6.86
89225	4.67	4.83
89235	7.69	7.95
89300	12.45	12.87
89300QW	12.45	12.87
89310	12.03	12.43
89320	16.84	17.40
89321	16.84	17.40
89325	14.91	15.41
89329	29.30	30.28
89330	13.83	14.29
89355	4.67	4.83
89365	7.69	7.95

MAMMOGRAPHY SERVICES

The following fee schedules are effective for mammography services furnished **on or after January 1, 2004.** Inclusion or exclusion of a specific fee schedule does not represent a determination that the Medicare program either covers or does not cover that service.

CODE/MD	LOC 01/02	LOC 03	LOC 04
G0202TC	93.74	101.98	106.82
G0204TC	92.32	100.46	105.25
G0206TC	74.19	80.79	84.72
76082TC	14.96	16.25	17.00
76083TC	14.96	16.25	17.00
76090TC	14.96	16.25	17.00
76091TC	49.58	54.47	57.73
76092TC	46.76	51.43	54.58

SKILLED NURSING FACILITY SERVICES

The following fee schedules are effective for radiology, other diagnostic and other skilled nursing facility services furnished **on or after January 1, 2004.** Inclusion or exclusion of a specific fee schedule does not represent a determination that the Medicare program either covers or does not cover that service.

CODE/MOD	FEE 01/02	FEE 03	FEE 04	PC/TC
G0106TC	85.27	93.83	99.63	1
G0117	42.83	45.13	46.73	0
G0118	25.19	26.78	27.76	0
G0120TC	85.27	93.83	99.63	1
G0124	22.51	23.19	23.88	0
G0130TC	30.98	34.13	36.29	1
Q0091	37.60	39.57	40.84	0
Q0092	11.78	12.83	13.46	3
33967	262.15	273.75	286.54	0
33968	35.81	37.98	40.45	0
36260	592.53	629.29	668.45	0
36261	360.80	382.33	403.67	0
36262	272.18	289.76	307.35	0
36489	241.48	254.35	263.17	0
36491	87.46	92.59	97.98	0
36530	392.23	415.30	438.86	0
36531	319.93	338.89	357.74	0
36532	195.61	207.63	220.70	0
36533	698.44	745.88	779.24	0
36534	166.30	174.65	183.28	0
36535	194.43	206.75	217.22	0
36550	31.29	39.55	48.46	9
36823	1242.32	1319.07	1402.65	0
37195	307.17	337.86	358.58	5
62252TC	40.15	43.53	45.39	1
70010TC	163.71	179.66	190.18	1
70015TC	51.82	57.04	60.59	1
70030TC	15.43	16.92	17.90	1
70100TC	19.31	21.10	22.22	1
70110TC	23.79	26.24	27.94	1

Skilled Nursing Facility Service Fee Schedule (continued)

CODE/ MOD	FEE 01/02	FEE 03	FEE 04	PC/ TC
70120TC	23.79	26.24	27.94	1
70130TC	30.27	33.37	35.51	1
70134TC	28.50	31.47	33.55	1
70140TC	23.79	26.24	27.94	1
70150TC	30.27	33.37	35.51	1
70160TC	19.31	21.10	22.22	1
70170TC	36.40	40.12	42.69	1
70190TC	23.79	26.24	27.94	1
70200TC	30.27	33.37	35.51	1
70210TC	23.79	26.24	27.94	1
70220TC	30.27	33.37	35.51	1
70240TC	15.43	16.92	17.90	1
70250TC	23.79	26.24	27.94	1
70260TC	34.28	37.84	40.33	1
70300TC	10.48	11.60	12.40	1
70310TC	15.43	16.92	17.90	1
70320TC	30.27	33.37	35.51	1
70328TC	18.25	19.96	21.04	1
70330TC	32.39	35.65	37.87	1
70332TC	79.86	87.84	93.23	1
70336TC	424.94	466.66	494.34	1
70350TC	14.02	15.40	16.32	1
70355TC	22.03	24.34	25.97	1
70360TC	15.43	16.92	17.90	1
70370TC	49.58	54.47	57.73	1
70371TC	79.86	87.84	93.23	1
70373TC	68.43	75.39	80.16	1
70380TC	25.56	28.14	29.90	1
70390TC	68.43	75.39	80.16	1
70450TC	179.26	196.87	208.58	1
70460TC	214.47	235.56	249.58	1
70470TC	268.30	294.60	312.02	1
70480TC	179.26	196.87	208.58	1
70481TC	214.47	235.56	249.58	1
70482TC	268.30	294.60	312.02	1
70486TC	179.26	196.87	208.58	1
70487TC	214.47	235.56	249.58	1
70488TC	268.30	294.60	312.02	1
70490TC	179.26	196.87	208.58	1
70491TC	214.47	235.56	249.58	1
70492TC	268.30	294.60	312.02	1
70496TC	403.63	443.56	470.27	1
70498TC	403.63	443.56	470.27	1
70540TC	415.47	453.29	476.43	1
70542TC	498.73	544.16	571.97	1
70543TC	922.09	1005.62	1056.43	1
70544TC	424.94	466.66	494.34	1
70545TC	424.94	466.66	494.34	1
70546TC	822.31	894.27	936.23	1
70547TC	424.94	466.66	494.34	1
70548TC	424.94	466.66	494.34	1
70549TC	822.31	894.27	936.23	1
70551TC	424.94	466.66	494.34	1
70552TC	509.62	559.53	592.57	1
70553TC	944.34	1037.03	1098.53	1
71010TC	17.55	19.20	20.25	1
71015TC	19.31	21.10	22.22	1
71020TC	23.79	26.24	27.94	1
71021TC	28.50	31.47	33.55	1
71022TC	28.50	31.47	33.55	1
71023TC	30.27	33.37	35.51	1
71030TC	30.27	33.37	35.51	1
71034TC	54.65	60.08	63.73	1
71035TC	19.31	21.10	22.22	1
71040TC	55.36	60.84	64.51	1
71060TC	84.21	92.69	98.45	1
71090TC	64.90	71.59	76.23	1
71100TC	22.03	24.34	25.97	1
71101TC	25.56	28.14	29.90	1
71110TC	30.27	33.37	35.51	1
71111TC	34.28	37.84	40.33	1
71120TC	24.85	27.38	29.11	1
71130TC	26.97	29.66	31.47	1
71250TC	224.13	246.11	260.69	1
71260TC	268.30	294.60	312.02	1
71270TC	335.43	368.27	390.00	1
71275TC	457.15	498.14	522.78	1
71550TC	418.31	457.30	481.80	1
71551TC	501.10	547.50	576.45	1
71552TC	914.52	994.92	1042.10	1
71555TC	424.94	466.66	494.34	1
72010TC	39.22	43.16	45.83	1
72020TC	15.43	16.92	17.90	1
72040TC	23.09	25.48	27.15	1
72050TC	34.28	37.84	40.33	1
72052TC	42.75	46.96	49.76	1
72069TC	18.25	19.96	21.04	1
72070TC	24.85	27.38	29.11	1
72072TC	28.50	31.47	33.55	1
72074TC	34.98	38.60	41.12	1
72080TC	25.56	28.14	29.90	1
72090TC	25.56	28.14	29.90	1
72100TC	25.56	28.14	29.90	1
72110TC	34.98	38.60	41.12	1
72114TC	44.87	49.24	52.12	1
72120TC	34.28	37.84	40.33	1
72125TC	224.13	246.11	260.69	1
72126TC	268.30	294.60	312.02	1
72127TC	335.43	368.27	390.00	1
72128TC	224.13	246.11	260.69	1
72129TC	268.30	294.60	312.02	1
72130TC	335.43	368.27	390.00	1
72131TC	224.13	246.11	260.69	1
72132TC	268.30	294.60	312.02	1
72133TC	335.43	368.27	390.00	1
72141TC	424.94	466.66	494.34	1
72142TC	509.62	559.53	592.57	1
72146TC	471.11	517.13	547.53	1
72147TC	509.62	559.53	592.57	1
72148TC	471.11	517.13	547.53	1
72149TC	509.62	559.53	592.57	1
72156TC	944.34	1037.03	1098.53	1
72157TC	944.34	1037.03	1098.53	1
72158TC	944.34	1037.03	1098.53	1
72170TC	19.31	21.10	22.22	1
72190TC	25.56	28.14	29.90	1
72191TC	444.79	484.84	509.03	1
72192TC	224.13	246.11	260.69	1
72193TC	259.70	285.19	302.09	1
72194TC	321.29	352.58	373.17	1

Skilled Nursing Facility Service Fee Schedule (continued)

CODE/ MOD	FEE 01/02	FEE 03	FEE 04	PC/ TC
72195TC	418.31	457.30	481.80	1
72196TC	501.10	547.50	576.45	1
72197TC	925.88	1010.96	1063.59	1
72198TC	424.94	466.66	494.34	1
72200TC	19.31	21.10	22.22	1
72202TC	23.79	26.24	27.94	1
72220TC	22.03	24.34	25.97	1
72240TC	180.32	198.01	209.75	1
72255TC	163.71	179.66	190.18	1
72265TC	154.88	170.16	180.36	1
72270TC	231.79	254.67	269.95	1
72275TC	84.59	94.52	102.19	1
72285TC	317.41	348.40	368.85	1
72295TC	297.27	326.25	345.35	1
73000TC	19.31	21.10	22.22	1
73010TC	19.31	21.10	22.22	1
73020TC	17.55	19.20	20.25	1
73030TC	22.03	24.34	25.97	1
73040TC	79.86	87.84	93.23	1
73050TC	25.56	28.14	29.90	1
73060TC	22.03	24.34	25.97	1
73070TC	19.31	21.10	22.22	1
73080TC	22.03	24.34	25.97	1
73085TC	79.86	87.84	93.23	1
73090TC	19.31	21.10	22.22	1
73092TC	18.25	19.96	21.04	1
73100TC	18.25	19.96	21.04	1
73110TC	19.67	21.48	22.61	1
73115TC	60.54	66.74	71.02	1
73120TC	18.25	19.96	21.04	1
73130TC	19.67	21.48	22.61	1
73140TC	15.43	16.92	17.90	1
73200TC	187.38	205.62	217.61	1
73201TC	224.13	246.11	260.69	1
73202TC	281.61	309.24	327.56	1
73206TC	407.00	444.17	467.00	1
73218TC	415.47	453.29	476.43	1
73219TC	498.73	544.16	571.97	1
73220TC	922.09	1005.62	1056.43	1
73221TC	415.47	453.29	476.43	1
73222TC	498.73	544.16	571.97	1
73223TC	922.09	1005.62	1056.43	1
73500TC	17.55	19.20	20.25	1
73510TC	22.03	24.34	25.97	1
73520TC	25.56	28.14	29.90	1
73525TC	79.86	87.84	93.23	1
73530TC	19.31	21.10	22.22	1
73540TC	22.03	24.34	25.97	1
73542TC	79.86	87.84	93.23	1
73550TC	22.03	24.34	25.97	1
73560TC	19.31	21.10	22.22	1
73562TC	22.03	24.34	25.97	1
73564TC	23.79	26.24	27.94	1
73565TC	18.25	19.96	21.04	1
73580TC	99.17	108.94	115.45	1
73590TC	19.31	21.10	22.22	1
73592TC	18.25	19.96	21.04	1
73600TC	18.25	19.96	21.04	1
73610TC	19.67	21.48	22.61	1
73615TC	79.86	87.84	93.23	1
73620TC	18.25	19.96	21.04	1
73630TC	19.67	21.48	22.61	1
73650TC	17.55	19.20	20.25	1
73660TC	15.43	16.92	17.90	1
73700TC	187.38	205.62	217.61	1
73701TC	224.13	246.11	260.69	1
73702TC	281.61	309.24	327.56	1
73706TC	407.00	444.17	467.00	1
73718TC	415.47	453.29	476.43	1
73719TC	498.73	544.16	571.97	1
73720TC	922.09	1005.62	1056.43	1
73721TC	415.47	453.29	476.43	1
73722TC	498.73	544.16	571.97	1
73723TC	922.09	1005.62	1056.43	1
73725TC	424.94	466.66	494.34	1
74000TC	19.31	21.10	22.22	1
74010TC	22.03	24.34	25.97	1
74020TC	23.79	26.24	27.94	1
74022TC	28.50	31.47	33.55	1
74150TC	214.47	235.56	249.58	1
74160TC	259.70	285.19	302.09	1
74170TC	321.29	352.58	373.17	1
74175TC	444.79	484.84	509.03	1
74181TC	418.31	457.30	481.80	1
74182TC	501.10	547.50	576.45	1
74183TC	925.88	1010.96	1063.59	1
74185TC	424.94	466.66	494.34	1
74190TC	49.58	54.47	57.73	1
74210TC	44.87	49.24	52.12	1
74220TC	44.87	49.24	52.12	1
74230TC	49.58	54.47	57.73	1
74235TC	99.17	108.94	115.45	1
74240TC	55.36	60.84	64.51	1
74241TC	56.42	61.98	65.69	1
74245TC	90.57	99.53	105.52	1
74246TC	63.01	69.40	73.77	1
74247TC	64.90	71.59	76.23	1
74249TC	98.11	107.80	114.27	1
74250TC	49.58	54.47	57.73	1
74251TC	49.58	54.47	57.73	1
74260TC	56.42	61.98	65.69	1
74270TC	65.61	72.35	77.02	1
74280TC	85.27	93.83	99.63	1
74283TC	97.76	107.42	113.88	1
74290TC	28.50	31.47	33.55	1
74291TC	15.43	16.92	17.90	1
74305TC	30.27	33.37	35.51	1
74320TC	120.02	131.85	139.74	1
74327TC	67.73	74.63	79.38	1
74328TC	120.02	131.85	139.74	1
74329TC	120.02	131.85	139.74	1
74330TC	120.02	131.85	139.74	1
74340TC	99.17	108.94	115.45	1
74350TC	120.02	131.85	139.74	1
74355TC	99.17	108.94	115.45	1
74360TC	120.02	131.85	139.74	1
74363TC	231.79	254.67	269.95	1
74400TC	64.90	71.59	76.23	1
74410TC	74.44	81.85	86.84	1
74415TC	80.56	88.60	94.02	1

Skilled Nursing Facility Service Fee Schedule (continued)

CODE/ MOD	FEE 01/02	FEE 03	FEE 04	PC/ TC
74420TC	99.17	108.94	115.45	1
74425TC	49.58	54.47	57.73	1
74430TC	40.28	44.30	47.01	1
74440TC	42.75	46.96	49.76	1
74445TC	42.75	46.96	49.76	1
74450TC	55.36	60.84	64.51	1
74455TC	60.54	66.74	71.02	1
74470TC	47.47	52.19	55.37	1
74475TC	154.88	170.16	180.36	1
74480TC	154.88	170.16	180.36	1
74485TC	120.02	131.85	139.74	1
74710TC	40.28	44.30	47.01	1
74740TC	49.58	54.47	57.73	1
74742TC	120.02	131.85	139.74	1
74775TC	55.36	60.84	64.51	1
75552TC	424.94	466.66	494.34	1
75553TC	424.94	466.66	494.34	1
75554TC	424.94	466.66	494.34	1
75555TC	424.94	466.66	494.34	1
75600TC	477.23	523.88	554.71	1
75605TC	477.23	523.88	554.71	1
75625TC	477.23	523.88	554.71	1
75630TC	497.85	546.70	579.11	1
75635TC	582.54	633.08	662.22	1
75650TC	477.23	523.88	554.71	1
75658TC	477.23	523.88	554.71	1
75660TC	477.23	523.88	554.71	1
75662TC	477.23	523.88	554.71	1
75665TC	477.23	523.88	554.71	1
75671TC	477.23	523.88	554.71	1
75676TC	477.23	523.88	554.71	1
75680TC	477.23	523.88	554.71	1
75685TC	477.23	523.88	554.71	1
75705TC	477.23	523.88	554.71	1
75710TC	477.23	523.88	554.71	1
75716TC	477.23	523.88	554.71	1
75722TC	477.23	523.88	554.71	1
75724TC	477.23	523.88	554.71	1
75726TC	477.23	523.88	554.71	1
75731TC	477.23	523.88	554.71	1
75733TC	477.23	523.88	554.71	1
75736TC	477.23	523.88	554.71	1
75741TC	477.23	523.88	554.71	1
75743TC	477.23	523.88	554.71	1
75746TC	477.23	523.88	554.71	1
75756TC	477.23	523.88	554.71	1
75774TC	477.23	523.88	554.71	1
75790TC	51.82	57.04	60.59	1
75801TC	205.88	226.15	239.65	1
75803TC	205.88	226.15	239.65	1
75805TC	231.79	254.67	269.95	1
75807TC	231.79	254.67	269.95	1
75809TC	30.27	33.37	35.51	1
75810TC	477.23	523.88	554.71	1
75820TC	36.40	40.12	42.69	1
75822TC	56.06	61.60	65.30	1
75825TC	477.23	523.88	554.71	1
75827TC	477.23	523.88	554.71	1
75831TC	477.23	523.88	554.71	1
75833TC	477.23	523.88	554.71	1
75840TC	477.23	523.88	554.71	1
75842TC	477.23	523.88	554.71	1
75860TC	477.23	523.88	554.71	1
75870TC	477.23	523.88	554.71	1
75872TC	477.23	523.88	554.71	1
75880TC	36.40	40.12	42.69	1
75885TC	477.23	523.88	554.71	1
75887TC	477.23	523.88	554.71	1
75889TC	477.23	523.88	554.71	1
75891TC	477.23	523.88	554.71	1
75893TC	477.23	523.88	554.71	1
75894TC	915.61	1005.47	1065.09	1
75896TC	795.94	874.00	925.74	1
75898TC	40.28	44.30	47.01	1
75900TC	795.71	873.90	925.85	1
75940TC	477.23	523.88	554.71	1
75945TC	173.13	190.12	201.39	1
75946TC	87.39	96.11	101.99	1
75960TC	564.51	619.70	656.19	1
75961TC	398.32	437.38	463.26	1
75962TC	597.37	656.02	694.95	1
75964TC	317.76	348.78	369.24	1
75966TC	597.37	656.02	694.95	1
75968TC	317.76	348.78	369.24	1
75970TC	437.78	480.63	508.99	1
75978TC	597.37	656.02	694.95	1
75980TC	205.88	226.15	239.65	1
75982TC	231.79	254.67	269.95	1
75984TC	74.44	81.85	86.84	1
75989TC	120.02	131.85	139.74	1
75992TC	597.37	656.02	694.95	1
75993TC	317.76	348.78	369.24	1
75994TC	597.37	656.02	694.95	1
75995TC	597.37	656.02	694.95	1
75996TC	317.76	348.78	369.24	1
75998TC	51.01	56.48	60.41	1
76000TC	49.58	54.47	57.73	1
76001TC	99.17	108.94	115.45	1
76003TC	49.58	54.47	57.73	1
76005TC	49.58	54.47	57.73	1
76010TC	19.31	21.10	22.22	1
76020TC	19.31	21.10	22.22	1
76040TC	30.27	33.37	35.51	1
76061TC	38.16	42.02	44.65	1
76062TC	54.65	60.08	63.73	1
76065TC	28.50	31.47	33.55	1
76066TC	42.40	46.58	49.37	1
76075TC	117.90	129.57	137.38	1
76076TC	29.21	32.23	34.33	1
76078TC	29.21	32.23	34.33	1
76080TC	40.28	44.30	47.01	1
76086TC	99.17	108.94	115.45	1
76088TC	138.98	152.57	161.57	1
76093TC	668.03	733.49	776.86	1
76094TC	906.06	994.72	1053.37	1
76095TC	271.48	298.02	315.56	1
76096TC	49.58	54.47	57.73	1
76098TC	15.43	16.92	17.90	1
76100TC	47.47	52.19	55.37	1
76101TC	54.30	59.70	63.33	1

Skilled Nursing Facility Service Fee Schedule (continued)

CODE/ MOD	FEE 01/02	FEE 03	FEE 04	PC/ TC
76102TC	66.67	73.49	78.20	1
76120TC	40.28	44.30	47.01	1
76125TC	30.27	33.37	35.51	1
76150	15.43	16.92	17.90	3
76355TC	312.70	343.17	363.24	1
76360TC	312.70	343.17	363.24	1
76362TC	361.93	412.68	456.40	1
76370TC	112.13	123.20	130.60	1
76375TC	133.91	146.96	155.56	1
76380TC	132.50	145.44	153.99	1
76394TC	470.87	531.49	581.23	1
76400TC	424.94	466.66	494.34	1
76490TC	66.36	76.02	84.50	1
76506TC	54.30	59.70	63.33	1
76511TC	27.69	30.90	33.37	1
76512TC	30.17	34.05	37.24	1
76513TC	32.99	37.09	40.38	1
76514TC	2.59	2.95	3.25	1
76516TC	20.27	22.92	25.12	1
76519TC	23.09	25.96	28.27	1
76529TC	22.15	25.11	27.59	1
76536TC	54.30	59.70	63.33	1
76604TC	49.58	54.47	57.73	1
76645TC	40.28	44.30	47.01	1
76700TC	75.14	82.61	87.63	1
76705TC	54.30	59.70	63.33	1
76770TC	75.14	82.61	87.63	1
76775TC	54.30	59.70	63.33	1
76778TC	75.14	82.61	87.63	1
76800TC	54.30	59.70	63.33	1
76802TC	43.12	48.31	52.38	1
76805TC	79.86	87.84	93.23	1
76810TC	47.86	54.99	61.34	1
76815TC	54.30	59.70	63.33	1
76816TC	42.40	46.58	49.37	1
76818TC	61.95	68.26	72.59	1
76819TC	61.95	68.26	72.59	1
76825TC	75.14	82.61	87.63	1
76826TC	27.45	30.33	32.37	1
76827TC	66.79	73.78	78.70	1
76828TC	43.35	47.92	51.16	1
76830TC	58.42	64.46	68.66	1
76831TC	58.42	64.46	68.66	1
76856TC	58.42	64.46	68.66	1
76857TC	58.29	63.68	67.04	1
76870TC	58.42	64.46	68.66	1
76872TC	70.43	77.38	82.02	1
76873TC	81.75	90.51	96.82	1
76880TC	54.30	59.70	63.33	1
76885TC	58.42	64.46	68.66	1
76886TC	54.30	59.70	63.33	1
76930TC	58.42	64.46	68.66	1
76932TC	58.42	64.46	68.66	1
76936TC	239.33	262.94	278.70	1
76937TC	17.80	20.75	23.49	1
76940TC	67.42	77.16	85.68	1
76941TC	57.83	63.50	67.26	1
76942TC	94.45	103.23	108.73	1
76945TC	57.83	63.50	67.26	1
76946TC	58.42	64.46	68.66	1
76948TC	58.42	64.46	68.66	1
76950TC	49.58	54.47	57.73	1
76965TC	211.18	231.85	245.55	1
76970TC	40.28	44.30	47.01	1
76975TC	58.42	64.46	68.66	1
76977TC	31.68	34.89	37.08	1
76986TC	99.17	108.94	115.45	1
77280TC	131.44	144.30	152.81	1
77285TC	211.65	232.52	246.44	1
77290TC	247.22	271.59	287.84	1
77295TC	1060.12	1164.32	1233.56	1
77300TC	51.00	55.99	59.30	1
77301TC	1060.12	1164.32	1233.56	1
77305TC	71.26	78.43	83.30	1
77310TC	88.81	97.63	103.56	1
77315TC	100.58	110.46	117.02	1
77321TC	153.35	168.35	178.28	1
77326TC	89.87	98.77	104.74	1
77327TC	131.44	144.30	152.81	1
77328TC	187.38	205.62	217.61	1
77331TC	18.61	20.34	21.43	1
77332TC	51.00	55.99	59.30	1
77333TC	72.32	79.57	84.48	1
77334TC	123.20	135.27	143.28	1
77600TC	115.66	127.00	134.53	1
77605TC	154.53	169.78	179.96	1
77610TC	115.66	127.00	134.53	1
77615TC	154.53	169.78	179.96	1
77620TC	115.66	127.00	134.53	1
77750TC	50.64	55.61	58.90	1
77761TC	95.64	105.14	111.52	1
77762TC	136.86	150.29	159.21	1
77763TC	169.83	186.41	197.36	1
77776TC	83.15	91.55	97.27	1
77777TC	160.53	176.24	186.64	1
77778TC	194.69	213.79	226.47	1
77781TC	770.03	845.48	895.45	1
77782TC	770.03	845.48	895.45	1
77783TC	770.03	845.48	895.45	1
77784TC	770.03	845.48	895.45	1
77789TC	16.84	18.44	19.47	1
77790TC	18.61	20.34	21.43	1
78000TC	37.10	40.88	43.47	1
78001TC	49.58	54.47	57.73	1
78003TC	37.10	40.88	43.47	1
78006TC	90.57	99.53	105.52	1
78007TC	98.11	107.80	114.27	1
78010TC	69.85	76.91	81.73	1
78011TC	91.63	100.67	106.70	1
78015TC	98.11	107.80	114.27	1
78016TC	131.79	144.68	153.21	1
78018TC	206.23	226.53	240.05	1
78020TC	52.90	59.15	64.00	1
78070TC	69.85	76.91	81.73	1
78075TC	206.23	226.53	240.05	1
78102TC	77.74	85.56	90.88	1
78103TC	120.37	132.23	140.13	1
78104TC	154.88	170.16	180.36	1
78110TC	36.40	40.12	42.69	1
78111TC	98.11	107.80	114.27	1

Skilled Nursing Facility Service Fee Schedule (continued)

CODE/ MOD	FEE 01/02	FEE 03	FEE 04	PC/ TC
78120TC	66.67	73.49	78.20	1
78121TC	109.77	120.34	127.23	1
78122TC	174.55	191.64	202.97	1
78130TC	107.65	118.06	124.88	1
78135TC	184.56	202.57	214.47	1
78140TC	149.46	164.17	173.96	1
78160TC	138.98	152.57	161.57	1
78162TC	121.43	133.37	141.31	1
78170TC	201.52	221.30	234.44	1
78185TC	89.87	98.77	104.74	1
78190TC	216.59	237.84	251.94	1
78191TC	277.48	304.48	322.23	1
78195TC	154.88	170.16	180.36	1
78201TC	89.87	98.77	104.74	1
78202TC	108.71	119.20	126.06	1
78205TC	224.13	246.11	260.69	1
78206TC	214.66	232.75	242.78	1
78215TC	110.83	121.48	128.41	1
78216TC	131.79	144.68	153.21	1
78220TC	141.10	154.85	163.92	1
78223TC	138.98	152.57	161.57	1
78230TC	83.15	91.55	97.27	1
78231TC	120.37	132.23	140.13	1
78232TC	133.91	146.96	155.56	1
78258TC	108.71	119.20	126.06	1
78261TC	155.59	170.92	181.14	1
78262TC	161.24	177.00	187.43	1
78264TC	156.65	172.06	182.32	1
78270TC	59.48	65.60	69.84	1
78271TC	63.01	69.40	73.77	1
78272TC	88.45	97.25	103.16	1
78278TC	184.56	202.57	214.47	1
78290TC	115.66	127.00	134.53	1
78291TC	116.36	127.76	135.31	1
78300TC	94.93	104.38	110.74	1
78305TC	138.98	152.57	161.57	1
78306TC	161.94	177.76	188.21	1
78315TC	181.38	199.15	210.93	1
78320TC	224.13	246.11	260.69	1
78350TC	29.21	32.23	34.33	1
78428TC	85.98	94.59	100.41	1
78445TC	71.26	78.43	83.30	1
78455TC	151.23	166.07	175.93	1
78456TC	155.01	171.42	183.09	1
78457TC	100.58	110.46	117.02	1
78458TC	152.64	167.59	177.50	1
78460TC	89.87	98.77	104.74	1
78461TC	179.26	196.87	208.58	1
78464TC	268.30	294.60	312.02	1
78465TC	447.20	491.09	520.20	1
78466TC	99.17	108.94	115.45	1
78468TC	138.98	152.57	161.57	1
78469TC	198.34	217.88	230.90	1
78472TC	209.53	230.24	244.08	1
78473TC	312.70	343.17	363.24	1
78478TC	59.84	65.98	70.23	1
78480TC	59.84	65.98	70.23	1
78481TC	198.34	217.88	230.90	1
78483TC	298.10	327.30	346.64	1
78494TC	264.98	289.92	305.75	1
78496TC	264.98	289.92	305.75	1
78580TC	130.03	142.78	151.24	1
78584TC	121.43	133.37	141.31	1
78585TC	213.77	234.80	248.80	1
78586TC	98.46	108.18	114.67	1
78587TC	105.88	116.16	122.91	1
78588TC	121.90	134.04	142.21	1
78591TC	107.65	118.06	124.88	1
78593TC	130.73	143.54	152.03	1
78594TC	188.09	206.38	218.40	1
78596TC	268.30	294.60	312.02	1
78600TC	108.71	119.20	126.06	1
78601TC	128.97	141.64	150.06	1
78605TC	128.97	141.64	150.06	1
78606TC	146.99	161.51	171.21	1
78607TC	248.98	273.49	289.81	1
78610TC	60.54	66.74	71.02	1
78615TC	146.28	160.75	170.43	1
78630TC	191.15	209.99	222.54	1
78635TC	97.05	106.66	113.09	1
78645TC	130.03	142.78	151.24	1
78647TC	224.13	246.11	260.69	1
78650TC	175.96	193.16	204.54	1
78660TC	80.56	88.60	94.02	1
78700TC	115.66	127.00	134.53	1
78701TC	134.62	147.72	156.35	1
78704TC	150.17	164.93	174.75	1
78707TC	169.13	185.65	196.57	1
78708TC	169.13	185.65	196.57	1
78709TC	169.13	185.65	196.57	1
78710TC	224.13	246.11	260.69	1
78715TC	60.54	66.74	71.02	1
78725TC	68.43	75.39	80.16	1
78730TC	55.36	60.84	64.51	1
78740TC	80.56	88.60	94.02	1
78760TC	101.29	111.22	117.81	1
78761TC	121.43	133.37	141.31	1
78800TC	128.97	141.64	150.06	1
78801TC	160.18	175.86	186.25	1
78802TC	210.24	231.00	244.87	1
78803TC	248.98	273.49	289.81	1
78804TC	165.73	183.11	195.38	1
78805TC	128.97	141.64	150.06	1
78806TC	244.39	268.55	284.70	1
78807TC	248.98	273.49	289.81	1
79000TC	99.17	108.94	115.45	1
79001TC	49.58	54.47	57.73	1
79020TC	99.17	108.94	115.45	1
79030TC	99.17	108.94	115.45	1
79035TC	99.17	108.94	115.45	1
79100TC	99.17	108.94	115.45	1
79200TC	99.17	108.94	115.45	1
79400TC	99.17	108.94	115.45	1
79403TC	158.16	172.42	181.05	1
79440TC	99.17	108.94	115.45	1
85060	24.81	25.74	26.70	8
85396	21.71	22.95	24.28	0
86490	11.19	12.36	13.18	3
86510	12.25	13.50	14.36	3
86580	10.13	11.22	12.00	3

Skilled Nursing Facility Service Fee Schedule (continued)

CODE/ MOD	FEE 01/02	FEE 03	FEE 04	PC/ TC
86585	7.89	8.65	9.14	3
88104TC	18.61	20.34	21.43	1
88106TC	14.02	15.40	16.32	1
88107TC	23.55	25.66	26.93	1
88108TC	20.73	22.62	23.79	1
88125TC	5.42	5.99	6.39	1
88160TC	25.67	27.94	29.29	1
88161TC	24.26	26.42	27.72	1
88162TC	12.96	14.26	15.15	1
88172TC	14.72	16.16	17.11	1
88173TC	41.57	45.05	46.96	1
88180TC	45.80	49.61	51.68	1
88182TC	46.05	50.19	52.68	1
88300TC	8.95	9.79	10.32	1
88302TC	23.20	25.28	26.54	1
88304TC	28.14	30.60	32.04	1
88305TC	51.34	55.89	58.57	1
88307TC	72.07	78.51	82.36	1
88309TC	82.31	89.53	93.75	1
88311TC	3.65	4.09	4.43	1
88312TC	39.68	42.86	44.50	1
88313TC	35.09	37.92	39.39	1
88314TC	25.32	27.56	28.89	1
88318TC	22.02	23.85	24.86	1
88319TC	59.58	64.43	66.99	1
88323TC	30.97	33.64	35.18	1
88342TC	35.56	38.59	40.28	1
88346TC	38.74	42.01	43.82	1
88347TC	50.40	54.55	56.78	1
88348TC	279.53	301.91	313.43	1
88349TC	343.69	370.80	384.42	1
88355TC	66.42	72.43	76.08	1
88356TC	59.83	65.49	69.12	1
88358TC	8.61	10.38	12.16	1
88362TC	125.41	135.90	141.67	1
88365TC	64.53	69.75	72.49	1
91000TC	3.30	3.71	4.04	1
91010TC	83.37	90.67	94.93	1
91011TC	97.15	105.50	110.25	1
91012TC	103.27	112.25	117.43	1
91020TC	89.38	97.13	101.61	1
91030TC	74.06	80.02	83.10	1
91032TC	133.18	144.26	150.31	1
91033TC	136.25	148.37	155.58	1
91052TC	68.41	73.93	76.81	1
91055TC	75.12	81.16	84.28	1
91060TC	6.60	7.42	8.08	1
91065TC	67.70	73.17	76.03	1
91110TC	703.73	758.41	785.17	1
91122TC	196.64	212.88	221.63	1
92060TC	15.66	17.01	17.79	1
92065TC	14.25	15.49	16.21	1
92081TC	25.20	27.27	28.39	1
92082TC	34.38	37.16	38.60	1
92083TC	39.68	42.86	44.50	1
92135TC	22.37	24.23	25.25	1
92136TC	56.30	61.69	65.19	1
92235TC	93.26	101.31	105.93	1
92240TC	233.84	252.59	262.26	1
92250TC	54.51	58.82	60.99	1
92265TC	57.46	62.15	64.64	1
92270TC	44.04	47.71	49.71	1
92275TC	54.28	58.73	61.10	1
92283TC	27.32	29.56	30.75	1
92284TC	78.89	85.05	88.09	1
92285TC	35.09	37.92	39.39	1
92286TC	109.38	118.03	122.38	1
92541TC	28.50	30.98	32.43	1
92542TC	32.74	35.55	37.14	1
92543TC	17.43	18.91	19.75	1
92544TC	26.38	28.70	30.07	1
92545TC	24.97	27.18	28.50	1
92546TC	59.93	64.81	67.39	1
92548TC	109.65	120.06	126.73	1
92585TC	72.33	80.05	85.60	1
93024TC	43.35	47.92	51.16	1
93278TC	45.83	51.06	55.02	1
93303TC	147.58	162.47	172.61	1
93304TC	75.03	82.81	88.24	1
93307TC	147.58	162.47	172.61	1
93308TC	75.03	82.81	88.24	1
93312TC	147.60	163.44	174.84	1
93314TC	147.60	163.44	174.84	1
93320TC	66.43	73.40	78.31	1
93321TC	43.35	47.92	51.16	1
93325TC	112.73	124.64	133.11	1
93350TC	68.67	75.97	81.17	1
93501TC	648.76	714.82	760.22	1
93505TC	77.86	86.33	92.50	1
93508TC	477.23	523.88	554.71	1
93510TC	1418.60	1563.11	1662.48	1
93511TC	1380.67	1521.18	1617.72	1
93514TC	1380.67	1521.18	1617.72	1
93524TC	1804.82	1988.73	2115.24	1
93526TC	1854.64	2043.78	2173.97	1
93527TC	1804.82	1988.73	2115.24	1
93528TC	1804.82	1988.73	2115.24	1
93529TC	1804.82	1988.73	2115.24	1
93530TC	648.76	714.82	760.22	1
93531TC	1854.64	2043.78	2173.97	1
93532TC	1804.82	1988.73	2115.24	1
93533TC	1804.82	1988.73	2115.24	1
93555TC	238.62	262.18	277.91	1
93556TC	374.88	411.52	435.72	1
93561TC	21.21	23.77	25.80	1
93562TC	13.20	14.84	16.15	1
93571TC	173.13	190.12	201.39	1
93572TC	87.39	96.11	101.99	1
93600TC	75.38	83.19	88.63	1
93602TC	42.87	47.25	50.26	1
93603TC	64.90	71.59	76.23	1
93609TC	104.12	114.75	122.07	1
93610TC	52.77	58.38	62.38	1
93612TC	62.43	68.93	73.48	1
93615TC	12.25	13.50	14.36	1
93616TC	12.25	13.50	14.36	1
93618TC	151.94	167.32	177.83	1
93619TC	295.64	325.61	346.12	1
93624TC	76.44	84.33	89.81	1
93631TC	247.28	275.96	297.89	1

Skilled Nursing Facility Service Fee Schedule (continued)

CODE/ MOD	FEE 01/02	FEE 03	FEE 04	PC/ TC
93640TC	274.20	301.74	320.43	1
93641TC	274.20	301.74	320.43	1
93642TC	274.20	301.74	320.43	1
93660TC	60.64	65.57	68.17	1
93701TC	34.03	36.78	38.21	1
93721	27.92	31.00	33.26	3
93724TC	151.94	167.32	177.83	1
93731TC	19.20	21.30	22.83	1
93732TC	19.91	22.06	23.62	1
93733TC	28.63	31.76	34.05	1
93734TC	13.31	14.64	15.54	1
93735TC	17.44	19.40	20.87	1
93736TC	25.09	27.96	30.12	1
93741TC	25.56	28.14	29.90	1
93742TC	25.56	28.14	29.90	1
93743TC	28.03	30.80	32.65	1
93744TC	25.56	28.14	29.90	1
93875TC	61.02	67.41	71.91	1
93880TC	156.80	174.29	187.29	1
93882TC	111.79	123.79	132.44	1
93886TC	163.28	181.90	195.98	1
93888TC	111.33	124.09	133.77	1
93922TC	71.15	78.63	83.92	1
93923TC	111.08	123.03	131.65	1
93924TC	138.64	153.16	163.40	1
93925TC	181.52	200.90	214.78	1
93926TC	129.57	143.08	152.58	1
93930TC	147.85	164.98	178.08	1
93931TC	107.08	119.05	127.94	1
93965TC	67.14	74.16	79.09	1
93970TC	151.04	168.89	182.73	1
93971TC	108.50	121.05	130.63	1
93975TC	204.73	227.15	243.55	1
93976TC	122.29	136.36	147.07	1
93978TC	136.20	152.44	165.12	1
93979TC	99.67	111.06	119.69	1
93980TC	170.45	188.82	202.10	1
93981TC	172.21	190.24	202.95	1
93990TC	128.51	141.94	151.40	1
94010TC	22.85	24.90	26.14	1
94060TC	38.87	42.78	45.44	1
94070TC	103.63	113.11	118.94	1
94200TC	15.43	16.92	17.90	1
94240TC	22.50	25.01	26.87	1
94250TC	22.37	24.23	25.25	1
94260TC	20.61	22.82	24.40	1
94350TC	25.56	28.14	29.90	1
94360TC	24.39	27.20	29.33	1
94370TC	23.55	25.66	26.93	1
94375TC	18.96	20.72	21.82	1
94400TC	28.27	31.38	33.66	1
94450TC	20.73	22.62	23.79	1
94620TC	83.15	91.06	96.16	1
94621TC	62.31	68.64	72.98	1
94680TC	66.77	72.81	76.47	1
94681TC	95.75	104.94	110.91	1
94690TC	70.77	76.79	80.18	1
94720TC	35.34	38.98	41.51	1
94725TC	105.99	115.97	122.30	1
94750TC	47.10	51.33	53.86	1
94770TC	60.89	66.63	70.29	1
95004	4.01	4.47	4.82	5
95805TC	567.11	615.67	643.21	1
95806TC	130.53	145.39	156.60	1
95807TC	413.36	451.50	475.19	1
95808TC	443.03	483.42	508.18	1
95810TC	579.37	630.14	659.80	1
95811TC	627.18	681.74	713.33	1
95812TC	127.42	138.86	145.76	1
95813TC	154.62	168.13	176.00	1
95816TC	99.40	108.55	114.22	1
95819TC	118.82	129.45	135.83	1
95822TC	143.91	156.93	164.83	1
95827TC	87.87	96.78	102.88	1
95829TC	1024.20	1102.47	1139.70	1
95858TC	15.67	17.50	18.90	1
95860TC	37.33	40.49	42.25	1
95861TC	28.98	32.14	34.44	1
95863TC	36.04	39.74	42.30	1
95864TC	68.91	76.06	81.06	1
95867TC	22.38	24.72	26.36	1
95868TC	27.09	29.95	31.97	1
95869TC	8.72	9.70	10.43	1
95870TC	8.72	9.70	10.43	1
95872TC	23.56	26.15	28.05	1
95875TC	38.16	42.02	44.65	1
95900TC	39.80	43.15	45.00	1
95903TC	34.50	37.45	39.11	1
95904TC	34.86	37.83	39.50	1
95920TC	49.58	54.47	57.73	1
95921TC	14.02	15.40	16.32	1
95922TC	14.02	15.40	16.32	1
95923TC	61.35	66.33	68.96	1
95925TC	34.98	38.60	41.12	1
95926TC	34.98	38.60	41.12	1
95927TC	34.98	38.60	41.12	1
95930TC	45.68	49.32	51.17	1
95933TC	30.74	34.04	36.40	1
95934TC	8.72	9.70	10.43	1
95936TC	8.72	9.70	10.43	1
95937TC	12.96	14.26	15.15	1
95950TC	155.64	174.31	188.95	1
95953TC	244.65	270.10	287.94	1
95954TC	117.28	127.16	132.64	1
95955TC	77.63	86.24	92.61	1
95956TC	473.88	516.78	542.86	1
95957TC	66.08	73.02	77.92	1
95958TC	67.97	75.20	80.38	1
95961TC	49.58	54.47	57.73	1
95962TC	49.58	54.47	57.73	1

PC/TC Indicator

0 = Physician service codes
1 = Diagnostic test for radiology services
2 = Professional component only codes
3 = Technical component only codes
5 = Incident codes

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Mandatory Electronic Submission of Medicare Claims Based on the Administrative Simplification Compliance Act

Including Specific Conditions under Which a Waiver May Be Granted for Submission of Electronic Claims

The Administrative Simplification Compliance Act (ASCA) went into effect October 16, 2003, along with the HIPAA Transactions rule. We recently published information concerning CMS' contingency plan for HIPAA transactions and code sets. CMS did not implement a contingency plan for ASCA, although much discussion has taken place with regards to a "waiver" for certain providers in certain circumstances. The information that follows provides additional guidance regarding such waivers. All providers, even those meeting an exception, are encouraged to submit as many of their claims electronically as possible.

Providers that do not qualify as "small," and that do not meet any of the remaining exception or waiver criteria provided below, must submit their claims to Medicare electronically. Submission of paper claims constitutes an attestation by a provider that at least one of the paper claim exception or waiver criteria applies at the time of submission.

Definition of "Small Provider;" FTE Definition and Calculation Methodology

A "small provider" is defined at 42 CFR section 424.32(d)(1)(vii) to mean

a) A provider of services (as that term is defined in section 1861(u) of the Social Security Act) with fewer than 25 full-time equivalent (FTE) employees; or
b) A physician, practitioner, facility or supplier that is not otherwise a provider under section 1861(u) with fewer than 10 FTEs.

To simplify implementation, Medicare will consider all providers that have fewer than 25 FTEs and that are required to bill a Medicare intermediary to be small; and will consider all physicians, practitioners, facilities, or suppliers with fewer than 10 FTEs and that are required to bill a Medicare carrier or DMERC to be small.

The ASCA law and regulation do not modify pre-existing laws or employer policies defining full time employment. Each employer has an established policy, subject to certain non-Medicare state and federal regulations, that define the number of hours employees must work on average on a weekly, biweekly, monthly, or other basis to qualify for full-time benefits. Some employers do not grant full-time benefits until an employee works an average of 40 hours a week, whereas another employer might consider an employee who works an average of 32 hours a week to be eligible for fulltime benefits. An employee who works an average of 40 hours a week would always be considered full time, but employees who work a lesser number of hours weekly on average could also be considered full time according to the policy of a specific employer.

Everyone on staff for whom a health care provider withholds taxes and files reports with the Internal Revenue Service (IRS) using an employer identification number (EIN) is considered an employee, including if applicable, a physician(s) who owns a practice and provides hands on services and those support staff who do not furnish health care services but do retain records of, perform billing for, order supplies related to, provide personnel services for, and otherwise perform support services to enable the provider to function. Unpaid volunteers are not employees. Individuals that perform services for a provider under contract, such as individuals employed by a billing agency or medical placement service, for whom a provider does not withhold taxes, are not considered members of a provider's staff for FTE calculation purposes when determining whether a provider can be considered as "small" for electronic billing waiver purposes.

Medical staff sometimes work part time, or may work full time but their time is split among multiple providers. Part time employee hours must also be counted when determining the number of FTEs employed by a provider. For example, if a provider has a policy that anyone who works at least 35 hours per week on average qualifies for fulltime benefits, and has 5 full-time employees and 7 part-time employees, each of whom works 25 hours a week, that provider would have 10 FTEs (5+[7 x 25= 175 divided by 35= 5]).

In some cases, the EIN of a parent company may be used to file employee tax reports for multiple providers under multiple provider numbers. In that instance, it is acceptable to consider only those staff, or staff hours worked for a particular provider as identified by provider number, UPIN, or national provider identifier (NPI) when implemented to calculate the number of FTEs employed by that provider. For example, ABC Health Care Company owns hospital, home health agency (HHA), ambulatory surgical center (ASC), and durable medical equipment (DME) subsidiaries. Some of those providers bill intermediaries and some carriers. All have separate provider numbers but the tax records for all employees are reported under the same EIN to the IRS. There is a company policy that staff must work an average of 40 hours a week to qualify for full time benefits.

Some of the same staff split hours between the hospital and the ASC, or between the DME and HHA subsidiaries. To determine total FTEs by provider number, it is acceptable to base the calculation on the number of hours each staff member contributes to the support of each separate provider by provider number. First, each provider would need to

Mandatory Electronic Submission of Medicare Claims Based on ASCA (continued)

determine the number of staff who work on a full time basis under a single provider number only; do not count more than 40 hours a week for these employees. Then each provider would need to determine the number of part time hours a week worked on average by all staff who furnished services for the provider on a less than full time basis. Divide that total by 40 hours to determine their full time equivalent total. If certain staff members regularly work an average of 60 hours per week, but their time is divided 50 hours to the hospital and 10 hours to the ASC, for FTE calculation purposes, it is acceptable to consider the person as 1 FTE for the hospital and .25 FTE for the ASC.

In some cases, a single provider number and EIN may be assigned, but the entity's primary mission is not as a health care provider. For instance, a grocery store's primary role is the retail sale of groceries and ancillary items including over the counter medications, but the grocery store has a small pharmacy section that provides prescription drugs and some DME to Medicare beneficiaries. A large drug store has a pharmacy department that supplies prescriptions and DME to Medicare beneficiaries but most of the store's revenue and most of their employees are not involved with prescription drugs or DME and concentrate on non-related departments of the store, such as film development, cosmetics, electronics, cleaning supplies, etc. A county government uses the same EIN for all county employees but their health care provider services are limited to furnishing of emergency medical care and ambulance transport to residents.

Legal issues regarding the definition of providers, particularly when multiple providers have data reported under the same EIN, will be addressed in the NPI regulation when published in the *Federal Register* in final. For FTE calculation purposes in the interim, it is acceptable to include only those staff of the grocery store, drug store, or county involved with or that support the provision of health care in the FTE count when assessing whether a small provider waiver may apply. This process will be modified if warranted by the definitions established in the NPI final rule.

Support staff who should be included in the FTE calculation in these instances include but are not necessarily limited to those that restock the pharmacy or ambulance, order supplies, maintain patient records, or provide billing and personnel services for the pharmacy or emergency medical services department if under the same EIN, according to the number of hours on average that each staff member contributes to the department that furnishes the services or supplies for which the Medicare provider number was issued.

Providers that qualify as "small" automatically qualify for waiver of the requirement that their claims be submitted to Medicare electronically. Those providers are encouraged to submit their claims to Medicare electronically, but are not required to do so under the law. Small providers may elect to submit some of their claims to Medicare electronically, but not others. Submission of some claims electronically does not negate their small provider status nor obligate them to submit all of their claims electronically. The small provider exception for submission of paper claims does not apply to health care claim clearinghouses that are agents for electronic claim submission for small providers. HIPAA defines a clearinghouse as an entity that translates data to or from a standard format for electronic transmission. As such, HIPAA requires that clearinghouses submit claims electronically effective October 16, 2003 without exception.

Exception Criteria

In some cases, it has been determined that due to limitations in the claims transaction formats adopted for national use under HIPAA, it would not be reasonable or possible to submit certain claims to Medicare electronically. Providers are to self-assess to determine if they meet these exceptions. At the present time, only the following claim types are considered to meet this condition:

1. **Roster billing of vaccinations covered by Medicare**—Although flu shots and similar covered vaccines and their administration can be billed to Medicare electronically, one claim for one beneficiary at a time, in the past, some suppliers have been allowed to submit a single claim on paper with the basic provider and service data to which was attached a list of the Medicare beneficiaries to whom the vaccine was administered and related identification information for those beneficiaries. The claim implementation guides adopted under HIPAA can submit single claims to payer for single individuals, but cannot be used to submit a single claim for multiple individuals.

   Flu shots are often administered in senior citizen centers, grocery stores, malls, and other locations in the field. It is not always reasonable or hygienic to use a laptop computer to register all necessary data to enable generation of an electronic (HIPAA-compliant) claim in such field settings. In some cases, a single nurse who is not accompanied by support staff might conduct mass immunizations. Due to the low cost of these vaccinations, it is not always cost effective to obtain all of the data normally needed for preparation of a HIPAA-compliant claim. Such suppliers rarely have a long-term health care relationship with their patients and do not have a need for the extensive medical and personal history routinely collected in most other health care situations.

   It is in the interest of Medicare and public health to make it as simple as possible for mass immunization activities to continue. Although suppliers are encouraged to submit these claims to Medicare electronically, one claim for one beneficiary at a time, this is not required. In the absence of an electronic format that would allow a single claim for the same service to be submitted on behalf of multiple patients using abbreviated data, providers/suppliers currently allowed to submit paper roster bills may continue to submit paper roster bills for vaccinations. Providers or suppliers that furnish vaccinations and other medical services or supplies must bill those other medical services or supplies to Medicare electronically though unless the provider qualifies as "small" or meets other exception criteria.

   This vaccinations waiver applies only to injections such as flu shots frequently furnished in non-traditional medical situations, and does not apply to injections

Mandatory Electronic Submission of Medicare Claims Based on ASCA (continued)

furnished in a traditional medical setting such as a doctor's office or an outpatient clinic when supplied as a component of other medical care or examination. In traditional medical situations where the provider is required to bill the other services furnished to the patient electronically, the flu shot or other vaccination is also to be included in the electronic claim sent to Medicare for the patient.

2. **Claims for payment under a Medicare demonstration project that specifies paper submission**—By their nature, demonstration projects test something not previously done, such as coverage of a new service. As a result of the novelty, the code set that applies to the new service may not have been included as an accepted code set in the claim implementation guide(s) previously adopted as HIPAA standards. The HIPAA regulation itself makes provisions for demonstrations to occur that could involve use of alternate standards. In the event a Medicare demonstration project begins that requires some type of data not supported by the existing claim formats adopted under HIPAA, Medicare could mandate that the claims for that demonstration be submitted on paper. In the event demonstration data can be supported by an adopted HIPAA format, Medicare will not require use of paper claims for a demonstration project. Demonstrations typically involve a limited number of providers and limited geographic areas. Providers that submit both demonstration and regular claims to Medicare may be directed to submit demonstration claims on paper. Non-demonstration claims will continue to be submitted electronically, unless another exception or waiver condition applies.

3. **Medicare Secondary Payment Claims (MSP)**—MSP claims occur when one or more payers are primary to Medicare. The claim formats adopted for national use under HIPAA include segments for provider or payer use to submit secondary claims as well as initial claims. Since a patient rarely has more than two insurers in total, the formats were designed for a provider to bill a payer secondarily and include payment data from one primary in the claim. In actuality, there may have been more than one primary payer. The claim formats adopted under HIPAA do not currently contain the ability to report individual service level payments made by more than one primary payer.

   The paper claim format has no fields for reporting of more than one primary payment data when Medicare is secondary. When paper claims are submitted, a copy of the primary plan's explanation of benefits (EOB) must always be attached if there is one or more payers that pay prior to Medicare. Since the HIPAA claim formats do allow service level data to be submitted electronically when there is only one payer primary to Medicare, those claims can be sent to Medicare electronically. When more than one payer is primary, the formats cannot accommodate this additional reporting and the only alternative is for providers to submit those claims to Medicare on paper with copies of the EOBs/remittance advices (RAs).

   The payment segments of the claim formats adopted under HIPAA include fields for reporting of the identity of the primary payer, service procedure code, allowed amount, payment amount, and claim adjustment reason codes and amounts applied by the other payer when the billed amount of the service was not paid in full. These segments correspond to segments reported in the X12 835 remittance advice format. Since the HIPAA requirements apply only to electronic transactions, and not to paper transactions such as paper EOBs or RA notices, there is no requirement that payers use the same codes in their paper EOBs or RAs as in their electronic RAs. Medicare uses the same code set in both paper and electronic RAs, but other payers may not. Payers can elect to use different code sets in their paper transactions than their electronic transactions, or to use text messages in their paper transactions and not use codes at all. Payers that do not use the standard claim adjustment reason codes in their paper EOBs or RAs, generally use proprietary codes or messages for which there is no standard crosswalk to the 835 claim adjustment reason codes.

   Providers that receive those paper EOBs/RAs cannot reasonably furnish standard claim adjustment reason codes for use in the HIPAA claim and COB formats. As a result, when there is only one payer primary to Medicare and those claims must be sent to Medicare electronically, those providers cannot complete the situational CAS segment for those claims. The coordination of benefits implementation guide adopted under HIPAA does not require that this segment be completed in this situation. This is acceptable, although this will prevent the primary payer data in the claim from balancing, akin to balancing when the data is reported in an 835 transaction. There is no requirement in the implementation guide that these payment segments balance in a claim transaction. Providers should not try to convert non-standard messages or codes to standard claim adjustment reason codes to submit these claims to Medicare electronically. Medicare does not use the CAS segment data elements to calculate the Medicare payment in any case. However, providers must still report the primary's allowed, contract amount when Obligation to Accept in Full (OTAF) applies, and payment amounts for the individual services to enable Medicare to calculate payment.

4. **Claims submitted by Medicare beneficiaries**.

Unusual Circumstances

Congress granted the Secretary considerable discretion to decide what other circumstances should qualify as "unusual circumstances" for which a waiver of the electronic claim submission requirement would be appropriate. The Secretary delegated that authority to CMS. In the event it is determined that enforcement of the electronic claim submission requirement would be against equity and good conscience as result of an "unusual circumstance," CMS will waive the electronic claim submission requirement for temporary or extended periods. In those situations,

Mandatory Electronic Submission of Medicare Claims Based on ASCA (continued)

providers are encouraged to file claims electronically where possible, but electronic filing is not required.

CMS has in turn delegated certain authority to the Medicare contractors (carrier, DMERC, or intermediary) to determine whether an "unusual circumstance" applies. Providers who feel they should qualify for a waiver as result of an "unusual circumstance" must submit their waiver requests to the Medicare carrier, DMERC or intermediary to whom they submit their claims. The Medicare contractor must issue a form letter in the event of receipt of a written waiver request that does not allege an "unusual circumstance."

In some cases, an "unusual circumstance" or the applicability of one of the other exception criteria may be temporary; in which case, the related waiver would also be temporary. Once the criteria no longer applied, that provider would again be subject to the requirement that claims be submitted to Medicare electronically. Likewise, some exception and waiver criteria apply to only a specific type of claim, such as secondary claims when more than one other payer is primary. Other claim types not covered by an exception or waiver must still be submitted to Medicare electronically, unless the provider is small or meets other unusual circumstance criteria.

Unusual Circumstance Waivers Subject to Provider Self-Assessment

The following circumstances *always* meet the criteria for waiver. Providers that experience one of the following "unusual circumstances" are automatically waived from the electronic claim submission requirement. A provider is expected to self-assess when one of these circumstances applies, rather than apply for contractor or CMS waiver approval. A provider may continue to submit claims to Medicare on paper when one of these circumstances applies. A provider is not expected to pre-notify their Medicare contractor(s) that one of the circumstances applies as a condition of paper submission.

1. **Dental claims**—Medicare does not provide dental benefits. Medicare does cover certain injuries of the mouth that may be treated by dentists, but those injury treatments are covered as medical benefits. Less than .01 percent of Medicare expenditures were for oral and maxillofacial surgery costs in 2002. The X12 837 professional implementation guide standard for submission of medical claims requires submission of certain data that not traditionally reported in a dental claim but which is needed by payers to adjudicate medical claims. As result, Medicare contractors have not implemented the dental claim standard adopted for national use under HIPAA. Due to the small number of claims they would ever send to Medicare, most dentists have not found it cost effective to invest in software they could use to submit medical claims to Medicare electronically. For these reasons, dentists will not be required to submit claims to Medicare electronically. They can continue to submit claims, when appropriate, to Medicare on paper.
2. **Disruption in electricity or phone/communication services**—In the event of a major storm or other disaster outside of a provider's control, a provider could lose the ability to use personal computers, or transmit data electronically. If such a disruption is expected to last more than two business days, all of the affected providers are automatically waived from the electronic submission requirement for the duration of the disruption. If duration is expected to be two business days or less, providers should simply hold claims for submission when power and/or communication restored.
3. **A provider is not small based on FTEs, but submits fewer than 10 claims to Medicare per month on average** (not more than 120 claims per year). This would generally apply to a provider that rarely deals with Medicare beneficiaries.
4. **Non-Medicare Managed Care Organizations** that are able to bill Medicare for co-payments may continue to submit those claims on paper. These claims are not processable by the MSP Pay module and must be manually adjudicated by Medicare contractors.

Unusual Circumstance Waivers Subject to Medicare Contractor Approval

Medicare contractors may *at their discretion* approve a single waiver for up to 90 days after the date of the decision notice for a provider if the contractor considers there to be "good cause" that prevents a provider to submit claims electronically for a temporary period. "Good cause" would apply if a provider has made good faith efforts to submit claims electronically, but due to testing difficulties, or a similar short-term problem that the provider is making reasonable efforts to rectify, the provider is not initially able to submit all affected claims electronically effective October 16, 2003.

Unusual Circumstance Waivers Subject to Medicare Contractor Approval and CMS Decision

A provider may submit a waiver request to their Medicare contractor in the following "unusual circumstances." It is the responsibility of the provider to submit documentation appropriate to establish the validity of the waiver request in these situations. Requests received without documentation to fully explain and justify why enforcement of the requirement would be against equity and good conscience in these cases will be denied.

If the Medicare contractor agrees that the waiver request has merit, CMS approval is required. The contractor will forward an explanation as to why contractor staff recommends CMS approval with the waiver request. If the contractor does not consider an "unusual circumstance" to be met, and does not recommend CMS approval, the contractor will issue a "denial of an unusual circumstance waiver request" letter.

1. Provider alleges that the claim transaction implementation guides adopted under HIPAA do not support electronic submission of all data required for claim adjudication may request a waiver. (If a waiver is approved in this case, it will apply only to the specific claim type(s) affected by the implementation guides deficiency.)

Mandatory Electronic Submission of Medicare Claims Based on ASCA (continued)

Note: Pending issuance of future instructions concerning submission of medical records for electronic claims, providers and Medicare contractors can continue current policies and practices regarding submission of attachments with claims (see "Paper Claims/Attachments," below).

2. A provider is not small, but all those employed by the provider have documented disabilities that would prevent their use of a personal computer for electronic submission of claims.
3. Any other unusual situation that is documented by a provider to establish that enforcement of the electronic claim submission requirement would be against equity and good conscience.

Submission of a Request for an Unusual Circumstance Waiver

If a provider believes the above criteria are met, he/she should submit a request for an unusual circumstance waiver to:

Attention: ASCA Waiver
Medicare EDI
P.O. Box 44071
Jacksonville, FL 32231-4071

Be sure to include documentation appropriate to establish the validity of the waiver request. A waiver request should include the providers' name, address, contact person, the reason for the waiver, and why the provider considers enforcement of the electronic billing requirement to be against equity and good conscience.

Enforcement

A separate enforcement instruction will be issued to Medicare contractors. Enforcement will be conducted on a post-payment basis and will entail targeted investigation of providers that appear to be submitting extraordinary numbers of paper claims. If an investigation establishes that a provider incorrectly submitted paper claims, the provider will be notified that any paper claims submitted after a certain date (a reasonable period will be allowed for implementation of necessary provider changes) will be denied by Medicare.

Paper Claims/Attachments

Providers should continue to submit claims that may require documentation via their normal process in place prior to the October 16, 2003, HIPAA implementation date, and ***if additional medical record documentation is needed await our request for it***, until further notification is provided. ❖

Source: CMS Pub 100-4 Transmittal 44, CR 2966

Additional Guidance Relating to Health Insurance Portability and Accountability Act (HIPAA) Contingency Plan

Under Medicare's HIPAA contingency plan, contractors may not add new users of legacy formats. The contingency plan applies only to those trading partners already exchanging electronic transactions prior to October 16, 2003.

Effective Immediately:

- New electronic submitters may only test on the HIPAA format (X12N 4010A1) for inbound claims.
- New electronic submitters may only go into production on the HIPAA format for inbound claims.
- Current electronic submitters may not begin testing or submitting inbound claims for any new providers in other than the HIPAA-compliant format.
- New electronic remittance receivers may only test and go into production on the HIPAA format.
- Any entity (e.g., clearinghouse) currently receiving electronic remittance advice may not add a new provider receiving electronic remittance advice in a pre-HIPAA format.

In addition, submitters must move their entire workload into production within 30 days after successfully completing testing of the HIPAA 4010A1 claim format.

First Coast Service Options, Inc. (FCSO) offers PC-ACE Pro32® at-cost software to enable providers to become HIPAA compliant. You can learn more about the software at *http://www.fcso.com.* Select "Online Services"; there is a link to PC-ACE Pro32® under "Medicare Provider Services." If additional marketing information is needed, contact 1-904-791-8767, option 1. ❖

Source: CMS JSM-20, Dated November 25, 2003

ELECTRONIC DATA INTERCHANGE

Remittance Advice Remark and Reason Code Update

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

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

The following list summarizes changes made from March 1, 2003 to June 30, 2003 and is effective **January 1, 2004.**

New Remark Codes

Code	Current Narrative
N202	Additional information/explanation will be sent separately.
N203	Missing/incomplete/invalid anesthesia time/units.
N204	Services under review for possible pre-existing condition. Send medical records for prior 12 months.
N205	Information provided was illegible.
N206	The supporting documentation does not match the claim.
N207	Missing/incomplete/invalid birth weight.
N208	Missing/incomplete/invalid DRG code.
N209	Missing/invalid/incomplete taxpayer identification number (TIN).
N210	You may appeal this decision.
N211	You may not appeal this decision

Modified Remark Codes

Code	Current Modified Narrative
M13	Only one initial visit is covered per specialty per medical group.
M18	Certain services may be approved for home use. Neither a hospital nor a skilled nursing facility (SNF) is considered to be a patient's home.
M25	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
M26	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service/any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to the refund requirement in two cases: • If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or • If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request review at any time within 120 days of the date of this notice. However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund.

Remittance Advice Remark and Reason Code Update (continued)

Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.

The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program.

Contact this office if you have any questions about this notice.

M60 Missing/incomplete/invalid Certificate of Medical Necessity.

M86 Service denied because payment already made for some/similar procedure within set time frame.

M117 Not covered unless submitted via electronic claim.

M129 Missing/incomplete/invalid indicator of X-ray availability for review.

M134 Performed by a facility/supplier in which the provider has a financial interest.

MA01 If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 120 days of the date of this notice, unless you have a good reason for being late.

An institutional provider, e.g., hospital, skilled nursing facility (SNF), home health agency (HHA) or hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.

If your carrier issues telephone review decisions, a professional provider should phone the carrier's office for a telephone review if the criteria for a telephone review are met.

MA02 If you do not agree with this determination, you have the right to appeal. You must file a written request for reconsideration within 120 days of the date of this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days.

An institutional provider, e.g., hospital, skilled nursing facility (SNF), home health agency (HHA) or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF non-certified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section1879 of the Social Security Act, and the patient chooses not to appeal.

MA03 If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision.

An institutional provider, e.g., hospital, skilled nursing facility (SNF), home health agency (HHA) or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.

MA20 Skilled nursing facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.

MA24 Christian science sanitarium/skilled nursing facility (SNF) bill in the same benefit period.

MA93 Non-PIP (Periodic Interim Payment) Claim.

MA101 A skilled nursing facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.

MA106 PIP (Periodic Interim Payment) claim.

MA121 Missing/incomplete/invalid date the X-ray was performed.

N30 Patient ineligible for this service.

N32 Claim must be submitted by the provider who rendered the service.

N40 Missing/incomplete/invalid X-ray.

N69 PPS (Prospective Payment System) code changed by claims processing system. Insufficient visits or therapies.

N71 Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim.

Remittance Advice Remark and Reason Code Update (continued)

You are required by law to accept assignment for these types of claims.

N72 PPS (Prospective Payment System) code changed by medical reviewers. Not supported by clinical records.

N100 PPS (Prospect Payment System) code corrected during adjudication.

N103 Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while they are in State or local custody under a penal authority, unless under state or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the state or local government pursues such debt in the same way and with the same vigor as any other debt.

N106 Payment for services furnished to skilled nursing facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.

N107 Services furnished to skilled nursing facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services.

N113 Only one initial visit is covered per physician, group practice or provider.

N115 This decision was based on a local medical review policy (LMRP). An LMRP 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.

N117 This service is paid only once in a patient's lifetime.

N119 This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive days in any inpatient or skilled nursing facility (SNF) within those 28 days.

N120 Payment is subject to home health prospective payment system partial episode payment adjustment. Patient was transferred/discharged/readmitted during payment episode.

N121 No coverage for items or services provided by this type of practitioner for patients in a covered skilled nursing facility (SNF) stay.

N177 We did not send this claim to patient's other insurer. They have indicated no additional payment can be made.

Deactivated Remark Codes

Code **Current Modified Narrative**

M43 Payment for this service previously issued to you or another provider by another carrier/intermediary.

M48 Payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.

M63 We do not pay for more than one of these on the same day.

M98 Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.

M101 Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.

M106 Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the fee schedule for this item or service.

M140 Service not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday.

MA11 Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Contact us if the patient is covered by any of these sources.

MA78 The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.

MA104 Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician.

MA124 Processed for IME only.

MA129 This provider was not certified for this procedure on this date of service.

N18 Payment based on the Medicare allowed amount.

N60 A valid NDC is required for payment of drug claims effective October 02.

N73 A skilled nursing facility is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents.

N101 Additional information is needed in order to process this claim. Resubmit the claim with the identification number of the provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters "HSP" and entered into item #32 on the claim form. You may bill only one site of service provider number per claim.

N164 Transportation to/from this destination is not covered.

Remittance Advice Remark and Reason Code Update (continued)

N165 Transportation in a vehicle other than an ambulance is not covered.

N166 Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.

N168 The patient must choose an option before a payment can be made for this procedure/equipment/supply/service.

N169 This drug/service/supply is covered only when the associated service is covered.

X12 N 835 Health Care Claim Adjustment Reason Codes

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 additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year after each X12 trimester meeting at *http://www.wpc-edi.com/codes/Codes.asp*; select Claim Adjustment Reason Codes from the pull down menu. All reason code changes approved in June 2003 are listed here.

The request for a reason code change may come from non-Medicare entities. If Medicare requests a change, it may be included in a Medicare instruction in addition to the regular code update notification. The regular code update notification will be issued on a periodic basis to provide a summary of changes in the reason and remark codes introduced since the last update notification, and will establish the deadline for Medicare contractors t o implement the reason and remark code changes that may not already have been implemented as part of a previous Medicare policy change instruction.

A reason code may be retired if it is no longer applicable or a similar code exists. Retirements are effective for a specified future and succeeding versions, but contractors also can discontinue use of retired codes in prior versions. The committee approved the following reason code changes in June 2003.

Reason Code Changes (as of June 30, 2003)

Code **Current Narrative Notes**

155 This claim is denied because the patient refused the service/procedure.

38 Services not provided or authorized by designated (network/primary care) providers.

107 Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.

The following is a comprehensive list of retired reason codes. System limitation prohibits using codes that are retired effective version 4010 for any pre-4010 formats/versions being generated during the contingency plan period invoked by CMS.

Code **Current Narrative Notes**

28 Coverage not in effect at the time the service was provided.

36 Balance does not exceed co-payment amount.

37 Balance does not exceed deductible.

41 Discount agreed to in Preferred Provider contract.

46 This (these) service(s) is (are) not covered.

48 This (these) procedure(s) is (are) not covered.

57 Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.

63 Correction to a prior claim.

64 Denial reversed per medical review.

65 Procedure code was incorrect. This payment reflects the correct code.

67 Lifetime reserve days. (Handled in QTY, QTY01=LA)

68 DRG weight. (Handled in CLP12)

71 Primary payer amount.

72 Coinsurance day. (Handled in QTY, QTY01=CD)

73 Administrative days.

77 Covered days. (Handled in QTY, QTY01=CA)

79 Cost Report days. (Handled in MIA15)

80 Outlier days. (Handled in QTY, QTY01=OU)

81 Discharges. Inactive for 003040

82 PIP days.

83 Total visits.

84 Capital Adjustment. (Handled in MIA)

86 Statutory Adjustment.

88 Adjustment amount represents collection against receivable created in prior overpayment.

92 Claim paid in full.

93 No claim level adjustments.

98 The hospital must file the Medicare claim for this inpatient non-physician service.

99 Medicare Secondary Payer Adjustment Amount.

120 Patient is covered by a managed care plan.

123 Payer refund due to overpayment.

124 Payer refund amount - not our patient.

A3 Medicare Secondary Payer liability met.

B2 Covered visits.

B3 Covered charges.

B19 Claim/service adjusted because of the finding of a Review Organization.

B21 The charges were reduced because the service/care was partially furnished by another physician.

D1 Claim/service denied. Level of subluxation is missing or inadequate.

D2 Claim lacks the name, strength, or dosage of the drug furnished.

Remittance Advice Remark and Reason Code Update (continued)

D3 Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.

D4 Claim/service does not indicate the period of time for which this will be needed.

D5 Claim/service denied. Claim lacks individual lab codes included in the test.

D6 Claim/service denied. Claim did not include patient's medical record for the service.

D7 Claim/service denied. Claim lacks date of patient's most recent physician visit.

D8 Claim/service denied. Claim lacks indicator that 'X-ray is available for review.'

D9 Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.

D10 Claim/service denied. Completed physician financial relationship form not on file.

D11 Claim lacks completed pacemaker registration form.

D12 Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.

D13 Claim/service denied. Performed by a facility/ supplier in which the ordering/referring physician has a financial interest.

D14 Claim lacks indication that plan of treatment is on file.

D15 Claim lacks indication that service was supervised or evaluated by a physician. ❖

Source: CMS Pub. 100-4, Transmittal 32, CR 2975

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

Submitting Medicare Provider Number on Electronic Claims

When reporting your Medicare provider number in the ANSI 837-4010A1 electronic claim format you must place the provider number in the REF01 segment in the 2010AA loop using the 1C qualifier. This is not a required segment, so if the provider number is not reported then no error is given at the time the claim is submitted via the gateway. The claim is accepted into the Fiscal Intermediary Shared System (FISS) and reason code 32000 (no Medicare provider number is present) is assigned. At this point, there is no way for the system to determine who the provider is; therefore, the claim cannot be adjudicated to the submitting provider and the provider cannot view the claims via the Direct Data Entry (DDE) system.

Although REF01 segment is not required, it is very important that providers enter the Medicare provider number in this segment to avoid payment delays. ❖

EDUCATIONAL RESOURCES

First Medifest of 2004 to be Held in Jacksonville in May

MEDIFEST Class Schedule and Registration Form

May 27-28, 2004
Omni Jacksonville Hotel
245 Water Street
Jacksonville, FL 32202
Please contact hotel for directions and/or reservations 1-(904)-355-6664

Select one class per session (time slot)

DAY 1
Thursday, May 27

9:00AM - 10:30AM SESSION 1/DAY 1
- o Direct Data Exchange (DDE) (A)
- o Fraud & Abuse (A/B)
- o Global Surgery (B)
- o HOPPS (A)
- o Pathology (B)
- o Preventive Services (B)

10:45 AM – 12:15 PM SESSION 2/DAY 1
- o 57, 78, & 79 Modifier Workshop (B)
- o Life after a Claim Denial (B)
- o MSP for Part A Providers (A)
- o SNF (Consolidated Billing) (A/B)
- o Understanding LMRPs (A/B)
- o Urology (B)

1:30PM - 4:30PM SESSION 3/DAY 1/WORKSHOPS
- o ANSI 101 (HIPPA) (A/B)
- o Evaluation and Management Services (B)
- o Provider Enrollment (B)
- o MSP for Part B Providers (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
Friday, May 28

9:00AM – 12:00PM SESSION 1/DAY 2/WORKSHOPS
- o ANSI 101 (HIPPA) (A/B)
- o Evaluation and Management Services (B)
- o Provider Enrollment (B)
- o Medicaid (A) *****this course ends at 10:30 am***
- o MSP for Part B Providers (B)
- o Rehab Services (A/B)

1:30AM - 3:00PM SESSION 2/DAY 2
- o Anesthesia (B)
- o Appeals Process for Part A Providers (A)
- o Global Surgery (B)
- o Medicaid (B)
- o Inquiries received by the Medical Director's Office (A)
- o Preventive Services (B)

3:30PM - 5:00PM SESSION 3/DAY 2
- o 24, 25, & 57 Modifier Workshop
- o Diagnostic Radiology (B)
- o Fraud & Abuse (A/B)
- o Life after a Claim Denial (B)
- o Reason Code Resolution (A)
- o Understanding LMRPs (A/B)

For seminar cost and complete class descriptors, please visit our Web site at http://www.floridamedicare.com

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Provider's Name	
Street Address	
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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.

EDUCATIONAL RESOURCES

Announcing the New Medlearn Matters… Information for Medicare Providers

Educational Resource for Medicare Providers

The Centers for Medicare & Medicaid Services and your Medicare Learning Network introduces *Medlearn Matters…Information for Medicare Providers*, a new educational resource for Medicare Providers. *Medlearn Matters…Information for Medicare Providers* is designed to inform you of important changes to the Medicare system in a user-friendly format that will accommodate your busy schedule.

Please let us know if these articles help you understand these changes more readily. Provide us with suggestions for improvements to articles. If there is a special topic of interest that you believe warrants an article, let us know and we will consider a special edition for that topic. To provide feedback, please go to: *http://www.cms.hhs.gov/medlearn/suggestform.asp*

Bookmark this page, use it frequently, and let us know how best to continue providing good service to you.

Background

The Centers for Medicare & Medicaid Services (CMS) is committed to partnering with the Medicare physician, provider, and supplier communities so services to Medicare beneficiaries can be timely and of the highest quality. One way of providing the best services to Medicare patients is assuring that the providers of care have ready access to Medicare's latest coverage and reimbursement rules and policies in a brief, accurate, and easy-to-understand format.

CMS recognizes that the Medicare provider communities have been hampered by the number, frequency, and complexity of Medicare changes. CMS also appreciates the feedback from those same providers who indicate that Medicare rules and changes are not always relayed to them in an easy, timely, and consistent manner.

To address those issues, CMS has implemented a new initiative – "Consistency in Medicare Contractor Outreach Material" or CMCOM, designed to provide more timely information on Medicare changes. The product of this effort, *Medlearn Matters…Information for Medicare Providers*, is a series of articles prepared by actual clinicians and billing experts. *Medlearn Matters…Information for Medicare Providers* articles are tailored, in content and language, to the specific provider types who are affected by Medicare changes.

Previously, each Medicare carrier and intermediary was responsible for crafting educational articles within days of release of the related Medicare change. With this new effort, the Medicare carrier or fiscal intermediary will still be responsible for local provider education. However, they will benefit from the availability of *Medlearn Matters…Information for Medicare Providers* articles to support their efforts. These articles are easily accessible from the Medlearn Web site, which providers already access for other Medicare information.

Enlisting the expertise of medical professionals to develop these articles and providing them from a single location will result in more consistent, accurate, and timely information than in the past. This initiative supplements and should improve the ability of your carrier or intermediary to provide better service to you.

Those of you who have relied on Medicare Program Memorandums or Manual Transmittals on the Web, may be familiar with the Change Request (CR) documents and their accompanying CR numbers. Since you may have used the original CRs to get early information on upcoming changes, we think you will agree that those documents were not always clear as to provider impact and action needed.

One reason is that those CRs were written to provide instructions to Medicare carriers, intermediaries, and Medicare system maintainers. Thus, the focus of the message was quite different and probably contained more information than providers needed to know. The intent of *Medlearn Matters…Information for Medicare Providers* articles is to help focus the information more toward providers, to give you only the information you need and thus reduce the amount of time you need to spend on that information.

The articles will be placed on the Medlearn Web site on the new *Medlearn Matters…Information for Medicare Providers* page. Each article's number will usually correspond to the number of the Change Request (CR) that officially announced the change, but the number will be preceded by MM to show it is a related *Medlearn Matters…Information for Medicare Providers* article. There are exceptions, designated as Special Editions. These articles will be numbered in a distinctive manner, as "SEyynn" where "SE" stands for Special Edition, the "yy" is the two-digit year the article was released, and "nn" is the number of the special edition for that year. Thus, this first Special Edition article is numbered as SE0301.

To view all the articles available, please visit*: http://www.cms.hhs.gov/medlearn/matters*

We hope you find this new vehicle of assistance to you and we invite your feedback. ❖

Source: CMS Pub 10020 Transmittal 54, CR 3129, CMS Medlearn Matters Number: SE0401

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).

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

Reader Survey—*Medicare A Bulletin*

We want readers of this publication to find it to be a helpful tool that is easy to use and undestand . This survey is your opportunity to suggest ways we can better meet your needs. After the survey closes, we will publish the results on our Web site and work to implement suggested enhancements as appropriate. Thank you for taking the time to complete this survey!

Please complete the questions below and return your reply to us by March 31, 2004.

Overall Satisfaction

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

5 4 3 2 1

Accuracy

"When I read the *Medicare A Bulletin* I feel comfortable that the information presented is accurate."

5 4 3 2 1

"When I read the *Medicare A Bulletin* I am confident that the information is up-to-date."

5 4 3 2 1

Clarity

"Medicare rules and guidelines are complex; however, I generally find the articles in the *Medicare A Bulletin* clear."

5 4 3 2 1

"Medicare rules and guidelines are complex; however, I usually find the articles in the *Medicare A Bulletin* easy to read."

5 4 3 2 1

Value

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

5 4 3 2 1

Layout/Format

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

5 4 3 2 1

Comments/Feedback –

What else could we do to improve the publication for you?

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Medicare Communication and Education – Publications
Attention : Robert Hannan
P.O. Box 45270 – 10T
Jacksonville, FL 32232-5270

or you may **fax** your survey to (904) 791-6292.

Addresses

CLAIMS STATUS

Coverage Guidelines
Billing Issues Regarding
Outpatient Services, CORF, ORF, PHP
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

APPEAL RECONSIDERATIONS

Claim Denials (outpatient services only)
Medicare Fair Hearings (Part A)
P. O. Box 45203
Jacksonville, FL 32232-5203

MEDICARE SECONDARY PAYER (MSP)

Information on Hospital Protocols
Admission Questionnaires
Audits
Medicare Secondary Payer
Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

General MSP Information
Completion of UB-92 (MSP Related)
Conditional Payment
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Automobile Accident Cases
Settlements/Lawsuits
Other Liabilities
Medicare Secondary Payer Subrogation
P. O. Box 44179
Jacksonville, FL 32231-4179

PROVIDER EDUCATION

Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Seminar Registration Hotline
1-904-791-8103

ELECTRONIC CLAIM FILING

"DDE Startup"
Direct Data Entry (DDE)
P. O. Box 44071
Jacksonville, FL 32231-4071

FRAUD AND ABUSE

Medicare Fraud and Abuse
P. O. Box 45087
Jacksonville, FL 32232-5087

REVIEW REQUEST

Denied claims that may have been payable under the Medicare Part A program
Medicare Part A Reconsiderations
P. O. Box 45053
Jacksonville, FL 32232-5053

OVERPAYMENT COLLECTIONS

Repayment Plans for Part A Participating Providers
Cost Reports (original and amended)
Receipts and Acceptances
Tentative Settlement Determinations
Provider Statistical and Reimbursement (PS&R) Reports
Cost Report Settlement (payments due to provider or Program)
Interim Rate Determinations
TEFRA Target Limit and Skilled Nursing Facility Routine Cost Limit Exceptions
Freedom of Information Act Requests (relative to cost reports and audits)
Provider Audit and Reimbursement Department (PARD)
P.O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

MEDICARE REGISTRATION

American Diabetes Association Certificates
Medicare Registration – ADA
P. O. Box 2078
Jacksonville, FL 32231-2078

Phone Numbers

PROVIDERS

Customer Service Representatives
Toll-Free
1-877-602-8816

BENEFICIARY

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

ELECTRONIC MEDIA CLAIMS

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

Electronic Eligibility
1-904-791-8131

Electronic Remittance Advice
1-904-791-6865

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

PC-ACE Support
1-904-355-0313

Testing
1-904-791-6865

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

Medicare Web Sites

PROVIDERS

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

BENEFICIARIES

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

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY

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

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)

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

RAILROAD MEDICARE

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

MEDICARE A BULLETIN

FIRST COAST SERVICE OPTIONS, INC. ❖ P.O. BOX 2078 ❖ JACKSONVILLE, FL 32231-0048