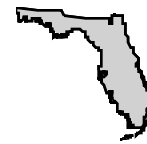


# Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers



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**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 website at [www.floridamedicare.com](http://www.floridamedicare.com).

#### Routing Suggestions:

- Medicare Manager
- Reimbursement Director
- Chief Financial Officer
- Compliance Officer
- DRG Coordinator
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



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**Medicare A  
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2005**

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

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

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32232-5270**

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## A PHYSICIAN'S FOCUS

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

As a contractor for the Centers for Medicare & Medicaid Services (CMS) (Medicare Part B carrier and Medicare Part A fiscal intermediary), First Coast Service Options, Inc. (FCSO) administers traditional Medicare Part B for Florida and Connecticut and Part A for a majority of Florida providers. Medicare contractor medical directors provide medical leadership for the capabilities and decision making of the carrier and intermediary. Medical policy development, medical review, quality improvement, and physician and allied professional relationships are major areas of focus.



Last December, Dr. John Montgomery took the challenge of a new, exciting position with our parent company, Blue Cross and Blue Shield of Florida. With this background, I am pleased to announce the appointment of a new contractor medical director, *Eugene J. Winter, M.D.*, effective June 18, 2005.

Dr. Winter received his M.D. from Wolfgang Goethe University, Frankfurt am Main, Germany. His post-graduate training included internships in Medicine and Surgery at Hanau Municipal Hospital-Frankfurt University and a fellowship in Cardiology at Frankfurt University Medical Center. He completed a residency in Internal Medicine at Vanderbilt University in Nashville, TN and later took a full time faculty position as an assistant professor of Medicine at Vanderbilt University School of Medicine where he taught and supervised medical students and resident physicians. He has extensive experience in both health care administration and patient care. He enjoyed private practice for over two decades with a special interest in practice management computer systems. Most recently, Dr. Winter served as the contractor medical director for CIGNA HealthCare Medicare Administration (Part B Tennessee). He is board certified in Internal Medicine since 1978.

Dr. Winter's contact information at our Jacksonville office is phone: 904-791-8182 and e-mail: [Eugene.Winter@fcso.com](mailto:Eugene.Winter@fcso.com).

I am excited about the opportunity to work closely with Dr. Winter in the Medicare program. We will share responsibilities in Medicare Part A and B.

James J. Corcoran, M.D., M.P.H.  
FCSO Chief Medical Director  
[James.Corcoran@fcso.com](mailto: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 2005	Mid-November 2004	January 1, 2005
Second Quarter 2005	Mid-February 2005	April 1, 2005
Third Quarter 2005	Mid-May 2005	July 1, 2005
<b>Fourth Quarter 2005</b>	<b>Mid August 2005</b>	<b>October 1, 2005</b>

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

**Who Receives the Bulletin?**

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

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

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

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

**What Is in the Bulletin?**

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

- The publication starts with a column by the Intermediary Medical Director.
- Following an administrative section are usually general information and coverage sections with informational and billing issues, processing guidelines, and medical coverage applicable to all Medicare Part A providers and facilities.

- Coverage guidelines and billing issues targeting specific facilities or Part A providers are usually included in individual sections named under the applicable facility type. These facility-specific sections are in the *Bulletin* only when an article in that category is published (for example, if no CORF/ORF information is in the issue, that section is omitted.)
- As needed, the *Bulletin* contains Electronic Data Interchange and Fraud and Abuse sections.
- The Local Medical Review Policy (LMRP)Local Coverage Determination (LCD) section contains notification of revisions to finalized medical policies and additions, revisions, and corrections to previously published LMRPs/LCDs. 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 website 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  
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 Jacksonville, FL 32232-5270

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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 website <http://www.floridamedicare.com>. It's very easy to do. Simply go to the website, click on the "eNews" link on the navigational menu and follow the prompts.



# GENERAL INFORMATION

## 2006 Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification

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

### Provider Types Affected

Physicians, suppliers, hospitals and other providers billing Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs)

### Provider Action Needed STOP – Impact to You

Medicare will soon issue the annual update of the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* to Medicare contractors. This update will apply for claims with service dates on or after October 1, 2005 and discharges and through dates on or after October 1, 2005 for institutional providers.

### CAUTION – What You Need to Know

An ICD-9-CM code is required for all professional claims, e.g., physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, ambulatory surgical centers (ASCs), and for all institutional claims, but **not** for ambulance supplier claims. Remember that as of October 1, 2004, Medicare no longer provides a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes.

### GO – What You Need to Do

Be ready to use the updated codes on October 1, 2005. Please refer to the *Background* and *Additional Information* sections of this article for further details regarding this instruction.

### Background

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

- Dates of service on or after October 1, 2005, and
- Discharges and through dates on or after October 1, 2005 for institutional providers

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

- Beginning in 1979, ICD-9-CM codes became mandatory for reporting provider services on Form CMS-1450.
- On April 1, 1989, the use of ICD-9-CM diagnosis codes became mandatory for all physician services submitted on Form CMS-1500.

- Effective October 1, 2003, an ICD-9-CM diagnosis code was required on all paper and electronic claims billed to Medicare carriers with the exception of ambulance claims (specialty type 59). See change request 2725, dated June 6, 2003, at [http://www.cms.hhs.gov/manuals/pm\\_trans/B03045.pdf](http://www.cms.hhs.gov/manuals/pm_trans/B03045.pdf).

**Note:** Effective for dates of service on and after October 1, 2004, CMS no longer provided a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets be date-of-service compliant, and ICD-9-CM diagnosis codes are a medical code set. See CR 3094, dated February 6, 2004 at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R95CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R95CP.pdf).

### Additional Information

#### Publication of ICD-9-CM Codes

- Updated ICD-9-CM codes are published in the *Federal Register* in April/May of each year as part of the proposed changes to the hospital inpatient prospective payment system, and are effective each October first. Physicians, practitioners, and suppliers must use the current and valid diagnosis code that is in effect beginning October 1, 2005.
- After the ICD-9-CM codes are published in the *Federal Register*, CMS places the new, revised, and discontinued codes on the following website: <http://www.cms.hhs.gov/medlearn/icd9code.asp>.

The update is available at this site since June.

- The updated ICD-9-CM diagnosis codes can also be viewed at the National Center for Health Statistics (NCHS) web site at: <http://www.cdc.gov/nchs/icd9.htm>.

This posting is available at this site since June.

- Providers are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

### Implementation

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

### Related Instructions

The ICD-9-CM codes are updated annually as stated in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service). That manual may be accessed on the CMS web site at [http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp).

## 2006 Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (continued)

The official instruction issued to your carrier can be found by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that web site, look for CR3888 in the CR NUM column on the right, and click on the file for that CR.

For additional information relating to this issue, please refer to your local carrier or intermediary at their toll free number, which may be found at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

Medlearn Matters articles are prepared as a service to the public and are not intended to grant rights or impose obligations. Medlearn Matters articles may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

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

Related Change Request (CR) Number: 3888

Related CR Release Date: June 24, 2005

Related CR Transmittal Number: 591

Effective Date: October 1, 2005

Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 591, CR 3888

## Modification of Roster Billing for Mass Immunizers Billing for Inpatient Part B Services (Type of Bills 12x and 22x)

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

### Provider Types Affected

Providers submitting roster bills for mass immunizations for Inpatient Part B services to Medicare fiscal intermediaries (FIs)

### Provider Action Needed STOP – Impact to You

Effective October 1, 2005, providers submitting roster bills for mass immunizations provided under Medicare Part B for inpatients must include additional data elements as required by the Health Insurance Portability and Accountability Act (HIPAA).

### CAUTION – What You Need to Know

Failure to submit these elements on claims submitted on type of bills (TOBs) 12x and 22x will delay processing and paying your roster billing claims.

### GO – What You Need to Do

Be sure billing staff are aware of the need to include the additional HIPAA-required data elements to your roster bills, as listed in this instruction.

### Background

Some potential "mass immunizers," such as hospital outpatient departments and home health agencies (HHAs), have expressed concerns about the complexity of billing for the influenza virus vaccine and its administration. Consequently, to accommodate for the possible increase in the number of beneficiaries who obtain needed preventive immunizations, simplified (roster) billing procedures are available to mass immunizers, and the simplified (roster) claims filing procedure has been expanded for pneumococcal Pneumonia vaccine (PPV).

A mass immunizer is defined as any entity that gives the influenza virus vaccine or PPV to a group of beneficiaries at public health clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. **To qualify for roster billing, immunizations of at least five beneficiaries on the same date are required.**

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For inpatient Part B services (TOBs 12x and 22x), the following data elements are also required on the roster when billing (TOBs 12x and 22x) effective October 1, 2005:

- Admission date
- Admission type
- Admission diagnosis
- Admission source code
- Patient status code
- Discharge date

### Implementation

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

### Additional Information

The revised pages of the Medicare Claims Processing Manual, Chapter 18, Section 10.3.2, contain further details regarding roster billing for mass immunizations. That revised section is attached to the official instruction issued to your intermediary regarding this change. That instruction may be viewed at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3735 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3735

Related CR Release Date: April 29, 2005

Related CR Transmittal Number: 542

Effective Date: October 1, 2005

Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 542, CR 3735

## New Patient Status Code to Define Discharges or Transfers to a Critical Access Hospital

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

### Provider Types Affected

Providers that bill Medicare fiscal intermediaries (FIs) for patients discharged or transferred to critical access hospitals (CAHs)

### Provider Action Needed

#### STOP – Impact to You

Effective for claims with discharge/ “to” dates on or after January 1, 2006, stop using a generic code when discharging or transferring to a CAH.

#### CAUTION – What You Need to Know

The new patient code of “66” must be entered on a claim when a patient is discharged or transferred to a CAH.

#### GO – What You Need to Do

Use patient status code 66 as defined by the National Uniform Billing Committee (NUBC) for discharges/transfers to a CAH.

### Background

Critical access hospitals were created by Congress in the Balanced Budget Act of 1997 and are hospitals with limited services located in rural areas. Their charge is to provide emergency care services, have an average stay of 96 hours or less, **and** are located more than 35 miles from a hospital or another CAH, or are located more than 15 miles from hospitals in areas with mountainous terrain or only secondary roads, or are certified by the state as being a “necessary provider” of health care services to residents in the area. More information about CAHs is available on the CMS website at:

<http://www.cms.hhs.gov/providers/cah/default.asp>.

Previous to the introduction of this new code, there was no patient status code to define discharges or transfers to a CAH. Providers used 01, 05, or some other code since there was no specific code available.

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Effective for claims with discharge dates or “to” dates on January 1, 2006, or later, the patient status code 66 must be used.

While there are no Medicare payment implications for the use of this code at this time for transfers, the patient status code is a required field and providers must code it correctly.

### Implementation

Medicare systems will actually implement the change on October 3, 2005, but the change will apply to claims with discharge/ “to” dates of January 1, 2006, or later.

### Additional Information

You may view the official instruction that was released to your intermediary at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3829 in the CR column on the right and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3829

Related CR Release Date: May 13, 2005

Related CR Transmittal Number: 156

Effective Date: Discharges/ “to” dates on or after January 1, 2006

Implementation Date: October 3, 2005 (relates to Medicare system implementation date)

Source: CMS Pub. 100-20, Transmittal 156, CR 3829

## Healthcare Provider Taxonomy Code Update

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

### Provider Types Affected

Medicare providers billing Medicare fiscal intermediaries (FIs)

### Provider Action Needed

#### STOP – Impact to You

This article includes information from CR 3803, which instructs FIs to obtain the most recent healthcare provider taxonomy code (HPTC) list, and use it to update their internal HPTC tables.

#### CAUTION – What You Need to Know

The Health Insurance Portability and Accountability Act (HIPAA) requires that submitted data that is part of a named code set be valid data from that code set.

Claims submitted with invalid data are not compliant with HIPAA.

#### GO – What You Need to Do

Because healthcare provider taxonomy is a named code set in the ANSI ASC X12N 837 Institutional Implementation Guide, Medicare FIs must validate inbound HPTCs against their internal HPTC tables. Please review the information included in the *Background* section, and be sure to stay current on all HIPAA requirements to ensure timely processing of your claims.

### Background

The healthcare provider taxonomy code (HPTC) set is an external non-medical data code set used to classify health care providers according to:

**Healthcare Provider Taxonomy Code Update (continued)**

- Provider type; or
- Practitioner specialty in an electronic environment (specifically within the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) health care transaction).

HPTCs are updated twice per year (April and October), and the HPTC list is available in the following two forms from the Washington Publishing Company website at: <http://www.wpc-edi.com/codes/taxonomy>.

- A free Adobe PDF download of the HPTC list; and
- An electronic representation of the HPTC list (available for purchase), which facilitates the automatic loading of the code set.

HIPAA requires that submitted data that is part of a named code set be valid data from that code set.

**Note:** Claims received with invalid data are noncompliant with HIPAA and will not be processed by Medicare.

**Implementation**

The implementation date for instruction in CR 3803 is October 3, 2005.

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**Additional Information**

For complete details, please see the official instruction issued to your intermediary regarding this change.

That instruction may be viewed by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3803 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3803

Related CR Release Date: April 29, 2005

Related CR Transmittal Number: 543

Effective Date: October 3, 2005

Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 543, CR 3803

**High-Osmolar Contrast Material—New HCPCS Drug Codes**

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

**Provider Types Affected**

Physicians, providers, and suppliers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), or fiscal intermediaries (FIs) for high osmolar contrast material (HOCM) and iloprost inhalation solution

**Provider Action Needed**

Effective July 1, 2005, for dates of service on or after July 1, 2005, HCPCS code Q4080, for iloprost inhalation solution, and HCPCS codes Q9958 – Q9964, for high osmolar contrast material, are being added to the HCPCS. Be aware of the new codes for iloprost inhalation solution and high osmolar contrast material when reporting these services to Medicare.

**Additional Information**

Effective July 1, 2005, the following codes are being added to the HCPCS for iloprost inhalation solution and high osmolar contrast material.

HCPCS Code	Short Descriptor	Long Descriptor
Q4080	Iloprost inhalation solution	Iloprost, inhalation solution, administered through DME, 20 mcg
Q9958	HOCM <=149 mg/ml iodine, 1 ml	High osmolar contrast material, up to 149 mg/ml iodine concentration, per ml
Q9959	HOCM 150-199 mg/ml iodine, 1 ml	High osmolar contrast material, 150 - 199 mg/ml iodine concentration, per ml
Q9960	HOCM 200-249 mg/ml iodine, 1 ml	High osmolar contrast material, 200 - 249 mg/ml iodine concentration, per ml
Q9961	HOCM 250-299 mg/ml iodine, 1 ml	High osmolar contrast material, 250 - 299 mg/ml iodine concentration, per ml
Q9962	HOCM 300-349 mg/ml iodine, 1 ml	High osmolar contrast material, 300 - 349 mg/ml iodine concentration, per ml
Q9963	HOCM 350-399 mg/ml iodine, 1 ml	High osmolar contrast material, 350 - 399 mg/ml iodine concentration, per ml
Q9964	HOCM >= 400 mg/ml iodine, 1 ml	High osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml



**High-Osmolar Contrast Material—New HCPCS Drug Codes (continued)**

Also, please note the following:

- As stated in Section 30 of Chapter 13 of the Medicare Claims Processing Manual (Publication 100-04), payment for HOCMs is included in the payment for the procedure and separate payment for the HOCMs is not allowed.
- As stated in CR 3846, the payment allowance limits for new drugs and biologicals not included in the average sales price (ASP) Medicare Part B drug pricing file or not otherwise classified (NOC) pricing file are based on 106 per cent of the wholesale acquisition cost (WAC). A Medlearn Matters article related to CR 3846 is available on CMS website at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3846.pdf>.
- Those billing Medicare carriers may note that code Q4080 will be assigned to status indicator “E” and codes Q9958-Q9964 will be assigned status indicator “B” in the Medicare physician fee schedule database.
- While Medicare carriers and DMERCs will accept Q4080 to report iloprost inhalation solution, only Medicare DMERCs will make payment for Q4080.
- Where appropriate, revenue code 0636 should be assigned when billing these HOCM HCPCS codes.
- Critical access hospital outpatient departments should bill for codes Q4080 and Q9958-Q9964 using type of bill (TOB) 85x. Payment for such services will be

based on reasonable cost and beneficiary deductible and coinsurance does apply.

- Skilled nursing facilities billing under Medicare Part B should use TOB 22x (for inpatient Part B) and 23x (outpatient) for codes Q4080 and Q9958-Q9964. Payments to the SNFs will also be made on a reasonable cost basis and beneficiary deductible and coinsurance does apply.

The official instruction issued to your FI/carrier/DMERC regarding this change may be found by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3847 in the CR NUM column on the right, and then click on the file for that CR.

If you have questions regarding this issue, contact your FI/carrier/DMERC on their toll free number, which is available at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3847

Related CR Release Date: June 10, 2005

Related CR Transmittal Number: 600

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 600, CR 3847

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## Third Update to the 2004 Medicare Physician Fee Schedule—Full Replacement of CR 3415

*CMS has issued the following “Medlearn Matters... Information for Medicare Providers” article.*

The Centers for Medicare & Medicaid Services (CMS) has advised Medicare contractors that instructions issue with Medlearn Matters article MM3415 based on change request (CR) 3415 has been fully replaced by CR 3505, Transmittal 306; dated October 1, 2004 – Full Replacement of CR 3415, 3rd Update to the 2004 Medicare Physician Fee Schedule Database. The original Medlearn Matters article MM3505, replacing MM3415, was published in the [First Quarter 2005 Medicare A Bulletin](#) (page 10).

You may see CR 3505 (Transmittal 306) on CMS website at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R306CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R306CP.pdf).

Also, see the Medlearn Matters article related to CR 3505 (Transmittal 306) at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3505.pdf>.

Related Change Request (CR) Number: 3415

Related CR Release Date: August 13, 2004

Related CR Transmittal Number: 278

Effective Date: January 1, 2004

Implementation Date: October 4, 2004

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

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## **Comprehensive Error Rate Testing Program—The Importance of Complying with Requests for Claim Documentation**

*CMS has issued the following “Medlearn Matters... Information for Medicare Providers” article.*

**Note:** The Centers for Medicare & Medicaid Services (CMS) revised this article on May 2, 2005 to show the 2004 national gross paid claims error rate in the “STOP” section, and to correct the phone number provided in the “Additional Information” section. The original special edition Medlearn Matters article SE0526 was published in the [Third Quarter 2005 Medicare A Bulletin](#) (pages 14-15).

### **Provider Types Affected**

Medicare fee-for-service (FFS) physicians, providers and suppliers

### **Provider Action Needed**

#### **STOP – Impact to You**

The 2004 national gross paid claims error rate was 10.1 percent. A portion of this error rate was due to providers not sending requested supporting documentation to the designated CERT contractor. Medicare FFS physicians, providers and suppliers must provide documentation and medical records that support their claims for covered Medicare services to the designated CERT contractor upon request. If you fail to submit documentation, the claim will be considered an error and you will receive a demand letter requesting refund of payment received for the “erroneous” claim.

#### **CAUTION – What You Need to Know**

During a CERT review, you may be asked to provide more information related to a claim you submitted, such as medical records or certificates of medical necessity, so that the CERT review contractor (CRC) can verify that billing was proper. Be assured that forwarding specifically requested records to the designated CERT contractor does not violate privacy provisions under the Health Insurance Portability and Accountability (HIPAA) law.

#### **GO – What You Need to Do**

If you receive a letter from CMS regarding a CERT request for medical documentation, you should respond promptly by submitting the requested supporting documentation within the time frame outlined in the request. Physicians, providers and suppliers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor. This special edition article provides an overview of the CERT program and stresses the importance of providing the requested medical documentation for the CERT review.

### **Background**

The Government Performance and Results Act of 1993 established performance measurement standards for federal agencies. To achieve the goals of this Act, CMS established the comprehensive error-rate testing (CERT) program in November 2003. The purpose of the CERT program is to measure and improve the quality and accuracy of Medicare claims submission, processing and payment. The results of these reviews are used to characterize and quantify local, regional and national error rate patterns. CMS uses this information to address the error rate through appropriate educational and interventional programs.

### **Methodology**

The CERT program was originally administered by the Department of Health and Human Services, Office of the Inspector General (OIG) from 1996 - 2002. During this

period, the OIG designed a sampling method that estimated only a national FFS paid claims error rate (the percentage of dollars that Medicare contractors erroneously allowed). Currently, CMS calculates a national paid claims error rate, a contractor specific error rate, services processed error rate (which measures whether the Medicare contractor made appropriate payment decisions on claims) and a **provider compliance error rate** (which measures how well providers prepared claims for submission). The CMS methodology includes:

- Randomly selecting a sample of claims submitted in a specific calendar year.
- Requesting medical records from providers who submitted the claims.
- Reviewing the claims and medical records to see if the claims complied with the Medicare coverage, coding, and billing rules.
- **When providers fail to submit the requested documentation, treating the claims as errors and sending the providers overpayment letters.**

The designated CERT review contractor currently reviews over 140,000 randomly selected claims and corresponding medical records each year, with a medical review staff that includes physicians and nurses who can use clinical judgment when necessary in reviewing medical records. Their medical review staff has access to national and local policies, contractor processing guidelines and automated edits.

**If you fail to submit the requested information in a timely fashion, an “error” is registered against both the Medicare contractor (your Medicare fiscal intermediary or carrier) and you, as the Medicare provider.** (At this point, the CERT review contractor has no choice but to register the claim submission as “erroneous” because there is insufficient supporting documentation to determine otherwise.) These errors have a corresponding negative impact on the other error rates that are calculated under the CERT program.

### **Your Role Is Critical To Improvement**

Our research has shown that providers do not comply with the requests for information because:

- They believe it is a violation of the Health Insurance Portability and Accountability Act (HIPAA) to send patient records to the designated CERT contractor; or
- They are unaware of the CERT process, and they may not appreciate the importance of cooperating in a timely fashion.

Medicare beneficiaries have consented to the release of medical information necessary to process their Medicare

**CERT Program—The Importance of Complying with Requests for Claim Documentation (continued)**

claims. **Providers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor.** Be assured that forwarding specifically requested records to the designated CERT contractor does not violate HIPAA Privacy statutes.

**If You Receive A Letter From CMS Regarding A CERT Medical Review...**

1. **Don't ignore it!** Respond promptly by submitting the requested supporting documentation within the time frame outlined in the request. The letter will provide a clearly defined list of the documentation required and where to submit the information.
2. Include any additional material that you believe supports the service(s) billed to the Medicare program.
3. Make sure your address files and telephone numbers that are on file with your carrier or fiscal intermediary are accurate to ensure that CERT documentation requests are received and allow time for you to respond timely.
4. Remember that physicians, providers and suppliers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor.

**Additional Information**

In an effort to assist Medicare physicians, providers and suppliers with CERT compliance, we have several resources available to explain the CERT process and how your responsiveness is in everyone's best interest.

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- CERT Web page (<http://www.cms.hhs.gov/cert>)
- CERT Newsletters (<http://www.cms.hhs.gov/cert/letters.asp>)
- A designated telephone number for Medicare physicians, providers and suppliers for general information and questions regarding the CERT initiative – 1-804-864-9940.

In addition, we are preparing a series of fact sheets, frequently asked questions, and future Medlearn Matters articles to provide further guidance regarding the CERT process.

**REMEMBER:**

Review can result in identification of overpayments as well as underpayments.

If CERT changes the payment decision on your claim by denying or reducing payment, you can still file an appeal with your Medicare contractor.

It is in everyone's interest to code and pay claims correctly. Your support of this process helps protect the solvency of the Medicare Program.

Your cooperation also allows your Medicare contractor to provide individualized education to you on your specific CERT errors.

Special Edition Number: SE0526  
Related Change Request (CR): N/A  
Effective Date: N/A

Source: CMS Special Edition Medlearn Article SE0526

## Implementation of the Comprehensive Error Rate Testing Shared System Module for Calculating Line Level Error Rates

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

**Provider Types Affected**

Providers billing Medicare fiscal intermediaries (FIs)

**Provider Action Needed****STOP – Impact to You**

This article includes information from Change Request (CR) 3812, which revises Medicare systems to capture the claim level covered charge amount into the Medicare Initial Allowed Charge field in time for Medicare FIs computing provider compliance error rates beginning October 3, 2005.

**CAUTION – What You Need to Know**

The provider compliance error rate is a good indicator of how well Medicare carriers/FIs are educating their provider communities. Currently, carriers, including durable medical equipment regional carriers (DMERCs), are able to compute this error rate. This change will allow FIs to do the same.

**GO – What You Need to Do**

Providers billing FIs may want to be familiar with how this error rate is computed and understand that Medicare will use these error rates to help focus on areas of improve-

ment in order to reduce claims errors. Providers can help reduce this error rate by carefully following billing instructions from their Medicare contractor (carrier or intermediary) and their billing agent and participating in education activities provided by their Medicare contractor.

**Background**

The Centers for Medicare & Medicaid Services (CMS) believes that strong outcome-oriented performance measures are a good way to 1) assess the degree to which a government program is accomplishing its mission, and 2) identify improvement opportunities. Therefore, CMS established the following programs to monitor the accuracy of the Medicare fee-for-service (FFS) program:

- **The Comprehensive Error Rate Testing (CERT) program** – This program calculates the error rates for carriers, durable medical equipment regional carriers (DMERCs), and FIs; and
- **The Hospital Payment Monitoring Program (HPMP)** – This program calculates the error rate for the quality improvement organizations (QIOs).

### *Implementation of the CERT Shared System Module for Calculating Line Level Error Rates (continued)*

The **national paid claims error rate** is a combination of error rates calculated by the CERT contractor and HPMP with each component representing about 50 percent of the error rate.

For fiscal year (FY) 2004, the performance measurement process for the Medicare FFS program is described in the FY2004 *Improper Medicare Fee-for-Service Payments Report*.

For FY 1996 to 2002, the Department of Health & Human Services (DHHS), Office of Inspector General (OIG) produced Medicare FFS error rates. The OIG designed a sampling method that estimated only a national FFS paid claims error rate (the percentage of dollars that carriers/DMERCs/FIs/QIOs erroneously paid). However, CMS has decided to calculate a number of additional rates 1) to better measure the performance of the carriers/DMERCs/FIs and 2) to gain insight about the causes of errors. These additional rates include:

- **Provider compliance error rate** (which measures how well providers prepared claims for submission).
- **Contractor-specific paid claims error rates** (which measure how accurately each specific carrier/DMERC/FI/QIO made claims payment decisions).

For the FY2004 *Improper Medicare Fee-for-Service Payments Report*, CMS calculated the Medicare FFS error rate and improper payment estimate using the following OIG-approved methodology:

- A sample of approximately 160,803 claims submitted in calendar year 2003 were randomly selected.
- Medical records were requested from providers that submitted the claims in the sample.
- The claims and medical records were reviewed to see if the claims complied with Medicare coverage, coding, and billing rules.
- Errors were assigned to claims denied or paid incorrectly.
- Providers who did not supply needed documentation were classified as non-responders.
- Non-response claims were treated as errors.
- Carriers/DMERCs/FIs sent overpayment letters to providers for claims that were overpaid.

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## Modified Edits for Matching Claims Data to Beneficiary Records—SE0516

The Centers for Medicare & Medicaid Services (CMS) has notified Medicare contractors that the special edition article SE0516 – Modified Edits for Matching Claim Data to Beneficiary Records published in the Third Quarter 2005 *Medicare A Bulletin* (pg. 18) is no longer valid. Please disregard instructions given in the special edition article SE0516.

We apologize for any inconvenience this may have caused. ❖

Source: CMS Special Edition Medlearn Matters SE0516

### **The Provider Compliance Error Rate**

One of the rates needed for the *Improper Medicare Fee-for-Service Payments Report* is the **Provider Compliance Error Rate**. This rate is based on how the claims looked when they first arrived at the carrier/DMERC/FI – before the carrier/DMERC/FI applied any edits or conducted any reviews. The Provider Compliance Error Rate is a good indicator of how well the carrier/DMERC/FI is educating the provider community since it measures how well providers prepared claims for submission.

CMS can calculate this rate for carriers and DMERCs because CMS gets information on how claims looked when they arrived at carriers and DMERCs; but CMS cannot calculate this rate for FIs because CMS does not get information on how claims looked when they arrived at FIs as part of FI reporting. As a result of CR 3812, FIs will begin to capture this information on claims they receive.

### **Implementation**

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

### **Additional Information**

The FY2004 *Improper Medicare Fee-for-Service Payments Report* can be reviewed at the following CMS website: <http://coverage.cms.fu.com/certpublic/2004-Medicare-Error-Rate-Short-Report-v9.pdf>.

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3812 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3812

Related CR Release Date: May 2, 2005

Related CR Transmittal Number: 111

Effective Date: October 3, 2005

Implementation Date: October 3, 2005

Source: CMS Pub. 100-8, Transmittal 111, CR 3812



## Correction of 2005 Payment Fees for Clinical Laboratory Travel—Codes P9603 and P9604

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

### Provider Types Affected

Clinical laboratories and providers billing Medicare carriers or fiscal intermediaries for travel to perform a specimen collection

### Provider Action Needed

#### STOP – Impact to You

This instruction relates corrections to the 2005 payment fees provided in CR 3526 for P9603 and P9604, which relate to transportation to a nursing home or homebound patient to perform a specimen collection.

#### CAUTION – What You Need to Know

Article MM3526 and related CR 3526 incorrectly stated the standard mileage rate for transportation to a nursing home or homebound patient to perform a specimen collection as \$.385 per mile. Effective for dates of service January 1, 2005 through December 31, 2005, the correct standard mileage rate for transportation is \$.405 per mile. Effective for dates of service January 1, 2005 through December 31, 2005, the personnel payment is \$.45 per mile. Accordingly, the corrected 2005 payment fees for code P9603 is \$.855 and for code P9604 is \$.855.

#### GO – What You Need to Do

To ensure accurate claims processing, review the information included in this instruction and stay current with updates for clinical laboratory fee schedule and laboratory services.

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### Additional Information

Please note that Medicare carriers and intermediaries will not automatically adjust any claims paid prior to the implementation of this correction. However, they will make corrections if the provider brings such claims to their attention.

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change, which may be found at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3785 in the CR NUM column on the right, and then click on the file for that CR.

If you have questions regarding this issue, contact your intermediary/carrier on their toll free number, which is available at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3785

Related CR Release Date: May 6, 2005

Related CR Transmittal Number: 154

Effective Date: January 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-20, Transmittal 154, CR 3785

## April 2005 and Revisions to January 2005 Quarterly Average Sales Price Medicare Part B Drug Pricing File

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

### Provider Types Affected

All Medicare providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs)

### Provider Action Needed

#### STOP – Impact to You

CR 3846 revises payment allowance limits in the January 2005 and the April 2005 drug pricing files. For the codes listed below, the revised payment limits supersede the payment limits cited in any previously published document.

#### CAUTION – What You Need to Know

Effective January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals (that are not paid on a cost or prospective payment basis) are 106 percent of the average sales price (ASP).

#### GO – What You Need to Do

Make sure that your billing staffs are aware of these changes.

### Background

The Medicare Modernization Act of 2003 (MMA), Section 303, revises the payment methodology for Part B

covered drugs and biologicals that are not paid on a cost or prospective payment basis. Effective January 1, 2005, these drugs and biologicals are paid based on the new ASP drug payment methodology.

The ASP file, used in the ASP methodology, is based on data that CMS receives quarterly from manufacturers. Each quarter, CMS will update your carrier and FI payment allowance limits with the ASP drug pricing files based on these manufacturers' data. Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. However, you should be aware that there are exceptions to this general rule as summarized below:

- For **blood and blood products** (with certain exceptions like blood clotting factors), payment allowance limits are determined in the same manner they were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. **The payment allowance limits will be updated quarterly.**

## GENERAL INFORMATION

### April 2005 and Revisions to January 2005 Quarterly ASP Medicare Part B Drug Pricing File (continued)

- For **infusion drugs** furnished through a covered item of durable medical equipment (DME) on or after January 1, 2005, payment allowance limits will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, regardless of whether or not the DME is implanted. **The payment allowance limits will not be updated in 2005.**

**Note:** For infusion drugs (furnished through a DME covered item) that were not listed in the published compendia as of October 1, 2003 (i.e., new drugs), the payment allowance limits are 95 percent of the first published AWP.

- For influenza, pneumococcal, and hepatitis B vaccines, payment allowance limits are 95 percent of the AWP as reflected in the published compendia. The payment allowance limits will be updated quarterly.
- For drugs (other than new drugs) not included in the ASP Medicare Part B drug pricing file or not otherwise classified (NOC) pricing file, payment allowance limits are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the WAC-based payment limit, FIs/carriers/DMERCs will follow

the methodology specified in the Medicare Claims Processing Manual for calculating the AWP, but substitute WAC for AWP. Please see Pub. 100-04, Chapter 17 (Drugs and Biologicals) at the following CMS website: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c17.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c17.pdf).

The payment limit is 100 percent of the lesser of the lowest brand or median generic WAC. Your FI or carrier may, at their discretion, contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files. If available, CMS will provide the payment limits either directly to the requesting FI/carrier or will post them in an MS Excel file on the CMS website. If the payment limit is available from CMS, FIs/carriers will substitute the CMS-provided payment limits for pricing based on WAC or invoice pricing.

- For **new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File**, payment allowance limits are based on 106 percent of the WAC. This policy applies only to new drugs that were first sold on or after January 1, 2005.

Table 1 below displays the revised first quarter 2005 payment allowance limits for the indicated codes, effective for services provided on or after January 1, 2005.

**Table 1**

CPT/ HCPCS	Short Description	HCPCS Code Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit
90371	Hep B ig, im	1 ml	\$115.878	\$115.878
J2790	Rho d immune globulin, inj	300 mcg	\$101.733	\$101.733
J2792	Rho (D) immune globulin	100 IU	\$13.101	\$13.101
Q0187	NovoSeven	per 1.2 mg	\$1,211.050	\$1,211.050

Table 2 below displays the revised second quarter 2005 payment allowance limits for the indicated codes, effective for services provided on or after April 1, 2005.

**Table 2**

CPT/ HCPCS	Short Description	HCPCS Code Dosage	2 <sup>nd</sup> Qtr 2005 Payment Limit	2 <sup>nd</sup> Qtr 2005 Independent ESRD Limit	2 <sup>nd</sup> Qtr 2005 Vaccine Limit	2 <sup>nd</sup> Qtr 2005 Blood Limit
90747	Hep B vacc, ill pat 4 dose im	40 mcg	\$113.915	\$113.915	\$113.915	
J0135	Adalimumab injection	20 mg	\$294.632	\$294.632		
J0287	Amphotericin b lipid complex	10 mg	\$11.724	\$11.724		
J0725	Chorionic gonadotropin	1000 units	\$2.976	\$2.976		
J2597	Inj desmopressin acetate	1 mcg	\$2.493	\$2.493		
J7190	Factor viii	1 IU	\$0.641	\$0.641		
J7192	Factor viii recombinant	1 IU	\$1.063	\$1.063		
J7193	Factor IX non-recombinant	1 IU	\$0.882	\$0.882		
J7194	Factor ix complex	1 IU	\$0.650	\$0.650		
J7195	Factor IX recombinant	1 IU	\$0.982	\$0.982		
J7197	Antithrombin iii injection	1 IU	\$1.543	\$1.543		
J7198	Anti-inhibitor	1 IU	\$1.241	\$1.241		

*April 2005 and Revisions to January 2005 Quarterly ASP Medicare Part B Drug Pricing File (continued)*

CPT/ HCPCS	Short Description	HCPCS Code Dosage	2 <sup>nd</sup> Qtr 2005 Payment Limit	2 <sup>nd</sup> Qtr 2005 Independent ESRD Limit	2 <sup>nd</sup> Qtr 2005 Vaccine Limit	2 <sup>nd</sup> Qtr 2005 Blood Limit
J7344	Nonmetabolic active tissue	1 sq. cm	\$52.777	\$52.777		
J9098	Cytarabine liposome	10 mg	\$359.359	\$359.359		
J9245	Inj melphalan hydrochl	50 mg	\$513.694	\$513.694		
J9266	Pegaspargase single dose vial	1 ea	\$1,499.306	\$1,499.306		
P9041	Albumin (human),5%	50 ml	\$14.545	\$14.545		\$14.545
P9043	Plasma protein fraction, 5%	50 ml	\$14.545	\$14.545		\$14.545
P9046	Albumin (human), 25%	20 ml	\$14.545	\$14.545		\$14.545
P9048	Plasma protein fraction, 5%	250 ml	\$29.099	\$29.099		\$29.099
Q0187	NovoSeven	Per 1.2 mg	\$1,228.438	\$1,228.438		
Q2002	Elliotts b solution per ml	1 ml	\$3.350	\$3.350		
Q2005	Corticoelin ovine triflutat	1 EA	\$379.067	\$379.067		
Q2012	Pegademase bovine	25 IU	\$158.048	\$158.048		
Q2018	Urofollitropin,	75 IU	\$43.865	\$43.865		
Q9941	IVIG lyophil	1 g	\$38.735	\$38.735		
Q9942	IVIG lyophil	10 mg	\$0.387	\$0.387		
Q9943	IVIG non-lyophil	1 g	\$56.221	\$56.221		
Q9944	IVIG non-lyophil	10 mg	\$0.562	\$0.562		
Q9954	Oral MR contrast	100 ml	\$8.844	\$8.844		

Notice that J2910 is no longer included in the April 2005 pricing file.

You should note that the new April 2005 ASP drug pricing files will contain three decimal places in the currency fields. You can find more information on the April 2005 ASP data format in CR 3436, which instructs the carriers/DMERCs/FIs to accommodate 3 places after the decimal point, and to follow standard rounding procedure, round to 2 decimal places, after multiplying the number in the “units” field of the line item by the payment allowance applicable to the HCPCS code.

You should also note that the absence or presence of a HCPCS code and its associated payment limit in the payment files do not indicate Medicare coverage of the drug or biological. Nor does inclusion of a payment limit within a specific column indicate Medicare coverage of the drug in that specific category. The carrier/DMERC/FI processing your claim will make these determinations.

To comply with these requirements, your FI will:

- Use the new April 2005 ASP drug pricing file to pay for Medicare Part B drugs, effective April 1, 2005 for dates of service from April 1, 2005 through June 30, 2005.
- Determine (for any drug or biological not listed in the ASP or NOC drug pricing files) the payment allowance limits in accordance with the policies described in CR 3232, dated December 16, 2004 (corrected). See [http://www.cms.hhs.gov/manuals/pm\\_trans/R397CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R397CP.pdf).
- Use the new April 2005 ASP drug pricing file for (1) those claims where the provider asks the FI/carrier/DMERC to retroactively adjust claims processed with the original April 2005 file, and (2) those claims with

dates of service on or after April 1, 2005 and before July 1, 2005 that are processed after July 4, 2005. **Your FI or carrier will not search and adjust claims that have already been processed unless brought to their attention;**

**Additional Information**

The new April 2005 and revisions to the January ASP pricing files are available at: <http://www.cms.hhs.gov/providers/drugs/asp.asp>.

For complete details of CR 3846, on which this article is based, please see the official instruction issued to your FI/carrier regarding this change. That instruction may be viewed at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3846 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3846  
 Related CR Release Date: May 13, 2005  
 Related CR Transmittal Number: 561  
 Effective Date: April 1, 2005  
 Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 561, CR 3846

## July Update to the 2005 Medicare Physician Fee Schedule Database

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

### Provider Types Affected

Physicians and providers billing Medicare carriers or fiscal intermediaries (FIs) for services paid under the Medicare physician fee schedule

### Provider Action Needed

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

### Background

CR 3870 amends payment files issued to carriers based upon the November 15, 2004, *Final Rule* for the 2005 Medicare physician fee schedule database. Key changes include two new G codes (G0375 and G0376) related to Medicare's national coverage determination for smoking cessation, which was effective March 22, 2005, and practice expense values for *Current Procedural Terminology (CPT)* codes 97810, 97811, 97813 and 97814. These CPT codes, which relate to acupuncture, are non-covered under the Medicare physician fee schedule.

### Additional Information

The changes to the fee schedule involve numerous CPT/HCPCS codes. While many of these changes are effective retroactive to January 1, 2005, please note that your carrier/

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FI will not reprocess claims already processed, unless you request them to do so.

The complete details of these changes to the July update to the 2005 Medicare physician fee schedule database are described in an attachment to CR 3870, which is the official instruction issued to your carrier/FI. That instruction may be viewed by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3870 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3870

Related CR Release Date: May 6, 2005

Related CR Transmittal Number: 558

Effective Date: January 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 558, CR 3870

## July Quarterly Update for 2005 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule

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

### Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs)

### Provider Action Needed

This article is based on CR 3779 and provides specific information regarding the July quarterly update of the 2005 durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule.

### Background

The DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Section 1834 (a), (h), and (i), and payment of a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in the Code of Federal Regulations (42 CFR 414.102).

CR 3779 provides specific details regarding the July quarterly update for the 2005 DMEPOS fee schedule, which are as follows:

### Batteries Used with Cochlear Implant Devices

Code **L8620** with the description of "Lithium ion battery for use with the cochlear implant device [replacement, each]" was added to the HCPCS effective January 1, 2005. When the fee schedule amounts were calculated and implemented for this code on January 1, 2005, pricing information for the different types of batteries used with cochlear implant devices was not included.

The fee schedule amounts for **L8620** are being revised as part of the quarterly update to include pricing information for the different types of lithium ion batteries used with cochlear implant devices. CMS is revising the fee schedule for the code using the standard gap-filling process. Local carriers, therefore, do not need to gap fill fees for this code.

**Note:** Previously paid claims for L8620 with dates of service from January 1, 2005 thru June 30, 2005 will be adjusted if resubmitted by suppliers as adjustments on or after July 1, 2005.



*July Quarterly Update for 2005 DMEPOS Fee Schedule (continued)*

Code **L8620** is being made invalid for Medicare claims with the dates of service on or after July 1, 2005.

The following codes are being added to the HCPCS effective for dates of service on or after July 1, 2005:

**K0731** Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each

**Short Description:** Lith ion batt cid, non-ear level

**K0732** Lithium ion battery for use with cochlear implant device speech processor, ear level, replacement, each

**Short Description:** Lith ion batt cid, ear level

These codes are to be used to bill for replacement batteries previously coded under **L8620** that are furnished on or after July 1, 2005. Also, please note that codes **L8110** and **L8120** do not meet the Medicare definition of prosthetic devices.

**Controlled Dose Inhalation Drug Delivery System**

The following code is also added to the HCPCS on July 1, 2005 and is effective for claims with service dates on or after April 1, 2005:

**K0730** Controlled dose inhalation drug delivery system.

**Note:** The allowed rental payment amount for this device is based on your Medicare contractor's individual consideration of each claim until fee schedule amounts can be established for this new code.

Code **K0670** was added to the HCPCS effective on April 1, 2005, but the fee schedule amount for K0670 was based on incorrect information and the amount is revised with this change. Your DMERC or FI will adjust previously processed claims for code K0670 with dates of service on or after April 1, 2005, but **only if you resubmit the claim for adjustment.**

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**2005 DMEPOS Pricing for Certain Items Based on Modifiers**

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

**Note:** Change request (CR) 3300 was revised by CR 3714 (Transmittal 489, dated March 4, 2005). CR 3714 removes the instruction in CR 3300 (Business Requirement 3300.6) that requires modifier AU to always be present with HCPCS code A4217. The presence of HCPCS code A4217 without modifier AU may be considered a DME supply and processed accordingly. To see CR 3714, go to the following CMS website: [http://www.cms.hhs.gov/manuals/pm\\_trans/R489CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R489CP.pdf).

To see the Medlearn Matters article related to CR 3714, go to: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3714.pdf>.

The original article addressing CR 3714 issues was published in the *Third Quarter 2005 Medicare A Bulletin* (pages 11-12).

**Provider Types Affected**

Durable medical equipment (DME) suppliers and home health agencies (HHAs)

**Provider Action Needed****STOP – Impact to You**

Medicare will allow for two modifiers effective January 1, 2005, to permit proper payment for DME, prosthetics, and orthotics (DMEPOS).

**Parenteral and Enteral Nutrition Equipment and Supplies**

There are no changes to the PEN fee schedule file for July 2005.

**Implementation**

The implementation date for this instruction is July 5, 2005.

**Additional Information**

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

The official instruction issued to your carrier/DMERC/intermediary regarding this change may be found by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3779 in the CR NUM column on the right, and click on the file for the desired CR.

For additional information relating to this issue, please refer to your carrier/DMERC/intermediary. To find their toll free phone numbers go to: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3779

Related CR Release Date: April 29, 2005

Related CR Transmittal Number: 536

Effective Date: January 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 536, CR 3779

## 2005 DMEPOS Pricing for Certain Items Based on Modifiers (continued)

### CAUTION – What You Need to Know

Please note updated instructions for proper reporting and payment of modifiers AU, AV, and AW when billing for HCPCS codes A4217, A4450, and A4452 and of modifier KF when billing for DME classified as class III devices.

### GO – What You Need to Do

Ensure that your billing practices comply with changes noted in this article to obtain accurate and timely payment for DMEPOS.

### Background

The following modifiers were added to the HCPCS to identify supplies and equipment that may be covered under more than one DMEPOS benefit category:

AU	Item furnished in conjunction with a urological, ostomy, or tracheostomy supply <b>Relevant HCPCS codes:</b> A4217, A4450 and A4452
AV	Item furnished in conjunction with a prosthetic device, prosthetic or orthotic <b>Relevant HCPCS codes</b> A4450 and A4452
AW	Item furnished in conjunction with a surgical dressing <b>Relevant HCPCS codes</b> A4450 and A4452

Currently, codes A4217, A4450 and A4452 for tape are the only codes that have been identified that would require use of the modifiers AU, AV, or AW. Providers must report the appropriate modifiers on claims for items identified by codes A4217, A4450, and A4452 that are furnished on or after January 1, 2005.

On January 3, 2005, Medicare systems will have an expanded file format that will allow entry of two modifiers. Until the file is expanded, the complete DMEPOS fee schedule, including modifiers, is available to your intermediary at: <http://www.cms.hhs.gov/providers/pufdownload/default.asp#dme>.

In addition, it provides instructions for proper reporting and payment of modifiers AU, AV, and AW when billing for HCPCS codes A4217, A4450 and A4452, as well as for modifier KF for class III devices.

Currently, the only situation in which more than one modifier will be used in pricing is when modifier KF is used in conjunction with existing DME modifiers NU, RR, and UE.

Elevating/stair climbing power wheelchairs are class III devices. (In previous transmittal 35, dated December 24, 2003). Billing for these devices is as follows:

#### HCPCS code K0011

Claims for the base power wheelchair portion of this device are to be billed using HCPCS code K0011 with modifier KF for claims received on or after April 1, 2004, with dates of service on or after January 1, 2004.

#### HCPCS code E2300

Claims for the elevation feature for this device should be billed using HCPCS code E2300 for claims with dates of service on or after January 1, 2004.

#### HCPCS code A9270

Claims for the stair-climbing feature for this device should be billed using HCPCS code A9270 for claims with dates of service on or after January 1, 2004.

Regional home health intermediaries (RHHIs) will not be able to implement the KF modifier until January 1, 2005.

For claims with dates of service prior to January 1, 2005:

- HHAs should note that claims for the base power wheelchair portion of stair-climbing wheelchairs must be submitted with HCPCS code E1399, and RHHIs should pay claims for stair-climbing wheelchair bases billed with code E1399 using the fee schedule amounts for K0011 with the KF modifier.
- All other claims for programmable power wheelchair bases should be paid using the fee schedule amounts for K0011 without the KF modifier.

Effective for claims with dates of service on or after January 1, 2005:

- HHAs must submit modifier KF along with the applicable HCPCS code for all DME items classified by the FDA as class III devices.

The fee schedule amounts for K0011, with and without modifier KF, appear on the online fee schedule file referenced at: [www.cms.hhs.gov/providers/pufdownload/default.asp#dme](http://www.cms.hhs.gov/providers/pufdownload/default.asp#dme).

#### Additional Information

The official instruction issued to the intermediary regarding this change may be found online, referenced via CR 3300, at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR 3300. Click on the link to open and view the file for the CR.

Related Change Request (CR) Number: 3300

Related CR Release Date: July 24, 2004

Related CR Transmittal Number: 236

Effective Date: January 1, 2005

Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 236, CR 3300

## Number of Durable Medical Equipment Pricing Files Maintained Online for Medicare—DMERC, FI, and RHHI Only

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

### Provider Types Affected

Providers and suppliers who bill durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs) for durable medical equipment, supplies, prosthetics and orthotics (DMEPOS)

### Provider Action Needed

This article is informational only. Providers/suppliers need take no action, but Medicare encourages you to submit claims to Medicare as soon as possible after services are supplied.

### Background

Medicare created a new minimum standard for the number of online price determination files that a Medicare DMERC or RHHI will maintain. The new minimum standard is eight fee screens/pricing files (the current period and seven prior files) for payment on a fee-for-service DMEPOS that you bill. This will allow Medicare to be more precise in paying the rate in effect at the time services are provided.

While this allows for more accurate pricing, this change does not alter Medicare’s timely filing requirements and providers/suppliers should bill Medicare as promptly as possible.

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### Additional Information

The official instruction issued to your DMERC/FI/RHHI regarding this change may be found at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3792 in the CR NUM column on the right, and click on the file for the desired CR.

For additional information relating to this issue, please contact your DMERC/FI/RHHI via their toll free number. That number may be found at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3792

Related CR Release Date: April 29, 2005

Related CR Transmittal Number: 546

Effective Date: October 1, 2005

Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 546, CR 3792

## Payments to Ambulatory Surgery Centers for New CPT Code 66711

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

### Provider Types Affected

Physicians and providers billing carriers for services involving ciliary body destruction

### Provider Action Needed

#### STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) inadvertently failed to include the new CPT code 66711 (ciliary body destruction, cyclophotocoagulation, endoscopic) in the ambulatory surgery center (ASC) list on January 1, 2005. CPT 66711 should have been added to the list effective January 1, 2005.

#### CAUTION – What You Need to Know

This article and related CR 3817 provide information on the appropriate CPT code for endoscopic treatment involving ciliary body destruction.

#### GO – What You Need to Do

Awareness of and implementation of these revised coding guidelines will help Medicare make prompt and correct payments for this procedure.

### Background

On an annual basis the American Medical Association Current Procedural Terminology (CPT) Editorial Panel revises and updates the CPT codes. The Centers for

Medicare & Medicaid Services (CMS) found that CPT code 66711 – Ciliary body destruction, cyclophotocoagulation, endoscopic, inadvertently was not added to the ASC list. CMS will add CPT code 66711 – Ciliary body destruction, cyclophotocoagulation, endoscopic, to the ASC list of covered procedures in the July 2005 update, with an effective date of January 1, 2005.

Prior to January 1, 2005, the procedure was included in the 2004 CPT code 66710 – Ciliary body destruction, cyclophotocoagulation that was included in the ASC list. The existing CPT code 66710 was revised to read Ciliary body destruction; cyclophotocoagulation, transscleral and CPT code 66711 was created, effective January 1, 2005.

**Note:** You may bill procedures performed between January 1, 2005 and July 1, 2005 retroactively using the new CPT code 66711, and payment may be made at the group 2 level.

### Additional Information

To see the official instruction regarding this update to the 2005 ASC list, go to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3817 in the CR NUM column on the right, and click on the file for that CR.

*Payments to Ambulatory Surgery Centers for New CPT Code 66711 (continued)*

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

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

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Related Change Request (CR) Number: 3817  
 Related CR Release Date: May 9, 2005  
 Related CR Transmittal Number: 155  
 Effective Date: January 1, 2005  
 Implementation Date: July 5, 2005

Source: CMS Pub. 100-20, Transmittal 155, CR 3817

**Update to the 2005 Ambulatory Surgical Center Master Listing**

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

**Note:** This is an informational article only. Medicare Part A providers billing First Coast Service Options, Inc. (your Florida fiscal intermediary) are not affected by these regulations.

**Provider Types Affected**

Ambulatory surgical centers (ASCs) providing services to Medicare beneficiaries and billing Medicare fiscal intermediaries (FIs) or carriers or for those services

**Provider Action Needed**

Be aware of the ASC Healthcare Common Procedure Coding System (HCPCS) codes that are being added to and deleted from the ASC list, effective July 1, 2005.

**Background**

The Centers for Medicare & Medicaid Services (CMS) is updating the ASC HCPCS codes list to reflect the Medicare-approved ASC procedures added to and deleted from the ASC list, as outlined in an interim final rule in the May 4, 2005 *Federal Register* (70 CFR 23690). (The interim rule is available on the CMS website at [http://www.cms.hhs.gov/suppliers/asc/1478\\_42805.pdf](http://www.cms.hhs.gov/suppliers/asc/1478_42805.pdf).)

The following codes are being added to the ASC list, effective for services performed on or after July 1, 2005:

<b>CPT Code</b>	<b>Short Descriptor</b>	<b>ASC Payment Group</b>	<b>ASC Payment Rate</b>
15001	Skin graft add-on	1	\$333.00
15836	Excise excessive skin tissue	3	\$510.00
15839	Excise excessive skin tissue	3	\$510.00
19296	Place po breast cath for rad	9	\$1339.00
19298	Place breast rad tube/caths	1	\$333.00
21120	Reconstruction of chin	7	\$995.00
21125	Augmentation, lower jaw bone	7	\$995.00
28108	Removal of toe lesions	2	\$446.00
29873	Knee arthroscopy/surgery	3	\$510.00
30220	Insert nasal septal button	3	\$510.00
31545	Remove vc lesion w/scope	4	\$630.00
31546	Remove vc lesion scope/graf	4	\$630.00
31603	Incision of windpipe	1	\$333.00
31636	Bronchoscopy, bronch stents	2	\$446.00
31637	Bronchoscopy, stent add-on	1	\$333.00
31638	Bronchoscopy, revise stent	2	\$446.00
33212	Insertion of pulse generator	3	\$510.00
33213	Insertion of pulse generator	3	\$510.00
33233	Removal of pacemaker system	2	\$446.00
36475	Endovenous rf, 1st vein	3	\$510.00
36476	Endovenous rf, vein add-on	3	\$510.00
36478	Endovenous laser, 1st vein	3	\$510.00
36479	Endovenous laser vein add-on	3	\$510.00
36834	Repair AV aneurysm	3	\$510.00



*Update to the 2005 Ambulatory Surgical Center Master Listing (continued)*

<b>CPT Code</b>	<b>Short Descriptor</b>	<b>ASC Payment Group</b>	<b>ASC Payment Rate</b>
37500	Endoscopy ligate perf veins	3	\$510.00
42665	Ligation of salivary duct	7	\$995.00
43237	Endoscopic us exam, esoph	2	\$446.00
43238	Upper gi endoscopy w/us fn bx	2	\$446.00
44397	Colonoscopy w/stent	1	\$333.00
45327	Proctosigmoidoscopy w/stent	1	\$333.00
45341	Sigmoidoscopy w/ultrasound	1	\$333.00
45342	Sigmoidoscopy w/us guide bx	1	\$333.00
45345	Sigmoidoscopy w/stent	1	\$333.00
45387	Colonoscopy w/stent	1	\$333.00
45391	Colonoscopy w/endoscope us	2	\$446.00
45392	Colonoscopy w/endoscopic fnb	2	\$446.00
46230	Removal of anal tags	1	\$333.00
46706	Repr of ana fistula w/glue	1	\$333.00
46947	Hemorrhoidopexy by stapling	3	\$510.00
49419	Insrt abdom cath for chemotx	1	\$333.00
51992	Laparo sling operation	5	\$717.00
52301	Cystoscopy and treatment	3	\$510.00
52402	Cystourethro cut ejacul duct	3	\$510.00
55873	Cryoablate prostate	9	\$1,339.00
57155	Insert uteri tandems/ovoids	2	\$446.00
57288	Repair bladder defect	5	\$717.00
58346	Insert heyman uteri capsule	2	\$446.00
58565	Hysteroscopy, sterilization	4	\$630.00
58970	Retrieval of oocyte	1	\$333.00
58974	Transfer of embryo	1	\$333.00
58976	Transfer of embryo	1	\$333.00
62264	Epidural lysis on single day	1	\$333.00
64517	N block inj, hypogastric plexus	2	\$446.00
64561	Implant neuroelectrodes	3	\$510.00
64581	Implant neuroelectrodes	3	\$510.00
64681	Injection treatment of nerve	2	\$446.00
65780	Ocular reconst, transplant	5	\$717.00
65781	Ocular reconst, transplant	5	\$717.00
65782	Ocular reconst, transplant	5	\$717.00
65820	Relieve inner eye pressure	1	\$333.00
66711	Ciliary endoscopic ablation	2	\$446.00
67343	Release eye tissue	7	\$995.00
67445	Explr/decompress eye socket	5	\$717.00
67570	Decompress optic nerve	4	\$630.00
67912	Correction eyelid w/implant	3	\$510.00
68371	Harvest eye tissue, alograft	2	\$446.00

The following HCPCS codes are being deleted from the ASC list, effective July 1, 2005:

<b>HCPCS</b>	<b>Code</b>	<b>Short Descriptor</b>
21440	Treat dental ridge fracture	
23600	Treat humerus fracture	
23620	Treat humerus fracture	
53850	Prostatic microwave thermotx	
69725	Release facial nerve	

The complete list of Medicare-approved ASC HCPCS codes, including the codes being added to and deleted from the ASC list effective July 1, 2005, is available as an

addendum to the interim rule (starting at page 104) on the CMS website at [http://www.cms.hhs.gov/suppliers/asc/1478\\_42805.pdf](http://www.cms.hhs.gov/suppliers/asc/1478_42805.pdf).

**Additional Information**

For complete details, please see the official instruction issued to your FI/carrier regarding this change. That instruction may be viewed by going to the CMS website at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

### Update to the 2005 Ambulatory Surgical Center Master Listing (continued)

From that Web page, look for CR 3905 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your Medicare FI/carrier at their toll-free number, which may be found on the CMS web site at <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

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Applicable FARS/DFARS apply.

Related Change Request (CR) Number: 3905

Related CR Release Date: June 17, 2005

Related CR Transmittal Number: 584

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 584, CR 3905

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## Medicare Chronic Care Improvement—Medicare Health Support Program

*CMS has issued the following “Medlearn Matters... Information for Medicare Providers” article.*

### Provider Types Affected

Physicians and providers in any one of the nine Chronic Care Improvement Organization (CCIO) areas as follows: (Each area specified shows the name of the CCIO with which Medicare has contracted followed by the geographic area served by that CCIO.)

**1. AETNA, Inc.**, Chicago, Illinois counties; **2. American Healthways**, Maryland and the District of Columbia; **3. CIGNA**, Northwest Georgia; **4. Health Dialog**, Western Pennsylvania; **5. Humana**, Central and South Florida; **6. Lifemasters**, Oklahoma; **7. McKesson**, Mississippi; **8. Visiting Nurse Service EverCare/United**, Brooklyn and Queens, New York; **9. XL Health**, selected counties in Tennessee

### Provider Action Needed

#### STOP – Impact to You

This article includes information from Change Request (CR) 3953 that describes the new Medicare Chronic Care Improvement program also known as “Medicare Health Support program” and identifies the nine selected CCIOs that contract with the Centers for Medicare & Medicaid Services (CMS) to provide chronic care services to certain beneficiaries enrolled in the traditional fee-for-service (FFS) Medicare program.

#### CAUTION – What You Need to Know

This is phase I of the Medicare Health Support program and will serve approximately 180,000 Medicare beneficiaries who have congestive heart failure and complex diabetes among their chronic conditions. Eligible beneficiaries do not have to change plans or providers to participate, and participation is totally voluntary. CCI programs will not restrict access to other Medicare services and will be provided at no extra cost to beneficiaries.

#### GO – What You Need to Do

See the Background and Additional Information sections for more information on this new program.

### Background

This article provides information on the CMS’ implementation of the Chronic Care Improvement program now

known as “Medicare Health Support”. Section 721 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) adds a new section 1807, “Voluntary Chronic Care Improvement Under Traditional Fee-for-Service (FFS) Medicare” to the Social Security Act. This requires Medicare to provide for the phased-in development, testing, evaluation, and implementation of chronic care improvement programs, and to expand the implementation of the chronic care improvement (CCI) programs to additional geographic areas.

This initiative also represents one of the multiple strategies developed by the Department of Health & Human Services (DHHS) to improve chronic care, accelerate the adoption of health information technology, reduce avoidable costs, and diminish health disparities among Medicare beneficiaries nationally.

Some key points of “Medicare Health Support” are as follows:

- The program will test whether providing disease management services to Medicare beneficiaries who are in traditional FFS programs leads to improved outcomes and lower total costs to Medicare.
- CCIOs contract with CMS to provide disease management to targeted Medicare FFS beneficiaries (about 20,000 beneficiaries serviced by each CCIO) who suffer from congestive heart failure and diabetes.
- The first CCI program will be phased in during 2005, operate for 3 years and be tested through randomized controlled trials. The hope is that the program or components of the program prove successful and can be expanded regionally and/or nationally.
- The programs will offer add-on services—such as self-care guidance and support—to chronically ill beneficiaries. The goal is to help them adhere to their physician’s plans of care and assure that they seek the medical care needed to reduce their health risks. Coordination and collaboration with the participants’ providers to enhance communication of relevant clinical information is also a key component of the CCI program.

*Medicare Chronic Care Improvement—Medicare Health Support Program (continued)*

- CCI programs will not restrict access to care and will be provided at no cost to eligible beneficiaries. Such beneficiaries do not have to change from their existing plans, nor do they have to change physicians or providers in order to participate. Further, they may stop participating at any time.
- Each of the contracted CCIOs are paid separately by CMS, outside of the Medicare FFS claims payment system, a fixed “per member per month” (PMPM) payment.
- The CCIOs will not focus on any single disease, but will help participants manage all their health care problems.
- The CCIOs will **not** pay any claims on behalf of enrolled beneficiaries and a beneficiary’s participation will not at all affect how claims from their physicians/providers are processed by Medicare.

The following chart identifies the CCIOs, details the specific program features of these CCIOs and delineates the geographic areas served by the CCIO:

<b>CCIO</b>	<b>Program Features</b>	<b>Geographic Area</b>
<b>AETNA, Inc.</b>	<ul style="list-style-type: none"> <li>• Advance Practice Nursing program for home health and nursing homes</li> <li>• Customized care plans</li> <li>• Caregiver education</li> <li>• Blood pressure monitors and weight scales provided based on participant need</li> <li>• Physician communication</li> <li>• Physician web access to clinical information</li> <li>• 24-hour nurse line</li> </ul>	Chicago Illinois counties
<b>American Healthways</b>	<ul style="list-style-type: none"> <li>• Personalized care plans</li> <li>• Direct-mail and telephonic messaging</li> <li>• Supplemental telephonic coaching</li> <li>• Gaps in care generate physician prompts</li> <li>• Intensive case management services as necessary</li> <li>• Remote monitoring devices (weight, blood pressure, and pulse) based on participant need</li> <li>• Physician web access to clinical information</li> <li>• Physician communication</li> <li>• 24-hour nurse line</li> </ul>	Maryland and the District of Columbia
<b>CIGNA</b>	<ul style="list-style-type: none"> <li>• Personalized plan of care</li> <li>• Telephonic nurse interventions</li> <li>• Oral and written communication in addition to telephonic coaching</li> <li>• Home monitoring equipment (weight, blood pressure and glucometers) based on participant need</li> <li>• Intensive case management for frail elderly and institutionalized participants, as required</li> <li>• Data exchange with physicians,</li> <li>• 24-hour nurse line</li> </ul>	Northwest Georgia
<b>Health Dialog</b>	<ul style="list-style-type: none"> <li>• Personal health coaches develop individual care management plans</li> <li>• Health education materials (web-based, faxed or mailed)</li> <li>• In-home biometric monitoring</li> <li>• Behavioral health case management and intensive case management as needed</li> <li>• Data exchange with physicians,</li> <li>• Active involvement of other community agencies</li> <li>• 24-hour nurse line</li> </ul>	Western Pennsylvania

## GENERAL INFORMATION

### Medicare Chronic Care Improvement—Medicare Health Support Program (continued)

CCIO	Program Features	Geographic Area
<b>Humana</b>	<ul style="list-style-type: none"> <li>• Trademarked Personal Nurse program model</li> <li>• Group education and support sessions</li> <li>• Biometric monitoring equipment, including glucometers and weight scales as necessary</li> <li>• Core telephonic support supplemented with RNs, social workers and pharmacists in the field interacting with providers and beneficiaries with complex needs</li> <li>• Data exchange with physicians,</li> <li>• On-site meetings with physicians and CME (continuing medical Central and South FL education) programs</li> <li>• Physician Web access to clinical information</li> <li>• Electronic medical record keeping systems will be piloted in five small physician-group practices</li> <li>• Active involvement of other community agencies</li> <li>• 24-hour nurse line</li> </ul>	Central and South Florida
<b>Lifemasters</b>	<ul style="list-style-type: none"> <li>• Single nurse as primary contact for beneficiary</li> <li>• Supported self-care model including education, medication compliance, behavior change</li> <li>• Home visits as appropriate</li> <li>• Team of local and call center-based nurses, physicians, pharmacists, and health educators</li> <li>• Digital weight scale and blood pressure monitors</li> <li>• Physician communication including customized care plans, alerts, decision support applications; access to patient care record and biometric monitoring data</li> <li>• Physician outreach includes in-person orientation for high volume physician practices</li> <li>• Physician web access to clinical information</li> <li>• Active involvement of other community agencies</li> <li>• 24-hour nurse line</li> </ul>	Oklahoma
<b>McKesson</b>	<ul style="list-style-type: none"> <li>• Extensive physician involvement, including on-site staff support</li> <li>• Data exchange with physicians,</li> <li>• Physician web access to clinical information</li> <li>• Telephonic outreach</li> <li>• Mail, fax, workbooks</li> <li>• Remote monitoring and biometric equipment for selected high risk participants</li> <li>• Pharmacist review of medications and collaboration with physicians</li> <li>• Management of long-term care residents and intensive case management, including end-of-life</li> <li>• 24-hour nurse line</li> </ul>	Mississippi
<b>Visiting Nurse Service EverCare/United</b>	<ul style="list-style-type: none"> <li>• Home health agency leading outreach in community</li> <li>• Management of high-risk participants who require extensive in home management</li> <li>• Telephonic outreach and health risk assessments</li> <li>• Use of Smart Cards to use at physician visits and hospital admissions to track service use and convey embedded information to providers</li> <li>• Physician web access to clinical information</li> <li>• Active involvement of other community agencies</li> <li>• 24-hour nurse line</li> </ul>	Brooklyn and Queens, New York



*Medicare Chronic Care Improvement—Medicare Health Support Program (continued)*

<b>CCIO</b>	<b>Program Features</b>	<b>Geographic Area</b>
<b>XL Health</b>	<ul style="list-style-type: none"> <li>• Biometric monitoring including glucometers and weight scales as necessary</li> <li>• RNs, social workers, and pharmacists in the field, interacting with providers and beneficiaries with complex needs</li> <li>• Medication counseling sessions by pharmacists at retail pharmacies</li> <li>• Specialized program for higher risk patients</li> <li>• Medication management and compliance</li> <li>• Data exchange with physicians,</li> <li>• Physician Web access to clinical information</li> <li>• 24-hour nurse line</li> </ul>	Selected counties in Tennessee

Physicians and providers with questions regarding the program can find additional information at <http://www.cms.hhs.gov/medicarereform/ccip/> on the CMS website, or they may direct their inquiries directly to the following CCIO contacts:

<p><b>AETNA:</b> Kathleen Giblin Aetna Health Management, LLC 151 Farmington Avenue, RT11 Hartford, CT 06156 <b>Or call 888-713-2836 or visit</b> <a href="http://www.aetna.com">http://www.aetna.com</a></p>	<p><b>LifeMasters:</b> Ron Lau, c/o Mel Lewis LifeMasters Supported Care 5000 Shoreline Court S#300 South San Francisco, CA 94080 <b>Or call 888-713-2837 or visit</b> <a href="http://www.lifemasters.com">http://www.lifemasters.com</a></p>
<p><b>American Healthways:</b> Michael Montijo, M.D., American Healthways American Healthways, Inc. 3841 Green Hills Village Drive Nashville, TN 37215 <b>Or call 866-807-4486 or visit</b> <a href="http://www.medicarehealthsupport.com">http://www.medicarehealthsupport.com</a></p>	<p><b>McKesson:</b> Sandeep Wadhwa McKesson Health Solutions 335 Interlocken Parkway Broomfield, CO 80021 <b>Or call 800-919-9110 or visit</b> <a href="http://www.mckesson.com">http://www.mckesson.com</a></p>
<p><b>Health Dialog:</b> Molly Doyle Health Dialog Services Corporation 60 State Street, Suite 1100 Boston, MA 02109 <b>Or call 800-574-8475 or visit</b> <a href="http://www.myhealthsupport.com">http://www.myhealthsupport.com</a> (available August 2005)</p>	<p><b>XL Health:</b> Paul Serini XLHealth 351 West Camden Street, Suite 100 Baltimore, Maryland 21201 <b>Or call 877-717-2247</b></p>
<p><b>Humana:</b> Heidi Margulis Humana, Inc. 500 West Main Street, 6th Floor Louisville, KY 40202 <b>Or call 800-372-8931 or visit</b> <a href="http://www.greenribbonhealth.com">http://www.greenribbonhealth.com</a></p>	<p><b>VNS/Evercare:</b> Paul Roth VNS CHOICE 5 Penn Plaza, 19th Floor New York, NY 10001-1810</p>
<p><b>CIGNA HealthCare:</b> David Post CIGNA 900 Cottage Grove, B227 Bloomfield, CT 06002 <b>Or call 866-563-4551 or visit</b> <a href="http://www.mhsgeorgia.com">http://www.mhsgeorgia.com</a> (available August 2005)</p>	

### Medicare Chronic Care Improvement—Medicare Health Support Program (continued)

#### Implementation

The implementation date for this instruction is October 20, 2005.

#### Additional Information

For complete details of CR 3953, please see the official instruction issued by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page look for CR 3953 in the CR column on the right and click on the file for that CR.

The Medicare fact sheet that describes the Medicare Chronic Care Improvement, “Medicare Health Support,” program may be found on the Web at:

<http://www.cms.hhs.gov/medicarereform/ccip/>.

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This document is an excellent overview of the program.

Medlearn Matters Article MM3410 provides some background information on the “Use of Group Health Plan Payment System to Pay Capitated Payments to Chronic Care Improvement Organizations Serving Medicare Fee-For-Service Beneficiaries Under Section 721 of the MMA” and may be viewed by going to: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3410.pdf>.

Related Change Request (CR) Number: 3953

Related CR Release Date: July 22, 2005

Related CR Transmittal Number: 26

Effective Date: October 20, 2005

Implementation Date: October 20, 2005

Source: CMS Pub. 100-19, Transmittal 26, CR 3953

## NATIONAL PROVIDER IDENTIFIER

### CMS Announces the National Provider Identifier Enumerator Contractor

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

#### Provider Types Affected

All health care providers – Medicare and non-Medicare

#### Provider Action Needed

Learn about the National Provider Identifier NPI and how and when to apply for one.

#### Background

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the availability of a new health care identifier for use in the HIPAA standard transactions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health & Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a final rule that adopted the National Provider Identifier (NPI) as this identifier.

The NPI must be used by covered entities under HIPAA (generally, health plans, health care clearinghouses, and health care providers that conduct standard transactions). The NPI will identify health care providers in the electronic transactions for which the Secretary has adopted standards (the standard transactions) after the compliance dates. These transactions include claims, eligibility inquiries and responses, claim status inquiries and responses, referrals, and remittance advices.

The NPI will replace health care provider identifiers that are in use today in standard transactions.

Implementation of the NPI will eliminate the need for health care providers to use different identification numbers to identify themselves when conducting HIPAA standard transactions with multiple health plans.

All health plans (including Medicare, Medicaid, and private health plans) and all health care clearinghouses must accept and use NPIs in standard transactions by May 23, 2007 (small health plans have until May 23, 2008). After those compliance dates, health care providers will use only their NPIs to identify themselves in standard transactions, where the NPI is required.

**Note:** While you are urged to apply for an NPI beginning May 23, 2005, the Medicare program is not accepting the NPI in standard transactions yet. Explicit instructions on time frames and implementation of the NPI for Medicare billing will be issued later in 2006.

#### NPI Enumerator Contract Awarded

Recently, CMS announced the selection of Fox Systems, Inc. as the contractor, to be called the Enumerator, to perform the support operations for the NPI project.

Fox Systems, Inc. will process NPI applications from health care providers and operate a help desk to assist health care providers in obtaining their NPIs.

#### Who may apply for the NPI?

All health care providers including individuals, such as physicians, dentists, and pharmacists, and organizations, such as hospitals, nursing homes, pharmacies, and group practices are eligible to apply for and receive an NPI.

**Note:** All health care providers who transmit health information electronically in connection with any of the HIPAA standard transactions are required by the NPI final rule to obtain NPIs. This is true even if they use business associates such as billing agencies to prepare the transactions.

*CMS Announces the National Provider Identifier Enumerator Contractor (continued)***The NPI Application Process**

Health care providers may begin applying for an NPI on May 23, 2005. Once the process begins, **it will be important to apply for your NPI** before the compliance date of May 2007 because health plans could require you to use your NPI before that date.

You will be able to apply for your NPI in one of three ways:

1. You may apply through an easy-to-use Web-based application process, beginning May 23, 2005.  
The Web address will be <https://nppes.cms.hhs.gov>, but please note – the website was available on May 23, 2005.
2. Beginning July 1, 2005, you may complete a paper application and send it to the Enumerator. A copy of the application, including the Enumerator's mailing address (where you will send it) will be available on <https://nppes.cms.hhs.gov> or you can call the Enumerator to receive a copy. The phone number is 1-800-465-3203 or TTY 1-800-692-2326. **But remember, paper applications may not be submitted until July 1, 2005.**
3. With your permission, an organization may submit your application in an electronic file. This could mean that a professional association, or perhaps a health care provider who is your employer, could submit an electronic file containing your information and the information of other health care providers. **This process will be available in the fall of 2005.**

You may apply for an NPI using only one of these methods. When gathering information for your application, be sure that all of your information, such as your social security number and the federal employer identification number, are correct. Once you receive your NPI, safeguard its use.

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If all information is complete and accurate, the Web-based process could result in you being issued a number within minutes. If there are problems with the information received, it could take longer. The paper application processing time is more difficult to estimate, depending on the information supplied in the application, the workload, and other factors.

The transition from existing health care provider identifiers to NPIs will occur over the next couple of years.

Each health plan with which you conduct business, including Medicare, will notify you when it will be ready to accept NPIs in standard transactions like claims. You can expect to hear about the importance of applying for an NPI from a variety of sources. Be clear that you only have to apply for, and acquire, one NPI. Your unique NPI will be used for all standard transactions, Medicare and non-Medicare.

Please be particularly aware that applying for an NPI does not replace any enrollment or credentialing processes with any health plans, including Medicare.

**Additional Information**

For additional information on NPIs:

- Visit <http://www.cms.hhs.gov/hipaa/hipaa2> on the Web.
- Beginning May 23, 2005, visit <https://nppes.cms.hhs.gov> or call the enumerator at 1-800-465-3203 or TTY 1-800-692-2326.
- For HIPAA information, you may call the HIPAA hotline: 1-866-282-0659, or write to [AskHIPAA@cms.hhs.gov](mailto:AskHIPAA@cms.hhs.gov) on the Web.

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Article SE0528

**Medicare Fee-for-Service Transition to the National Provider Identifier**

The Centers for Medicare & Medicaid Services (CMS) has the following announcements on plans for transitioning to the national provider identifier (NPI) in the Medicare fee-for-service program:

- Between **May 23, 2005 and January 2, 2006**, CMS claim processing systems will accept an existing legacy Medicare number and reject as unprocessable any claim that includes only an NPI.
- Beginning **January 3, 2006, and through October 1, 2006**, CMS systems will accept an existing legacy Medicare number **or** an NPI as long as it is accompanied by an existing legacy Medicare number.

- Beginning **October 2, 2006, and through May 22, 2007**, CMS systems will accept an existing legacy Medicare number **and/or** an NPI. This will allow for six to seven months of provider testing before only an NPI will be accepted by the Medicare program on May 23, 2007.
- Beginning **May 23, 2007**, our systems will **only** accept an NPI.

To apply for an NPI, visit: <https://nppes.cms.hhs.gov> on the CMS website.

To request a paper application, call 1-800-465-3203. ❖

Source: CMS Joint Signature Memorandum 05381, June 16, 2005

CMS Contractor Provider Education Resources Listserv Message 200506-01

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### National Provider Identifier Reminder

Reminder – Health care providers are required by law to apply for a national provider identifier (NPI). To apply online, visit: <https://nppes.cms.hhs.gov>, or call 1-800-465-3203 to request a paper application.

Visit <http://www.cms.hhs.gov/hipaa/hipaa2> for the latest information regarding the NPI, including a transcript from CMS' recent NPI Roundtable conference call. ❖

Source: CMS Joint Signature Memorandum 05402, June 29, 2005

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## AMBULANCE SERVICES

### Reminder Regarding Medicare Billing Rules for Ambulance Services Rendered to Medicare Patients During an Inpatient Hospital Stay

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

#### Provider Types Affected

Suppliers of ambulance services billing Medicare carriers for services provided to Medicare patients during an inpatient hospital stay.

#### Provider Action Needed

##### STOP – Impact to You

The purpose of this Special Edition is to remind ambulance service suppliers of the rules regarding payment for certain services provided to Medicare patients in an inpatient hospital stay.

##### CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) will add an edit in the Medicare claim processing systems to prevent payment by carriers for services that are bundled in the hospital payment under the applicable inpatient prospective payment system (PPS).

##### GO – What You Need to Do

Please see the Background and Additional Information sections of this article for further details.

#### Background

The Social Security Act (Section 1886(d) and (g)) established several prospective payment systems (PPS) for inpatient services furnished to Medicare beneficiaries. Under the inpatient PPS, Medicare fiscal intermediaries (FIs) reimburse hospitals a predetermined amount for services furnished to Medicare beneficiaries based on the beneficiary's condition and severity of treatment modalities.

All services received by hospital inpatients must be supplied by the hospital either directly or under arrange-

ments. With the exception of the days of admission and discharge, costs for transportation of a hospital inpatient by ambulance (to and from another hospital, freestanding facility, or physician's office) to receive specialized services, and costs for radiology services (including computed tomography scans) furnished to inpatients by a physician's office, another hospital or a radiology clinic are not payable by Medicare.

CMS will add an edit in its claim processing systems to prevent payment by carriers for services that are bundled to the hospital. As an initial implementation of this policy, Medicare will cease making payments to independent suppliers of ambulance services for beneficiaries in an inpatient hospital stay.

#### Additional Information

As a reminder, all Medicare claims processing information is in the Medicare Claims Processing Manual. This manual may be viewed at [http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp).

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

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

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Article SE0536

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# MEDICARE PRESCRIPTION DRUG

## New Educational Products Available

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

*The Fourth article in a series of: Information for Providers, Physicians, Pharmacies and their Staff About Medicare Prescription Drug Coverage*

### Provider Types Affected

Physicians, providers, suppliers, and their staff providing service to people with Medicare

### Important Points to Remember

- On January 1, 2006, new prescription drug coverage will be available to your Medicare patients.
- You should encourage your Medicare patients to learn more about this new coverage because it may save them money on prescription drugs.
- If your Medicare patients ask you questions about the new coverage, you can refer them to 1-800-MEDICARE and for additional information and assistance to <http://www.medicare.gov>.

This article announces new educational resources available to assist Medicare beneficiaries in their understanding of the new Medicare Prescription Drug Coverage.

### Release of Notices to Medicare Beneficiaries Who Automatically Qualify for Extra Help

Starting at the end of May through June, the Centers for Medicare & Medicaid Services (CMS) mailed notices to people who are automatically eligible for extra help paying for a Medicare prescription drug plan, including people with Medicare and Medicaid, Supplemental Security Income, and Medicare Savings Program coverage.

The notices will let these people know that Medicare prescription drug coverage is coming and that they will get extra help without needing to apply for it. The notices can be viewed on the CMS website at <http://www.cms.hhs.gov/medicarereform/lir.asp>.

This summer, the Social Security Administration (SSA) will mail a different letter to other people who do not automatically qualify for the extra help but may be potentially eligible for it. The letter will include an application that people can fill out and return to find out if they qualify for extra help paying for a Medicare prescription drug plan. This letter may be viewed on the Social Security Administration website at <http://www.ssa.gov/organizations/medicareoutreach2/>.

Select “Application for Help with Medicare Prescription Drug Plan Costs.”

### Posters - Now Available for Display

Posters titled “Have Limited Income? Social Security Can Help with Prescription Costs” may be ordered free of charge on the CMS website. The posters are suitable for display in a physician’s, providers, or supplier’s office; a pharmacy; or other health care setting where Medicare beneficiaries will see this information. The posters direct

Medicare beneficiaries with limited income and resources to a toll free number where they can find out if they are eligible for help with prescription drug costs.

To view and order the posters, go to the Medlearn Prescription Drug Coverage Web page located on the CMS website at <http://www.cms.hhs.gov/medlearn/drugcoverage.asp>.

We need your help in getting this information out to Medicare beneficiaries with limited income and resources. We encourage you to order and display the posters where Medicare beneficiaries will see them.

### Information Tool Available on Web

The new prescription drug coverage informational tool, “Learn About Your Medicare Prescription Coverage Options” was recently released on <http://www.medicare.gov>.

This awareness tool for people with Medicare provides information about what is coming and what actions they will need to take with regard to the new prescription drug coverage. By answering two to three questions, the individual will be provided with information such as: eligibility for extra help for people with limited income and resources, customized information based on the individual’s current coverage, as well as educational resources and links to publications about the new drug coverage.

### Summary

CMS understands the pressure on your clinical time with patients, which is why we ask that you inform your Medicare patients that this new prescription drug coverage could be valuable to them and worth exploring. In addition to the products discussed in this article, CMS plans to provide you with access to information you could make available to your patients in your offices.

### Additional Information

More information on provider education and outreach regarding drug coverage may be found on the CMS website at: <http://www.cms.hhs.gov/medlearn/drugcoverage.asp>.

Detailed drug coverage information for CMS partners and beneficiary advocates may be found on the CMS website at <http://www.cms.hhs.gov/partnerships/news/mma/default.asp>.

You can also find additional information regarding prescription drug plans on the CMS website at <http://www.cms.hhs.gov/pdps/>.

Further information on CMS implementation of the MMA may be found at the following CMS website: <http://www.cms.hhs.gov/medicarereform/>.

Source: CMS Special Edition Medlearn Article SE0537

## More Web-based Educational Products Available

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

**The Fifth article in a series of: Information for Providers, Physicians, Pharmacies and their Staff About Medicare Prescription Drug Coverage**

### Provider Types Affected

Physicians, providers, suppliers, and their staff providing service to people with Medicare

### Important Points to Remember

- On January 1, 2006, new prescription drug coverage will be available to your Medicare patients.
- It will cover brand name and generic drugs.
- This new drug coverage requires all people with Medicare to make a decision this fall. As a trusted source, your patients may turn to you for information about this new coverage. Because of this, we’re looking to you and your staff to take advantage of this “teachable moment” and help your Medicare patients.
- You should encourage your Medicare patients to learn more about this new coverage because it may save them money on prescription drugs. There is extra help available for people with limited income and resources.
- If your Medicare patients ask you questions about the new coverage, for additional information and assistance you may refer them to 1-800-MEDICARE and to <http://www.medicare.gov>.

**New Fact Sheets Available on <http://www.medicare.gov>**

There are fact sheets now available that explain Medicare’s new prescription drug coverage that can help your patients understand this new coverage:

- *Quick Facts about Medicare’s New Coverage for Prescription Drugs* – Publication Number 11102. This fact sheet provides basic information about Medicare’s new prescription drug coverage. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11102.pdf>.
- *Quick Facts about Medicare’s New Coverage for Prescription Drugs for People with Limited Income and Resources* – Publication Number 11105. This fact sheet provides basic information about Medicare’s new prescription drug coverage for a person with limited income and resources. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11105.pdf>.
- *Quick Facts about Medicare’s New Coverage for Prescription Drugs If You Applied for Extra Help* – Publication Number 11130. This fact sheet explains what you need to know after applying for extra help paying Medicare prescription drug coverage costs. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11130.pdf>.
- *Quick Facts about Medicare’s New Coverage for Prescription Drugs for People Who Get Supplemental Security Income* – Publication Number 11116. This fact sheet provides basic information about Medicare’s new prescription drug coverage for a person who gets Supplemental Security Income benefits or help from their state Medicaid program paying their Medicare premiums. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11116.pdf>.

- *Quick Facts about Medicare’s New Coverage for Prescription Drugs for People with Medicare and Medicaid* – Publication Number 11106. This fact sheet provides basic information about Medicare’s new prescription drug coverage for a person with full Medicaid benefits. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11106.pdf>.
- *Quick Facts about Medicare’s New Coverage for Prescription Drugs for People Who are Nursing Home Residents* – Publication Number 11121. This fact sheet explains how the new Medicare prescription drug coverage works for nursing home residents. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11121.pdf>.
- *Quick Facts about Medicare’s New Coverage for Prescription Drugs for People Who Get Help From Their State Pharmacy Program* – Publication Number 11108. This fact sheet explains what people who get help from their state pharmacy program to pay for their prescriptions need to know about the new Medicare prescription drug coverage. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11108.pdf>.
- *Do You Have a Medigap Policy with Prescription Drug Coverage?* – Publication Number 11113. This fact sheet explains how the new Medicare prescription drug coverage works for people who have a Medigap policy with prescription drug coverage. (4 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11113.pdf>.
- *Medicare Covers America* – Publication Number 11141. This brochure provides basic information for people with Medicare about Medicare prescription drug coverage. This information includes how Medicare prescription drug coverage works, how to get coverage, and how to join a Medicare prescription drug plan. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11141.pdf>.
- *Introducing Medicare Prescription Drug Coverage* – Publication Number 11142. This brochure provides basic information to people with Medicare about Medicare prescription drug coverage. This information includes who can join, when people can join, and when more information will be available. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11142.pdf>.

**New Fact Sheets and Tip Sheets Available on the CMS Website at <http://www.cms.hhs.gov/medicarereform/factsheets.asp>**

- *The Facts about Medicare Prescription Drug Plans* – Publication Number 11065. This fact sheet provides basic introductory information about Medicare’s new prescription drug coverage. (2 pages) <http://www.medicare.gov/Publications/pubs/pdf/11065.pdf>.
- *Quick Facts about Medicare’s New Coverage for Prescription Drugs (en Español)* – Publication Number 11102-S. This fact sheet provides basic information

**More Web-based Educational Products Available (continued)**

- about Medicare's new prescription drug coverage, in Spanish. <http://www.cms.hhs.gov/medicarereform/elnewcovprescdrug.pdf>.
- **Medicaid Spend Down – Tip Sheet** (3 pages) This tip sheet provides an example of the spend down requirement for patients who have Medicaid because of high medical expenses. This sheet shows the qualifications for patients to receive extra help. <http://www.cms.hhs.gov/medicarereform/medicaid%20spend%20down.pdf>.
  - **Food Stamps – Tip Sheet** (3 pages) This tip sheet provides information on income limits, resource limits and qualifications for extra help for people who have Medicare and are also on food stamps. <http://www.cms.hhs.gov/medicarereform/foodstamps.pdf>.
  - **Medicare Prescription Drug Coverage and other Federal Means – Tested Programs – Tip Sheet** (2 pages) This tip sheet is intended to help explain how Medicare prescription drug coverage will work with other federal means-tested programs such as food stamps, HUD housing assistance, Medicaid, low income home energy assistance, and supplemental security income. <http://www.cms.hhs.gov/medicarereform/lowincome.pdf>.

**Other Publications/Products**

- **Introducing Medicare's New Coverage for Prescription Drugs (bi-fold)** – This pamphlet provides general information about the New Medicare Prescription Drug Coverage, such as who can join, when, and the cost to join, as well as providing sources for additional information. This pamphlet is available at <http://www.medicare.gov/Publications/Pubs/pdf/11103.pdf>.
- **Vignettes/Bios/Case Studies**– These vignettes may be used to help explain how Medicare prescription drug coverage works with and affects other types of health care coverage. They may be used to supplement other outreach materials. (10 pages). These vignettes are available at <http://www.cms.hhs.gov/partnerships/news/mma/vignettesfinal.pdf>.

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**Posters Now Available!**

Posters titled "Have Limited Income? Social Security Can Help with Prescription Costs" can be ordered free of charge on the Centers for Medicare and Medicaid Services' (CMS) website.

The posters are suitable for display in a physician's, provider's, or supplier's office, a pharmacy, or other health care setting where Medicare beneficiaries will see this information. The posters direct Medicare beneficiaries with limited income to a toll free number where they can find out if they are eligible for help with prescription drug costs. Flat posters are suitable for wall display. Easel posters are suitable for counter display.

Source: CMS Joint Signature Memorandum 05355, May 20, 2005

- **Introducing Medicare's New Coverage for Prescription Drugs (Russian, Korean, Vietnamese, and Chinese)** – To access this product, go to <http://www.medicare.gov/medicarereform/default.asp>.

At the middle of the Web page, select the language desired from the drop-down menu. This will reveal a link to the document in the desired language.

**Outreach Toolkit**

A new outreach toolkit is also available. This toolkit is designed to equip community-level organizations with the materials needed to provide clear, accurate information and assistance about Medicare prescription drug coverage for their clients.

The toolkit contains basic, straightforward information that may be easily conveyed to people with Medicare. You may view and download this kit online from the CMS web site, as well as order a copy to be shipped to your office, by visiting the CMS website: <http://www.cms.hhs.gov/partnerships/tools/materials/medicaretraining/MPDCoutreachkit.asp>.

**Additional Information**

More information on provider education and outreach regarding drug coverage may be found on the CMS website at: <http://www.cms.hhs.gov/medlearn/drugcoverage.asp>.

Detailed drug coverage information for CMS partners and advocates for people with Medicare may be found on the CMS website at <http://www.cms.hhs.gov/partnerships/news/mma/default.asp>.

You may also find additional information regarding prescription drug plans on the CMS website at <http://www.cms.hhs.gov/pdps/>.

Further information on CMS implementation of the MMA may be found on the CMS website at <http://www.cms.hhs.gov/medicarereform/>.

Source: CMS Special Edition Medlearn Article SE0541

Order the size and style appropriate for your use. Artwork cannot be specified, as posters will be sent based on availability at the time the order is received.

To view and order the posters, go to the Medlearn Prescription Drug Coverage Web page located at <http://www.cms.hhs.gov/medlearn/drugcoverage.asp> on the CMS website.

We need your help in getting this information out to Medicare beneficiaries with limited income and resources. We encourage you to order and display the posters where Medicare beneficiaries will see them.



# GENERAL COVERAGE

## Changes to the Laboratory National Coverage Determination Edit Software for July 2005

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

### Provider Types Affected

Clinical diagnostic laboratories billing Medicare carriers or fiscal intermediaries (FIs)

### Provider Action Needed

CR 3806 announces changes to the list of codes included in the July 2005 release of the Medicare Laboratory National Coverage Determination (NCD) edit module for clinical diagnostic laboratory services.

These changes are a result of coding analysis completed by the Centers for Medicare & Medicaid Services (CMS).

### Background

The NCD for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published as a final rule on November 23, 2001. Nationally uniform software was developed by Computer Sciences Corporation and incorporated into Medicare claim processing systems so that laboratory claims subject to any of the 23 NCD are processed uniformly throughout the nation, effective January 1, 2003.

In addition, the laboratory edit module for the NCD is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCD developed through the NCD process. (See the Medicare Claims Processing Manual, Pub. 100-4, Chapter 16, Section, 120.2. This manual may be found at: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp).

CR 3806 announces the changes that will be included in the July 2005 release of the edit module for clinical diagnostic laboratory services. Those changes are as follows:

- In accordance with the coding analysis published on the coverage Internet site on November 23, 2004 (See <http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=138>), CMS is adding ICD-9-CM code 733.02 – idiopathic osteoporosis, to the list of “ICD-9-CM Codes Covered by Medicare” for the thyroid testing NCD.
- In accordance with the coding analysis published on the coverage Internet site on March 14, 2005 (See <http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=146>), CMS is adding diagnosis code 156.0 – malignant neoplasm of the gallbladder, and code 156.2 – malignant neoplasm of the ampulla of vater, to the list of “ICD-9-CM Codes Covered by Medicare” for the tumor antigen by immunoassay CA 19-9 NCD.
- In accordance with the coding analysis published on the coverage Internet site on March 14, 2005 (See <http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=147>),

CMS is deleting diagnosis code 784.69 – other symbolic dysfunction, from the list of “ICD-9-CM Codes Covered by Medicare” for the hepatitis panel NCD.

- In accordance with the coding analysis published on the coverage Internet site on March 17, 2005 (See <http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=149>), CMS is adding diagnosis code 789.39 – abdominal or pelvic swelling, mass or lump of other specified site, to the list of “ICD-9-CM Codes Covered by Medicare” for the tumor antigen by immunoassay CA 125 NCD.
- In accordance with the coding analysis published on the coverage Internet site on March 17, 2005 (See <http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=150>), CMS is adding diagnosis codes V77.1 – special screening for diabetes mellitus, V81.0 – special screening for ischemic heart disease, V81.1 – special screening for hypertension, and V81.2 – special screening for other an unspecified cardiovascular conditions, to the list of “ICD-9-CM Codes That Do Not Support Medical Necessity” for the blood counts NCD.

### Implementation Date

The implementation date for these changes is July 5, 2005.

### Additional Information

For complete details, please see the official instruction issued to your FI/carrier regarding these changes at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3806 in the CR NUM column on the right, and then click on the file for that CR.

If you have questions regarding this issue, contact your FI/carrier at their toll free number, which may be found at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3806

Related CR Release Date: April 29, 2005

Related CR Transmittal Number: 534

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 534, CR 3806

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## Smoking and Tobacco Use Cessation Counseling

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

### Provider Types Affected

Physicians, other Medicare-recognized practitioners, and providers billing Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and carriers for smoking and tobacco use cessation counseling

### Provider Action Needed

#### STOP – Impact to You

Medicare Part B covers two new levels of counseling, intermediate and intensive, for smoking and tobacco use cessation, effective March 22, 2005. The coverage is limited to beneficiaries who use tobacco and have a disease or adverse health effect found by the U.S. Surgeon General to be linked to tobacco use or who are taking certain therapeutic agents whose metabolism or dosage is affected by tobacco use as based on the Food and Drug Administration (FDA)-approved information. Patients must be competent and alert at the time that services are provided. Two attempts are covered each year and each attempt may include a maximum of four intermediate or intensive sessions. A maximum of eight sessions in one year are covered.

#### CAUTION – What You Need to Know

The Centers for Medicaid & Medicare Services (CMS) has established two new “G” codes for billing for the new levels of smoking and tobacco use cessation counseling, effective for dates of service on or after March 22, 2005.

**Note:** For the interim period of March 22, 2005, through July 4, 2005, when billing for smoking and tobacco use cessation counseling, use the unlisted code 99199. On July 5, 2005 and thereafter, when billing for this counseling, use the appropriate new “G” codes. Include one unit per session in the unit field of the claim.

#### GO – What You Need to Do

Make sure your billing staff is aware of the new codes and the interim coding requirements when submitting claims for the smoking and tobacco use cessation counseling services you provide on or after March 22, 2005.

### Background

Based on a 2004 request from the Partnership for Prevention to review the issue for a national coverage determination (NCD), CMS determined that the evidence is adequate to conclude that smoking and tobacco use cessation counseling, based on current Public Health Service (PHS) guidelines, is reasonable and necessary for certain individuals who use tobacco and have a disease or an adverse health effect caused or complicated by tobacco use. Patients must be competent and alert at the time that services are provided.

### What Is Covered

Medicare Part B covers smoking and tobacco cessation counseling when certain coverage conditions, frequency and other limitations are met. Medicare Part B coverage includes two attempts each year.

Each attempt may include a maximum of four intermediate or intensive sessions. A total of eight sessions are

covered in a 12-month period. The qualified practitioner and the patient have flexibility to choose between intermediate or intensive cessation strategies for each session.

### Billing Codes

The following two new Health Common Procedure Coding System (HCPCS) codes have been created for billing for the two new levels of smoking and tobacco-use cessation counseling Medicare now covers:

**G0375** Smoking and tobacco-use cessation counseling visit; intermediate, greater than three minutes up to ten minutes. **Short Descriptor:** Smoke/Tobacco counseling 3-10.

**G0376** Smoking and tobacco-use cessation visit; intensive, greater than ten minutes. **Short Descriptor:** Smoke/Tobacco counseling greater than 10.

Because these new “G” codes will not be in the Medicare system until July 5, 2005, for the interim period of March 22, 2005, through July 4, 2005, use the unlisted code 99199 when billing for smoking and tobacco use cessation counseling. Include one unit per session in the units field of the claim. Effective for claims received by Medicare on or after July 5, 2005, the claim should reflect HCPCS codes G0375 or G0376 (effective back to March 22, 2005, the effective date of the new coverage).

**Note:** CPT code 99199 is carrier priced. Also, providers whose claims are subject to payment under the outpatient prospective payment system (OPPS) should use the G codes instead of CPT code 99199. Such claims will be held by your FI until July 5, at which time they will be processed.

This additional coverage, as described by the above HCPCS codes G0375 and G0376 does not change the existing coverage for minimal cessation counseling (defined as three minutes or less in duration) bundled into the normal evaluation and management (E/M) visit.

Smoking and tobacco use cessation counseling claims are to be submitted with the appropriate diagnosis code. Diagnosis codes should reflect the condition the patient has that is adversely affected by the use of tobacco or the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by the use of tobacco.

**Note:** Providers are reminded that they should keep on file appropriate documentation in the patient’s medical records to adequately demonstrate that Medicare coverage conditions were met for any services provided and billed to Medicare for smoking and tobacco use cessation counseling.

Physicians and other Medicare-recognized practitioners who need to bill for E&M services on the same day as smoking cessation services are billed should use the appropriate CPT code in the 99201-99215 range **and** modifier 25 to show that the E&M service is a separately identifiable service from a smoking and tobacco-use cessation counseling service.

*Changes to the Laboratory National Coverage Determination Edit Software for July 2005 (continued)*

Claims from physicians or other providers where assignment was not taken are subject to the Medicare limiting charge, meaning charges to the beneficiary may be no more than 115 percent of the allowed amount.

**Billing to Fiscal Intermediaries**

Smoking and tobacco use cessation counseling services may be billed to FIs and RHHIs on types of bill (TOBs) 12x, 13x, 14x, 22x, 23x, 34x, 71x, 73x, 74x, 75x, 83x, and 85x.

On TOBs 71x and 73x (rural health clinics [RHCs] and federally qualified health centers [FQHCs]), FIs will pay for claims with revenue code 052x.

For TOB 13x (Indian health service [HIS]), FIs shall accept revenue code 0510.

Critical access hospitals under method II need to use the appropriate revenue code in the range of 096x through 098x.

For other TOBs, on claims received on or after July 5, 2005, FIs and RHHIs will pay for G0375 and G0376 codes when accompanied by revenue code 0942 (other therapeutic services; education/training).

Payment by FIs/RHHIs is as follows:

Type of Facility	Method of Payment
RHCs/FQHCs	All-inclusive rate (AIR) for the encounter
IHS/Tribally owned or operated hospitals and hospital based facilities	AIR
IHS/Tribally owned or operated non-hospital based facilities	Medicare physician fee schedule (MPFS)
IHS/Tribally owned or operated critical access hospitals	Facility specific visit rate
Hospitals subject to the OPPS	Ambulatory payment classification (APC)
Hospitals not subject to OPPS	Payment is made under current methodologies
Skilled nursing facilities (SNFs) <b>Note:</b> Included in Part A PPS for skilled patients	MPFS
Comprehensive outpatient rehabilitation facilities	MPFS
Home health agencies	MPFS
Critical access hospitals	<b>Method I:</b> Technical services are paid at 101 percent of reasonable cost. <b>Method II:</b> Professional services are paid at 115 percent of the MPFS database
Maryland Hospitals	Payment is based according to the Health Services Cost Review Commission. That is 94 percent of submitted charges subject to any unmet deductible, coinsurance, and non-covered charges policies.

**Additional Information**

**Note:** When these services are provided by a clinical nurse specialist in the RHC/FQHC setting, the services are considered “incident to” and do not constitute a billable visit. In addition, Medicare will not cover tobacco cessation services for patients in an inpatient hospital stay if tobacco cessation is the primary reason for the inpatient stay.

For complete details, please see the official instruction issued to your carrier/FI/RHHI regarding this change, which may be found by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3834 in the CR NUM column on the right, and then click on the files for that CR. You will note two documents with CR 3834 in that column. The file with transmittal number 36 will contain the NCD information and the one with transmittal number 562 will contain the changes to Medicare claims processing requirements.

If you have questions regarding this issue, contact your carrier/FI/RHHI on their toll free number, which is available at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3834

Related CR Release Date: May 20, 2005

Related CR Transmittal Number: 36 and 562

Effective Date: March 22, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 562, CR 3834

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## Cochlear Implantation Coverage

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

### Provider Types Affected

Physicians and providers billing Medicare carriers and fiscal intermediaries (FIs) for cochlear implantation services to Medicare patients

### Provider Action Needed

#### STOP – Impact to You

The coverage for cochlear implantation has expanded and is effective for services performed on or after April 4, 2005.

#### CAUTION – What You Need to Know

CMS will cover treatment of bilateral pre- or post-linguistic, sensorineural, moderate-to-profound hearing loss for individuals with hearing test scores equal to or less than 40 percent correct in the best aided listening condition on tape-recorded tests of open-set sentence recognition. More detailed coverage requirements are further listed in this article.

Additionally, CMS will cover cochlear implants of individuals with open-set sentence recognition test scores of greater than 40 percent to less than or equal to 60 percent correct, where the device was implanted in an acceptable clinical trial/study. See further details listed below.

#### GO – What You Need to Do

This revision is a binding national coverage determination (NCD) made under section 1862(a)(1) of the Social Security Act. The remainder of this article provides more detailed billing instructions for these services.

### Background

A cochlear implant device is an electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn or carried by the individual to capture, analyze, and code sound. The purpose of implanting the device is to provide awareness and identification of sounds and to facilitate communication for persons who are moderately to profoundly hearing impaired. Cochlear implant devices are available in single-channel and multi-channel models.

### Additional Information

The information in this section outlines the policy guidelines for cochlear implantation coverage, the coverage criteria for an acceptable clinical trial/study, billing requirements for cochlear implantation, and a listing of Healthcare Common Procedural Coding System (HCPCS) associated with cochlear implantation.

### Nationally Covered Indications

Medicare coverage is provided only for those patients who meet all of the following selection guidelines:

- Diagnosis of bilateral moderate-to-profound sensorineural hearing impairment with limited benefit (test scores of less than or equal to 40 percent correct in the best-aided listening condition on tape-recorded tests of open-set sentence cognition) from appropriate hearing (or vibrotactile) aids.
- Cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation.

- Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system.
- No contraindications to surgery.
- The device must be used in accordance with Food and Drug Administration (FDA)-approved labeling.

### Criteria for Acceptable Clinical Trials and Studies

The coverage criteria that allows for services for individuals meeting the above guidelines and with hearing test scores greater than 40 percent and less than or equal to 60 percent requires the provider to participate in and the patient to enroll in an acceptable clinical trial/study, which includes **one** of the following:

- Food and Drug Administration-approved category B investigational device exemption clinical trial as defined in 42 CFR 405.201.
- Trial under the CMS clinical trial policy as defined in Section 310.1 of the Medicare National Coverage Determinations Manual.
- Prospective, controlled comparative trial approved by CMS as consistent with the evidentiary requirements for national coverage analyses and meeting specific quality standards.

### Billing Requirements for Cochlear Implantation when Billing FIs and Carriers

These services should be billed on an approved electronic claim form or a paper CMS form 1500. For services performed on and after April 4, 2005:

Medicare Contractors (FIs and carriers) pay for:

1. Cochlear implant devices and services for moderate-to-profound hearing loss in patients with hearing test scores equal to or less than 40 percent.
2. Cochlear implant devices for patients with hearing test scores of greater than 40 percent to less than or equal to 60 percent hearing provided in a clinical trial setting that is billed with the QR modifier.
3. Other services related to cochlear implantation, but not the device itself, for patients with hearing test scores of greater than 60 percent hearing who are in a clinical trial. (These services must be identified with a modifier QV.)
4. Services for patients with hearing test scores of greater than 40 percent to less than or equal to 60 percent hearing who are in a prospective, controlled comparative trial approved by CMS. (These services must be billed with modifier QR.)
5. Any covered diagnostic audiology or therapy services related to the cochlear implant. (Modifier QR or QV does not need to be applied to CPT codes 92601-92604, 92506 and 92507.)

**Cochlear Implantation Coverage (continued)**

Also, when billing FIs for cochlear implantations, follow these additional instructions:

1. Submit claims on the following types of bill (TOB):
  - a. 11x
  - b. 12x
  - c. 13x
  - d. 83x (for non-OPPS providers)
  - e. 85x
2. Report diagnosis code V70.7 (Examination of participant in clinical trial) as the second or subsequent diagnosis code, along with the appropriate principal diagnosis code, for patients in a clinical trial.

**HCPCS associated with cochlear implantation**

Some of the Healthcare Common Procedural Coding System (HCPCS) codes used when billing for cochlear implant services and devices provided by audiologists or physicians, and for the services of 92506 and 92507, by speech language pathologists include:

69930	<i>Cochlear device implantation, with or without mastoidectomy</i>
92506	<i>Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status</i>
92507	<i>Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual</i>
92601	<i>Diagnostic analysis of cochlear implant, patient under 7 years of age; with programming</i>
92602	<i>Diagnostic analysis of cochlear implant, patient under 7 years of age; subsequent programming</i> <b>(Do not report 92602 in addition to 92601.)</b>
92603	<i>Diagnostic analysis of cochlear implant, age 7 years or older; with programming</i>
L8614	Cochlear device/system
L8619	Cochlear implant external speech processor, replacement
L7500	Repair of prosthetic device, hourly rate (It excludes V5335 repair of oral laryngeal prosthesis or artificial larynx.)
L7510	Repair of prosthetic device, repair or replace minor parts

**Note:** Codes 92601 and 92603 describe post-operative analysis and fitting of previously placed external devices, connection to the cochlear implant, and programming of the stimulator.

Codes 92602 and 92604 describe subsequent sessions for measurements and adjustment of the external transmitter and re-programming of the internal stimulator.

Medicare beneficiaries not meeting all of the coverage criteria for cochlear implantation specified above, or the specific coverage criteria for cochlear implantation in the context of a clinical trial/study, also specified above, are deemed not eligible for Medicare coverage under section 1862(a)(1)(A) of the Social Security Act.

A national coverage determination revision is binding on all carriers, FIs, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare appeals council, and administrative law judges (see 42 CFR section 405.732, 405.860).

Because it expands coverage, the NCD is also binding on a Medicare advantage organization. In addition, an administrative law judge may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

The official instruction issued to your FI or carrier regarding this change may be found by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3796 in the CR NUM column on the right, and click on the file(s) for that CR. You will note two files for CR 3796. The file with transmittal number 42 is the NCD itself and the file with transmittal number 601 contains the claims processing instructions.

For additional information relating to this issue, please refer to your local FI or carrier. To find the toll free phone number for your local FI or carrier, go to: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3796  
 Related CR Release Date: June 24, 2005  
 Related CR Transmittal Number: 42 and 601  
 Effective Date: April 4, 2005  
 Implementation Date: July 25, 2005

Source: CMS Pub. 100-4, Transmittal 601, CR 3796

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## Coverage of Aprepitant for Chemotherapy-Induced Emesis

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

### Provider Types Affected

Providers and suppliers rendering services to beneficiaries with cancer chemotherapy-induced nausea and vomiting (CINV)

### Provider Action Needed

#### STOP – Impact to You

Effective April 4, 2005, you may submit claims for the use of the oral anti-emetic drug aprepitant (Emend®), when used in combination with a 5-HT<sub>3</sub> antagonist and dexamethasone in beneficiaries receiving certain cancer chemotherapeutic agents as outlined below.

#### CAUTION – What You Need to Know

CMS has announced a national coverage determination (NCD) that covers the use of aprepitant (Emend®), an orally administered neurokinin-1 (NK1) antagonist, in both acute and delayed phases of chemotherapy-induced emesis. Effective April 4, 2005, CMS will cover the use of the oral anti-emetic drug combination of aprepitant (Emend®), a 5-HT<sub>3</sub> antagonist, and dexamethasone in beneficiaries receiving certain cancer chemotherapeutic agents (see *Background* section below).

#### GO – What You Need to Do

Make sure that your billing staffs are aware of this new coverage.

### Background

Aprepitant (Emend®), a human substance P/neurokinin-1 (NK1) receptor antagonist, is the first Food and Drug Administration-approved anti-emetic drug of its type. It has been approved to function in combination with other oral anti-emetics for the prevention of both acute and delayed chemotherapy-induced nausea and vomiting (CINV) associated with initial and repeat courses of highly emetogenic chemotherapeutic agents.

CINV can range in severity from mild to severe, with the most severe cases resulting in dehydration, malnutrition, metabolic imbalances, and potentially requiring withdrawal from future chemotherapy treatments. CINV incidence and severity are influenced by the specific chemotherapeutic agent(s) used, their dosage, schedule and route of administration, and by drug combinations. In addition, they can also be affected by patient-specific risk factors such as sex, age, history of motion sickness, and prior exposure to chemotherapeutic agents.

While progress has been made in reducing CINV, symptoms that occur more than a day after chemotherapy, during repeat cycles of chemotherapy, and when chemotherapy is given on more than one day or in very high doses remain hard to control. No single anti-emetic agent is completely effective in all patients.

CMS has determined that the evidence is adequate to conclude that use of the oral anti-emetic drug combination of aprepitant (Emend®), a 5-HT<sub>3</sub> antagonist, and dexamethasone is reasonable and necessary for a specified patient population receiving one or more of the following anti-cancer chemotherapeutic agents:

- Carmustine
- Cisplatin
- Cyclophosphamide
- Dacarbazine
- Mechlorethamine
- Streptozocin
- Doxorubicin
- Epirubicin
- Lomustine

**Note:** The evidence is adequate to conclude that aprepitant cannot function alone as a full replacement for intravenously administered anti-emetic agents for patients who are receiving highly emetogenic chemotherapy.

#### Important Billing Information

You must bill your claims for Aprepitant (Emend®), on Form CMS-1450 (UB-92), or the electronic equivalent, with the appropriate cancer diagnosis and HCPCS code of J8501 (Aprepitant, oral, 5mg) or appropriate CPT code. Those providers submitting claims to Medicare fiscal intermediaries (FIs) should also include revenue code 0636 (drugs requiring detailed coding).

For FIs, the following payment methodologies apply when aprepitant is provided by a hospitals or skilled nursing facility (SNF) outpatient department:

- Based on ambulatory payment classification (APC) for hospitals subject to the outpatient prospective payment system (OPPS).
- Under current payment methodologies for hospitals not subject to OPPS; or
- On a reasonable cost basis for SNFs.

Critical access hospital (CAH) claims will be paid as follows:

- Method I – technical services are paid at 101 percent of reasonable cost;
- Method II – technical services are paid at 101 percent of reasonable cost, and professional services are paid at 115 percent of the Medicare physician fee schedule database.

Claims submitted to Medicare’s durable medical equipment regional carriers (DMERCs) will be paid based on the average sales price (ASP) pricing file for claims with dates of service on or after April 4, 2005.

Effective January 1, 2005, the payment allowance limit is based on the ASP plus six percent.

**Note:** Inpatient claims submitted for oral anti-emetic drugs are processed under the current payment methodologies.

Your Medicare DMERC or FI will adjust claims with dates of service April 4, 2005 (effective date) through July 4 2005 (implementation date), if brought to their attention.

**Coverage of Aprepitant for Chemotherapy-Induced Emesis (continued)****Additional Information**

You can find more information about the coverage of aprepitant (Emend®) for chemotherapy-induced emesis by going to [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3831 in the CR NUM column on the right, and click on the file(s) for that CR. The file with transmittal number 40 will contain the national coverage determination and the file with transmittal number 590 will contain the claims processing instructions.

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

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

Related Change Request (CR) Number: 3831  
 Related CR Release Date: June 24, 2005  
 Related CR Transmittal Number: 40 and 590  
 Effective Date: April 4, 2005  
 Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 590, CR 3831

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## Updated Requirements for Autologous Stem Cell Transplantation for Amyloidosis

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

**Provider Types Affected**

Physicians and providers billing Medicare carriers and intermediaries for AuSCT

**Provider Action Needed**

This article is based on information contained in Change Request (CR) 3797, which informs physicians and providers that, effective for services on or after March 15, 2005, high dose mephalan (HDM) and autologous stem cell transplantation (AuSCT) is reasonable and necessary for all Medicare beneficiaries with primary amyloid light chain (AL) amyloidosis who meet the following criteria:

- 1) Amyloid deposition in two or fewer organs; and
- 2) Cardiac left ventricular ejection fraction (EF) greater than 45 percent.

Primary AL amyloidosis is covered for all beneficiaries who meet the above criteria regardless of age. All forms of non-primary (AL) amyloidosis remain non-covered.

**Background**

Stem cell transplantation is a process by which stem cells are harvested from either a patient’s or a donor’s bone marrow (or peripheral blood) for intravenous infusion. Autologous stem cell transplantation (AuSCT) is a technique for restoring a patient’s stem cells using the patient’s own previously stored cells (ICD-9-CM procedure code 41.01, 41.04, 41.07, and 41.09 and CPT-4 code 38241).

AuSCT **must** be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (high dose chemotherapy (HDCT)) and/or radiotherapy used to treat various malignancies.

Allogeneic stem cell transplant may also be used to restore function in recipients who have an inherited or acquired deficiency or defect.

**Coverage Policy Changes**

For Medicare beneficiaries age 64 years or older who have primary amyloid light chain (AL) amyloidosis (ICD-9-CM 277.3), the Centers for Medicare & Medicaid Services (CMS) previously had a national non coverage policy for

high-dose melphalan (HDM), together with autologous stem cell transplantation (AuSCT). This non-coverage policy was based on the lack of sufficient data to establish definitive conclusions regarding the efficacy of AuSCT, and for those beneficiaries age 63 years or younger, coverage of HDM/AuSCT was left to the local Medicare carrier’s/intermediary’s discretion.

However, CR3797 informs physicians, providers, and suppliers that (effective for services on or after March 15, 2005) when recognized clinical risk factors are employed to select patients for transplantation, HDM together with AuSCT is reasonable and necessary for Medicare beneficiaries of **any age group** with primary AL amyloidosis who meet the following criteria:

- Amyloid deposition in 2 or fewer organs; and
- Cardiac left ventricular Ejection Fraction (EF) greater than 45 percent.

Primary AL amyloidosis is covered for all beneficiaries who meet the above criteria regardless of age, and all forms of non-primary (AL) amyloidosis remain noncovered.

To clarify existing coverage, AuSCT must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (high dose chemotherapy (HDCT)) and/or radiotherapy used to treat various malignancies.

Please refer to the National Coverage Determinations Manual (Pub. 100-03), Section 110.8.1 for complete coverage guidelines; and the Medicare Claims Processing Manual (Pub. 100-04), Chapter 3, Section 90.3.2 (FI), plus Chapter 32, Section 90-90.6 (Carrier) for complete claims processing guidance.

**Updates to Medicare Claims Processing Manual**

CR3797 updates the Medicare Claims Processing Manual (Pub.100-04), Chapter 3, Section 90.3.2 (FI claims) and Chapter 32, Section 90.3 (carrier claims) with the new coverage guidelines for primary amyloid light chain (AL) amyloidosis for high-dose melphalan together with autologous stem cell transplantation (HDM/AuSCT).

**Updated Requirements for Autologous Stem Cell Transplantation for Amyloidosis (continued)**

The criteria for multiple myeloma (Durie-Salmon) within the fiscal intermediary (FI) section is also revised to coincide with the Nation Coverage Determination Manual (NCD) (Pub. 100-03), Section 110.8.1 and the non-coverage guidelines have been updated to remove the age requirement language to in Chapter 32, Section 90.3.2.

In addition, CMS removed reference to revenue code 0891 in the Medicare Claims Processing Manual (Pub. 100-04, Chapter 3, Section 90.3.3), since that revenue code no longer exists. CMS also removed the reference to physicians that does not belong in the hospital chapter. All other information within the claims processing manual remains the same.

**Implementation**

The implementation date for this instruction is May 16, 2005.

**Additional Information**

For complete details (including the manual updates listed in the previous section), please see the official

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instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that web page, look for CR 3797 in the CR NUM column on the right, and click on the files for that CR.

Please note that there will be two files representing CR 3797 on this web page. One file will contain the National Coverage Determination manual changes and the other will contain the changes to the Medicare Claims Processing Manual.

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

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

Source: CMS Pub. 100-4, Transmittal 526, CR 3797

**Continuous Positive Airway Pressure Therapy for Obstructive Sleep Apnea**

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

**Provider Types Affected**

Physicians, providers, and suppliers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs) for obstructive sleep apnea (OSA) related claims

**Provider Action Needed**

Providers need to be aware that on April 4, 2005, the Centers for Medicare & Medicaid Services (CMS) declared that the national coverage policy for continuous positive airway pressure (CPAP) therapy for OSA will remain unchanged. Unattended home sleep testing for the diagnosis of OSA is **not** considered reasonable and necessary.

Polysomnography must be performed in a facility-based sleep study laboratory, not in the home or a mobile facility.

**Background**

CR3843 is updating and confirming the national coverage determination (NCD) policy section 240.4 of the Medicare National Coverage Determinations Manual (Pub. 100-03), which states that polysomnography must be performed in a facility-based sleep study laboratory, not in the home or a mobile facility.

The use of CPAP is covered under Medicare when used in adult patients with moderate or severe OSA for whom surgery is a likely alternative to CPAP. The use of CPAP devices must be ordered and prescribed by the licensed treating physician to be used in adult patients with moderate to severe OSA if either of the following criteria using the apnea-hypopnea index (AHI) is met:

- AHI greater than or equal to 15 events per hour, or
- AHI greater than or equal to five 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 two hours of sleep recorded by polysomnography using actual recorded hours of sleep (i.e., the AHI may not be extrapolated or projected). Apnea is defined as a cessation of airflow for at least ten seconds.

Hypopnea is defined as an abnormal respiratory event lasting at least ten seconds with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a four percent oxygen desaturation.

Initial claims must be supported by medical documentation (separate documentation where electronic billing is used), such as a prescription written by the patient's attending physician that specifies:

- A diagnosis of moderate or severe obstructive sleep apnea, and
- Surgery is a likely alternative.

The claim must also certify that the documentation supporting a diagnosis of OSA (described above) is available.

**Continuous Positive Airway Pressure Therapy for Obstructive Sleep Apnea (continued)****Implementation**

The implementation date of CR 3843 is June 6, 2005.

**Additional Information**

The HCPCS codes that may be used for billing covered Medicare CPAP devices and various accessories are E0601, A7030-A7039, A7044-A7046, and E0561-E0562.

For complete details, please see the official instruction issued to your intermediary/carrier/DMERC regarding this change. That instruction may be viewed by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3843 in the CR NUM column on the right, and click on the file for the desired CR.

For additional information relating to this issue, please refer to your intermediary/carrier/DMERC. To find their toll free phone numbers go to: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3843

Related CR Release Date: May 6, 2005

Related CR Transmittal Number: 35

Effective Date: April 4, 2005

Implementation Date: June 6, 2005

Source: CMS Pub. 100-3, Transmittal 35, CR 3843

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**Expansion of Coverage for Percutaneous Transluminal Angioplasty**

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

**Provider Types Affected**

Hospitals, physicians, and suppliers billing Medicare carriers or fiscal intermediaries (FIs) for percutaneous transluminal angioplasty (PTA) services provided to Medicare beneficiaries

**Provider Action Needed****STOP – Impact to You**

MM 3811 and related CR 3811 announce the expansion of Medicare coverage for PTA of the carotid artery.

**CAUTION – What You Need to Know**

Effective March 17, 2005, Medicare revised its coverage of PTA of the carotid artery as detailed in this article and CR 3811.

**GO – What You Need to Do**

If you are a provider of PTA services, be aware of the coverage changes and make certain that your billing staff is aware of the expanded national coverage allowed to Medicare beneficiaries receiving PTA services

**Background**

Medicare covers PTA of the carotid artery concurrent with carotid stent placement when all the requirements stipulated by the Food and Drug Administration (FDA)-approved policies for category B investigational device exemption (IDE) clinical trials are met, effective for dates of service on or after July 1, 2001.

PTA of the carotid artery concurrent with the placement of an FDA-approved carotid stent for an FDA-approved indication is covered, when all the requirements stipulated by the FDA-approved policies for post approval studies are met, for dates of service on or after October 12, 2004.

**Expanded Coverage**

Effective March 17, 2005, The Centers for Medicare & Medicaid Services (CMS) expanded the coverage of PTA of the carotid artery concurrent with placement of an FDA-approved carotid stent with embolic protection for the following:

- Patients who are at high risk for carotid endarterectomy (CEA) and who also have symptomatic carotid artery stenosis = 70 percent. Coverage is limited to procedures performed using FDA-approved carotid artery stenting systems and embolic protection devices;
- Patients who are at high risk for CEA and have symptomatic carotid artery stenosis between 50 percent and 70 percent in accordance to the category B IDE clinical trials regulation (42 CFR 405.201), as a routine cost under the clinical trials policy (Medicare National Coverage Determination (NCD) Manual, Section 310.1), or according to the NCD on carotid artery stenting (CAS) post-approval studies (Medicare NCD Manual, Section 20.7); and
- Patients who are at high risk for CEA and have asymptomatic carotid artery stenosis = 80 percent (according to the Category B IDE clinical trials regulation (42 CFR 405.201)), as a routine cost under the clinical trials policy (Medicare NCD Manual 310.1), or according to the NCD on CAS post-approval studies (Medicare NCD Manual, Section 20.7).

CMS defines high risk patients as those having significant comorbidities and/or anatomic risk factors and are considered by a surgeon to be poor candidates for CEA. The significant comorbidities, include, but are not limited to, those listed in Section 20.7 of the Medicare NCD Manual as follows:

- Congestive heart failure (CHF) class III/IV
- Left ventricular ejection fraction (LVEF) < 30 percent
- Unstable angina
- Contralateral carotid occlusion
- Recent myocardial infarction (MI)
- Previous CEA with recurrent stenosis
- Prior radiation treatment to the neck



*Expansion of Coverage for Percutaneous Transluminal Angioplasty (continued)*

- Other conditions that were used to determine patients at high risk for CEA in the prior CAS trials and studies, such as ARCHER, CABERNET, SAPPHIRE, BEACH, and MAVERIC II.

Symptoms of carotid artery stenosis include carotid transient ischemic attack (distinct focal neurologic dysfunction persisting less than 24 hours), focal cerebral ischemia producing a non-disabling stroke (modified Rankin scale < 3 with symptoms for 24 hours or more), and transient molecular blindness (amaurosis fugax). Patients who have had a disabling stroke (modified Rankin > 3) would be excluded from coverage.

The appropriate documentation confirming that a patient is at high risk for CEA and records of the patient's symptoms of carotid artery stenosis should be available in the patient medical records prior to performing any procedure. The degree of carotid artery stenosis should be measured by duplex Doppler ultrasound or carotid artery angiography and recorded in the patient medical records. If the stenosis is measured by ultrasound prior to the procedure, then the degree of stenosis must be confirmed by angiography at the start of the procedure. If the stenosis is determined to be less than 70 % by angiography, the CAS should not proceed.

- Carotid artery stenting with embolic protection is reasonable and necessary only if performed in facilities that have been determined to be competent in performing the evaluation, procedure, and follow-up necessary to ensure optimal patient outcomes. All facilities must at least meet the minimum standards outlined in Pub 100-03, Section 20.7 of the NCD Manual in order to receive coverage for CAS for high-risk patients. Briefly, facilities must have high quality X-ray imaging equipment, device inventory, staffing, and infrastructure to support a dedicated CAS program.
- Advanced physiologic monitoring, including real time and archived physiologic, hemodynamic, and cardiac rhythm monitoring equipment, and associated support staff capable of interpreting findings and responding appropriately.
- Readily available emergency management equipment and systems, such as resuscitation equipment, a defibrillator, vasocative and antiarrhythmic drugs, endotracheal intubation capability, and anesthesia support.
- A clearly delineated program for granting CAS privileges and for monitoring the quality of the individual interventionists and the program as a whole. The oversight committee for this program is encouraged to apply published standards from national specialty societies recognized by the American Board of Medical Specialties to determine appropriate physician qualifications. Examples of standards and clinical competence guidelines include those published in the December 2004 edition of the American Journal of Neuroradiology and those published in the August 18, 2004, Journal of the American College of Cardiology.
- A data collection system maintained by the facility or its contractor on all CAS procedures done at that facility.

The data must be analyzed routinely to ensure patient safety (to be determined by the facility but should not be less frequent than 6-month intervals), will be used in re-credentialing the facility, and must be made available to CMS upon request.

For evaluation purposes, all facilities must provide written documentation to CMS indicating it meets one of the following criteria:

- Was a FDA-approved site that enrolled patients in prior CAS IDE trials, such as SAPPHIRE, and ARCHER;
- Is a FDA-approved site that is participating and enrolling patients in ongoing CAS IDE trials, such as CREST;
- Is a FDA-approved site for one or more FDA post-approval studies; or
- Has provided a written affidavit to CMS affirming that the facility meets the minimum facility standards.

The affidavit must include the facility's name and complete address, Medicare provider number, point-of-contact name and telephone number, CAS procedure data collection mechanism, and a senior facility administrative official's signature. (Note that a new affidavit is required every 2 years.) The affidavit should be sent to:

Director, Coverage and Analysis Group  
7500 Security Boulevard, Mail-stop C1-09-06  
Baltimore, MD 21244

**Note:** Performance of PTA to treat obstructive lesions of the vertebral and cerebral arteries remains noncovered.

All other indications of PTA for which CMS has not specifically indicated coverage remain noncovered.

**Additional Information**

All providers should note that the following relate to services on or after March 17, 2005:

- FIs and carriers will only pay CAS claims from providers who are listed on the approved facility list, which is at: <http://www.cms.hhs.gov/coverage/carotid-stent-facilities.asp>.
- Carriers will pay claims containing ICD-9 CM 433.10 and any of the following procedure codes: 37215, 37216, 0075T, or 0076T, for beneficiaries meeting the high risk criteria previously specified.
- FIs will pay claims containing ICD-9 CM 433.10 and both procedure codes 00.61 and 00.63.
- FIs will reject claims that do not have both procedure codes 00.61 and 00.63.
- FIs and carriers will deny CAS services for patients at high risk if the appropriate diagnosis code is not on the claim and use the appropriate Medicare Summary Notice (MSN) message and claim adjustment reason code in doing so.
- FIs and carriers will deny claims where the service was performed in an unapproved facility and use the appropriate MSN message and claim adjustment reason code in doing so.

**Expansion of Coverage for Percutaneous Transluminal Angioplasty (continued)**

**Note:** Providers must also bill V70.7 (Exam – clinical trial) as a secondary diagnosis for claims with “From” dates before October 1, 2005. Providers must bill V70.7 in order to avoid unintentional Medicare Code Editor (MCE) editing.

For claims that have “From” dates **on or after** October 1, 2005, hospitals are not required to bill V70.7 as the unintentional MCE editing will be corrected.

You may also want to review the following Medlearn Matters article 3489 and CR 3489 for additional information relating to Medicare coverage of PTA. They are available at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3489.pdf>

[http://www.cms.hhs.gov/manuals/pm\\_trans/R314CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R314CP.pdf).

The official instruction issued to your FI/carrier regarding this change may be found at:

[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

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From that Web page, look for CR 3811 in the CR NUM column on the right, and then click on the files for that CR. You will see two versions of CR 3811. One version identified by transmittal number 33 contains the NCD Manual revision, and transmittal number 531 contains the revisions to the Medicare Claims Processing Manual.

If you have questions regarding this issue, contact your intermediary/carrier on their toll free number, which is available at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3811

Related CR Release Date: April 22, 2005

Related CR Transmittal Number: 33 and 531

Effective Date: March 17, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 531, CR 3811

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## Coverage and Billing for Ultrasonic Stimulators for Nonunion Fracture Healing

*CMS has issued the following “Medlearn Matters... Information for Medicare Providers” article.*

### Provider Types Affected

Physicians, providers, and suppliers billing Medicare carriers and intermediaries, including regional home health intermediaries (RHHIs) and durable medical equipment regional carriers (DMERCs), for ultrasonic osteogenic stimulators.

### Provider Action Needed STOP – Impact to You

This article is based on Change Request (CR) 3836 which informs physicians, providers, and suppliers that the Centers for Medicare & Medicaid Services (CMS) announced a reconsideration of the national coverage determination (NCD) covering the use of ultrasonic osteogenic stimulators, effective April 27, 2005.

### CAUTION – What You Need to Know

Upon reconsideration of the existing policy, CMS determined that ultrasound stimulation for nonunion fracture healing will remain covered with an additional expansion of coverage to patients without prior surgeries to the non-healing fracture.

### GO – What You Need to Do

See the *Background* section of this article for further details regarding this change.

### Background

The Centers for Medicare & Medicaid Services (CMS) announced a reconsideration of the national coverage

determination (NCD) covering the use of ultrasonic osteogenic stimulators, effective April 27, 2005.

An ultrasonic osteogenic stimulator is a noninvasive device that emits low intensity, pulsed ultrasound signal to stimulate fracture healing. The device is applied to the surface of the skin at the fracture site and ultrasound waves are emitted via a conductive coupling gel to stimulate fracture healing. An ultrasonic osteogenic stimulator:

- Is not to be used concurrently with other noninvasive osteogenic devices; and
- Is intended for use with cast immobilization.

### Nationally Covered Indications

Ultrasonic osteogenic stimulators are covered as medically reasonable and necessary for the treatment of nonunion fractures when the following is demonstrated:

- A minimum of two sets of radiographs is obtained prior to starting treatment with the osteogenic stimulator, each separated by a minimum of 90 days. Each radiograph must include multiple views of the fracture site accompanied by a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.

The national noncoverage policy relating to ultrasonic osteogenic stimulators for fresh fractures and delayed unions remains in place. In addition, nonunion fractures of the

*Coverage and Billing for Ultrasonic Stimulators for Nonunion Fracture Healing (continued)*

skull, vertebrae and tumor-related fractures are excluded from coverage.

Effective for services performed on or after April 27, 2005 Medicare will cover an osteogenic stimulator for beneficiaries who meet the criteria described above.

- **Carriers and RHHIs** will allow payment for an osteogenic stimulator with the following CPT code:  
20979 *Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)*
- **Durable medical equipment regional carriers** will allow payment for osteogenic stimulators with the following HCPCS codes:  
E0760 for low intensity ultrasound, or  
E1399 for other ultrasound stimulation.
- **Regional home health intermediaries** pay for the ultrasonic osteogenic stimulator only when the services are submitted on type of bills (TOBs) 32x, 33x, or 34x.
- **Home Health Agencies (HHAs) need to know** that this ultrasonic osteogenic stimulator must be in the patient's home health plan of care if billed on TOBs 32x or 33x. HHAs billing on TOBs 32x, 33x and 34x for the osteogenic stimulator will be paid based on the durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) fee schedule.
- **Hospitals need to know** that they cannot bill for the ultrasonic osteogenic stimulator. Hospitals may only instruct patients on how to use the ultrasonic osteogenic stimulator and **not** provide the ultrasonic osteogenic stimulator.

**Implementation**

The implementation date for this change is August 1, 2005.

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**Additional Information**

See the Medicare National Determinations Manual (Pub. 100-03), Section 160.11 (Osteogenic Stimulators) at the following CMS web site: [http://www.cms.hhs.gov/manuals/103\\_cov\\_determ/ncd103c1\\_Part2.pdf](http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103c1_Part2.pdf).

For more information about the medical coverage of clinical trials, see the following CMS website: <http://www.cms.hhs.gov/coverage/8d.asp>.

For complete details on this change, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed by going to [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR3836 in the CR NUM column on the right, and click on the files for that CR. You will note two files for CR 3836. The file with transmittal number 41 is the NCD itself and the file with transmittal number 597 contains the billing requirements.

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

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

Related Change Request (CR) Number: 3836

Related CR Release Date: June 24, 2005

Related CR Transmittal Number: 41 and 597

Effective Date: April 27 2005

Implementation Date: August 1, 2005

Source: CMS Pub. 100-4, Transmittal 597, CR 3836

**Anti-Cancer Chemotherapy for Colorectal Cancer**

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

**Note:** CMS revised this article on May 23, 2005, to reflect the revision of the original CR 3742. The CR was revised to show that revenue code 0636 is used when billing Medicare fiscal intermediaries (FIs) for anti-cancer drugs furnished during a clinical trial on outpatient claims, but revenue code 0250 should be used when billing for anti-cancer drugs furnished during a clinical trial on inpatient claims. In addition, CMS revised the article on June 21, 2005, to reflect a revision to CR 3742. The CR was revised to show that Medicare FIs has implemented the change on or before July 5, 2005, instead of April 18, 2005. The effective date of CR 3742 and all other information remains the same. The original article was published in the [Third Quarter 2005 Medicare A Bulletin](#) (pages 39-40).

**Provider Types Affected**

Providers and suppliers billing Medicare FI and carriers, including durable medical equipment regional carriers (DMERCs) for anti-cancer chemotherapy

## Anti-Cancer Chemotherapy for Colorectal Cancer (continued)

### Provider Action Needed

This article is based on information contained in Change Request (CR) 3742, which states that the Centers for Medicare & Medicaid Services (CMS) will cover the off-label use of Oxaliplatin (Eloxatin™), Irinotecan (Camptosar®), Cetuximab (Erbix™), or Bevacizumab (Avastin™) in clinical trials identified by CMS and sponsored by the National Cancer Institute (NCI).

This national coverage decision does not:

- Modify existing requirements for coverage of these and other anti-cancer chemotherapeutic agents for FDA-approved indications or for off-label indications listed in an approved compendium; or
- Change existing coverage for any off-label uses of these drugs provided outside the clinical trials identified.

Medicare FIs, carriers, and DMERCs will continue to make local coverage determinations for medically accepted uses of off-label indications based on guidance provided by the Secretary of the Department of Health & Human Services (DHHS).

### Background

On January 28, 2005, CMS announced a national coverage determination (NCD) covering the off-label use of certain colorectal anti-cancer drugs in identified clinical trials of colorectal cancer and other cancer types. These clinical trials study the use of one or more off-label uses of these four drugs in colorectal and other cancer types.

**Note:** The clinical trials for which these drugs and other items and services are covered appear in Appendix A in the NCD on the CMS website at <http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=90>.

Anti-cancer chemotherapeutic agents are eligible for coverage in a clinical trial setting when the following occurs:

- They are used in accordance with Food and Drug Administration (FDA)-approved labeling;
- Their use is supported in one of the authoritative drug compendia; or
- The Medicare contractor (FI, carriers and DMERCs) determines an off-label use is medically accepted based on guidance provided by Secretary of DHHS.

Effective for services provided on or after January 28, 2005, CMS covers the following anti-cancer chemotherapeutic agents, which have been approved by the FDA for the treatment of colorectal cancer, when used in clinical trials identified by CMS and sponsored by the National Cancer Institute:

- Oxaliplatin (Eloxatin™)
- Irinotecan (Camptosar®)
- Cetuximab (Erbix™)
- Bevacizumab (Avastin™)

Under the concept of linking Medicare coverage determinations to clinical studies, the investigational items and services provided in qualified scientific studies are covered (including clinical trials, practical trials, and systematic data collection systems) when:

- They provide for the accrual of supporting evidence of medical necessity; and
- They collect data to support decisions about whether or not a technology is reasonable and necessary.

**Note:** The list of identified clinical trials for which the routine costs of the items and services are covered appears in the clinical trials section, on the CMS website at <http://www.cms.hhs.gov/coverage>.

Non-routine clinical costs include items and services that are provided in either the investigational or the control arms of a clinical trial specified by CMS for coverage. The following nonroutine items and services are not covered and include items and services:

- Provided solely to satisfy data collection, and that are not used in the direct clinical management of the patient;
- Provided solely to determine trial eligibility;
- Customarily provided by the research sponsors free-of-charge for any enrollee in the trial;
- That are statutorily excluded from Medicare coverage; or
- That do not fall into a benefit category.

This NCD, issued on January 28, 2005, does not withdraw Medicare coverage for items and services that may be covered according to the existing national coverage policy for Routine Costs in a Clinical Trial (See National Coverage Determination Manual, Section 310.1 on the CMS website at [http://www.cms.hhs.gov/manuals/103\\_cov\\_determ/ncd103index.asp](http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp)).

**Note:** The existing requirements for coverage of oxaliplatin, irinotecan, cetuximab, bevacizumab, or other anticancer chemotherapeutic agents for FDA-approved indications or for indications listed in an approved compendium are not modified.

Medicare contractors will continue to make reasonable and necessary coverage determinations under the Social Security Act (Section 1861(t)(2)(B)(ii)(II)) based on guidance provided by CMS for medically accepted uses of off-label indications of Oxaliplatin, Irinotecan, Cetuximab, Bevacizumab, or other anticancer chemotherapeutic agents provided outside of the identified clinical trials appearing on the CMS website noted previously.

Some important points to remember when billing Medicare for these anti-cancer drugs are as follows:

- FIs will accept claims for these drugs on types of bill (TOB) 11x, 12x, 13x, 18x, 21x, 22x, 23x, and 85x. Use revenue code 0636 used for anti-cancer drugs furnished during a clinical trial for outpatient claims and use revenue code 0250 for inpatient claims.
- Claims submitted to FIs should also contain an ICD-9-CM diagnosis code of V70.7 in the second diagnosis code position to show that the claim involves a clinical trial.
- When billing FIs, carriers and DMERCs on a claim other than an inpatient claim, include modifier QR to show the drug was furnished during a clinical trial.



*Anti-Cancer Chemotherapy for Colorectal Cancer (continued)*

- When using modifier QR, also be sure to include a HCPCS code of J9035, J9055, J9206, J9263, J8520, J8521, J9190, or J9201, as appropriate for the anti-cancer drug being billed.
- Providers are also to include modifier QR when billing for nonroutine costs associated with these clinical trials.
- DMERCs will accept claims with HCPCS codes of J8520 and J8521 as clinical trial codes for oral anticancer drugs, when accompanied by the QR modifier to show use in a clinical trial.
- When billing for covered routine costs associated with clinical trials as described in section 310 of the NCD manual, be sure to include modifier QV on the claim.
- Submit an appropriate cancer diagnosis code for the clinical trial on the claim.

**Note:** While this NCD is effective as of January 28, 2005, Medicare systems were not able to process claims containing modifier QR received before April 1, 2005. For that reason, provider were asked not to send claims for drugs or other nonroutine services covered under this NCD until April 1, 2005. Claims for nonroutine services containing modifier QV associated with this NCD were not affected.

**Additional Information**

For complete details, please see the official instruction issued to your FI/carrier/DMERC regarding this change. That instruction includes the NCD section 110.17 and it may be viewed by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3742 in the CR NUM column on the right, and click on the file for that CR.

You should see two versions of CR 3742 on this website. The version of CR 3742 with a transmittal number of R38NCD will contain the NCD information and the version with a transmittal number of R588CP will contain the Medicare claims processing instructions.

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

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

Related Change Request (CR) Number: 3742

Related CR Release Date: June 17, 2005

Related CR Transmittal Number: 38 and 588

Effective Date: January 28, 2005

Implementation Date: April 18, 2005 for Medicare carriers.

On or before July 5, 2005 for Medicare FIs

Source: CMS Pub. 100-4, Transmittal 588, CR 3742

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**Abarelix for the Treatment of Prostate Cancer**

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

**Note:** CMS has revised on July 26, 2005, to reflect changes made to CR 3775, which was revised and reissued on July 22, 2005. The changes made as a result of the revised CR 3775 are to clarify that GnRH therapy is GnRH agonist therapy. Also, providers billing Medicare intermediaries for the use of abarelix need to note that revenue code 0250 must be used on inpatient claims. The original article addressing coverage guidelines for abarelix was published in the [Third Quarter 2005 Medicare A Bulletin](#) (pages 51-52).

**Provider Types Affected**

Providers who care for Medicare beneficiaries with prostate cancer

**Provider Action Needed****STOP – Impact to You**

Effective March 15, 2005, you may bill for the use of abarelix (Plenaxis™) for certain patients with advanced, symptomatic prostate cancer.

**CAUTION – What You Need to Know**

Effective March 15, 2005, CMS is extending national coverage for the use of abarelix (Plenaxis™) as a palliative treatment, for the indications described below, in patients with advanced, symptomatic prostate cancer.

**GO – What You Need to Do**

Make sure that your billing staff is aware of this new coverage.

**Background****Treatment Options for Prostate Cancer**

Treatment options for prostate cancer vary depending on patient age, cancer stage, and individual medical conditions. Surgery (e.g., radical prostatectomy) or radiation is typically used for early-stage disease, whereas hormonal therapy, chemotherapy, and radiation (or combinations of these treatments) are used for more advanced disease.

Hormonal therapy for prostate cancer has evolved from orchiectomy and estrogens to the use, in recent years, of synthetic drugs known as gonadotropin-releasing hormone (GnRH) agonists, such as leuprolide (Lupron™) and goserelin (Zoladex™).

**Abarelix**

More recently, newer GnRH receptor antagonist compounds, such as abarelix (Plenaxis™), are, in contrast, thought to be devoid of agonist activity and to lack an initial androgen-stimulating effect. Abarelix (Plenaxis™) has been proposed as a substitute for GnRH agonists (with and without antiandrogens) in the treatment of patients with

## *Abarelix for the Treatment of Prostate Cancer (continued)*

advanced prostate cancer, for whom a surge in androgen blood levels may pose a risk of “clinical flare.” For this indication, abarelix is the first GnRH receptor antagonist that the Food and Drug Administration (FDA) has approved.

CMS determines that the evidence is adequate to conclude that abarelix (Plenaxis™) is reasonable and necessary as a palliative treatment in patients with advanced symptomatic prostate cancer who: (1) decline surgical castration; (2) when GnRH agonist therapy is not appropriate, and (3) who present with **one** of the following indications:

- Risk of neurological compromise due to metastases,
- Ureteral or bladder outlet obstruction due to local encroachment or metastatic disease, or
- Severe bone pain from skeletal metastases persisting on narcotic analgesia.

Please note that the following additional conditions for coverage must be met, in accordance with the FDA labeling requirements, to ensure that abarelix (Plenaxis™) is used only in patients for whom the drug is indicated:

In evaluating this prostate cancer patient, the physician must attest to, and accept the following qualifications and responsibilities, and must have enrolled in the post-marketing risk management program that the drug manufacturer has established.

The physician must attest willingness and ability to:

- Diagnose and manage advanced symptomatic prostate cancer.
- Diagnose and treat allergic reactions, including anaphylaxis.
- Have access to medication and equipment necessary to treat allergic reactions, including anaphylaxis.
- Have patients observed for development of allergic reactions for 30 minutes following each administration of abarelix (Plenaxis™).
- Understand the risks and benefits of palliative treatment with abarelix (Plenaxis™).
- Educate patients on the risks and benefits of palliative treatment with abarelix (Plenaxis™).
- Report serious adverse events as soon as possible to the manufacturer and/or the FDA.

Finally, be aware that CMS has also determined that the evidence is not adequate to conclude that abarelix (Plenaxis™) is reasonable and necessary for indications other than those specified above. Therefore, all other uses of abarelix (Plenaxis™) are not covered. Further, in light of the concern regarding safety risks of abarelix (Plenaxis™), off-label uses that may appear in listed statutory drug compendia on which Medicare and its contractors rely to make coverage determinations will remain noncovered until

CMS completes a reconsideration of this national coverage determination.

### Additional Information

The following claims processing points should be noted:

- Use HCPCS code J0128 for claims when billing Medicare for abarelix used for treatment of prostate cancer patients in accordance with the requirements specified by the NCD.
- Medicare fiscal intermediaries will accept abarelix claims on types of bill 11x, 13x, 18x, 83x, and 85x. Also, use revenue code 0636 on outpatient claims and revenue code 0250 on inpatient claims to reflect a drug requiring detailed coding.
- Medicare carriers and intermediaries will pay separately for abarelix chemotherapy injections when billed using an appropriate chemotherapy administration procedure code in addition to the visit furnished on the same day.
- For services performed **on or after March 15, 2005**, Medicare will deny claims for uses of abarelix that are not covered under the NCD, (NCD Manual Section 110.18). An appropriate remittance advice code will be sent to reflect the denial using MSN 6.5 (*Medicare cannot pay for this in injection because one or more requirements for coverage were not met, reason code 47 (this, these) diagnosis(es) is (are) not covered, missing, or are invalid*), and remark code M76 — *missing/incomplete invalid diagnosis or condition*.

You may find more information about abarelix for the treatment of prostate cancer by going to:

[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3775 in the CR NUM column on the right, and click on the file for that CR.

You might also want to look at Chapter 1, Part 2, Section 110.18 of the Medicare National Coverage Determinations Manual that is an attachment to CR 3775.

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

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

Related Change Request (CR) Number: 3775

Related CR Release Date: July 22, 2005

Related CR Transmittal Number: 612

Effective Date: March 15, 2005

Implementation Date: May 25, 2005

Source: CMS Pub. 100-4, Transmittal 612, CR 3775

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## C-Peptide Levels as a Criterion for Use with Infusion Pumps

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) revised this article on June 6, 2005, to show that the correct effective date for this service is December 17, 2004. The original Medlearn Matters article MM3705 was published in the [Third Quarter 2005 Medicare A Bulletin](#) (pages 38-39).

### Provider Types Affected

Physicians, suppliers, and providers providing continuous subcutaneous insulin infusion and related drugs/supplies in the treatment of diabetic patients in the home setting and billing Medicare carriers or fiscal intermediaries (FIs)

### Provider Action Needed

#### STOP – Impact to You

This article and related CR 3705 adds beta cell autoantibody testing as an alternative diagnostic per the updated C-peptide testing requirement for the use of insulin infusion pumps, effective for services performed on or after December 17, 2004.

#### CAUTION – What You Need to Know

Providers/suppliers treating Medicare diabetic patients with infusion pumps should be aware of this new Medicare coverage policy.

#### GO – What You Need to Do

Ensure that your staff is aware of this new coverage and that they bill according to the information in this article.

### Background

On August 26, 1999, the Centers for Medicare & Medicaid Services (CMS) issued the first decision memorandum (DM) for continuous subcutaneous insulin infusion pumps (CSII) that utilized a C-peptide testing requirement for Medicare coverage of CSII pump therapy. On May 11, 2001, CMS issued a second DM for insulin pump: "C-Peptide Levels as a Criterion for Use," and on January 1, 2002, CMS revised the laboratory value for the C-peptide testing requirement for Medicare coverage of CSII pump therapy.

Effective for services performed on or after December 17, 2004, in addition to meeting criterion A or B, the beneficiary with diabetes must be insulinopenic per the fasting C-peptide testing requirement or, as an alternative must be beta cell autoantibody positive. Insulinopenia is defined as a fasting C-peptide level that is less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method. For patients with renal insufficiency and a creatinine clearance (actual or calculated

from age, gender, weight, and serum creatinine) < 50 ml/minute, insulinopenia is defined as a fasting C-peptide level that is less than or equal to 200 percent of the lower limit of normal of the laboratory's measurement method. CMS establishes that fasting C-peptide levels will only be considered valid when a concurrently obtained fasting glucose is < 225 mg/dL.

Levels need only be documented once in the patient's medical records.

Coverage of all other uses of CSII that adheres with the category B IDE clinical trials regulation (42 CFR 405.201) or routine cost under the clinical trials policy (Medicare NCD Manual Chapter 1, Part 4, Section 310.1) will continue.

Those billing for these services should note that Medicare intermediaries and carriers will accept, effective for services on or after December 17, 2004, CPT code 84681 (C-peptide) or CPT code 86337 (insulin antibodies) when diagnosis codes 250.00-250.93 are also reported on a claim.

### Additional Information

The official instruction issued to your Medicare intermediary/carrier regarding this change may be found by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3705 in the CR NUM column on the right, and click on the file for that CR.

If you have questions regarding this issue, contact your carrier/intermediary on their toll free number, which is available at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3705

Related CR Release Date: March 30, 2005

Related CR Transmittal Number: 27 and 513

Effective Date: December 17, 2004

Implementation Date: February 18, 2005

Source: CMS Pub. 100-4, Transmittal 513, CR 3705

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# HOSPITAL SERVICES

## 2006 Rate-Year Update for Long-Term Care Hospital Prospective Payment System

*CMS has issued the following “Medlearn Matters... Information for Medicare Providers” article.*

### Provider Types Affected

Long-term care hospitals paid under the LTCH PPS by Medicare fiscal intermediaries (FIs).

### Provider Action Needed

#### STOP – Impact to You

This article is based on information from Change Request (CR) 3884 which updates the changes to long-term care hospital prospective payment system (LTCH PPS) for the 2006 rate year (July 1, 2005 – June 30, 2006). The final rule for LTCH PPS was published on May 6, 2005, and may be viewed on the Centers for Medicare & Medicaid Services (CMS) website at:

<http://www.cms.hhs.gov/providerupdate/regs/cms1483F.pdf>.

#### CAUTION – What You Need to Know

CR3884 provides updates to rates, budget neutrality factors, wage indexes, etc., for the 2006 rate year for LTCH PPS.

#### GO – What You Need to Do

See the Background Section of this article to find out further details regarding these changes.

### Background

CMS implemented a prospective payment system for long term care hospitals under the Medicare program on October 1, 2002, in accordance with provisions of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.

Payments under this system are made on a per discharge basis, using long-term care diagnosis-related groups (LTC-DRGs) that take into account differences in resource use of long-term care patients and the most recently available hospital discharge data. CMS is required to update the payments made under this prospective payment system annually. However, there are two significant updates for LTCH PPS:

- The rate-year update, which occurs in July of each year.
- The diagnosis related groups, which are updated in October of each year.

#### Rate-Year Updates

The following PRICER updates are for LTCH PPS rate-year 2006, (July 1, 2005 – June 30, 2006):

- The standard federal rate is \$38,086.04.
- The fixed loss amount is \$10,501.00.
- The budget neutrality adjustment is 0 percent. (The PRICER payment amount will include the adjustment factor as 1.00.)

- The labor-related share is 72.885 percent.
- The non-labor related share is 27.115 percent.
- The short-stay outlier percentage for “subsection II” LTCHs is 165 percent for this third transition year.
- Core-based statistical area (CBSA) designations will be used for assigning a wage index value for discharges occurring on or after July 1, 2005. There will be no transition blend under LTCH PPS for conversion to the CBSA labor market areas.

The wage index phase-in percentage for cost reporting periods beginning on or after October 1, 2005 is 4/5ths (80 percent). The wage index table in the PRICER will include three columns table containing the information below:

2/5ths	Discharges occurring in LTCH cost report periods beginning during fiscal year 2004 (October 1, 2003-September 30, 2004), which will be 2/5ths of the core-based statistical area (CBSA) wage index (not the MSA wage index)
3/5ths	Discharges occurring in LTCH cost report periods beginning during fiscal year 2005 (October 1, 2004-September 30, 2005), which will be 3/5ths of the CBSA wage index (not the MSA wage index).
4/5ths	Discharges occurring in LTCH cost report periods beginning in fiscal year 2006 (October 1, 2005-September 30, 2006), which will be 4/5 of the CBSA wage index (not the MSA index)

#### LTCH Notification Requirement

Within thirty days of the start of their cost reporting period (and whenever any change occurs during a cost reporting period), LTCHs and satellites of LTCHs must notify their FI and CMS of the name, address, and provider number of any Medicare providers with whom they are co-located, including:

- Acute care hospitals
- Inpatient rehabilitation facilities
- Inpatient psychiatric facilities
- Skilled nursing facilities.

Note that a co-located (or onsite) facility means a hospital, unit, or SNF that occupies space 1) in a building used by another hospital or unit or 2) in one or more buildings on the same campus (250 yards from the LTCH), as buildings used by another hospital or unit.



*2006 Rate-Year Update for Long-Term Care Hospital Prospective Payment System (continued)*

CR3884 instructs your FIs to pay claims with LTCH PPS Pricer Version 060 for discharges/through dates on or after July 1, 2005, and this PRICER will include all 2006 rate-year updates. In addition, FIs shall maintain and update records on facilities that are co-located.

## Implementation

The implementation date for this instruction is July 5, 2005.

## Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change.

That instruction may be viewed by going to:  
[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

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## Mass Adjustment of Certain Transplant Claims

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

### Provider Types Affected

Hospitals that submitted claims for certain transplants paid under the inpatient prospective payment system (IPPS) by Medicare fiscal intermediaries (FIs)

### Background

The Centers for Medicare & Medicaid Services (CMS) has discovered that certain transplant claims paid under the IPPS by Medicare FIs may have been processed incorrectly; i.e. overpaid. Specifically, acquisition charges related to heart, liver, intestine, lung, and pancreas transplants (diagnosis-related groups [DRGs] 103, 480, 495, and 513) were being passed with all other charges on the claim to the IPPS PRICER and were, therefore, used in calculating the outlier. However, acquisition charges are considered **pass-through payments** and should **not** be included in the outlier calculation.

CMS has directed Medicare FIs to adjust claims with discharge dates on or after August 8, 2003, containing DRGs 103, 480, 495, or 513 that were paid an outlier. **This adjustment will occur automatically without any action required by the provider.** CMS will determine at a later date if they need to go back further than August 8, 2003 and will notify you if a decision is made.

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From that Web page, look for CR3884 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3884

Related CR Release Date: June 10, 2005

Related CR Transmittal Number: 578

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 578, CR 3884

Medicare FIs must complete these mass adjustments by **December 31, 2005.**

### Additional Information

Additional information on inpatient hospital billing for transplants may be found in the Medicare Claims Processing Manual, Chapter 3 (Inpatient Hospital Billing), Section 90, on the CMS website at [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c03.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c03.pdf).

For additional information relating to this issue, please contact local FI at their toll-free number, which may be found on the CMS website at  
<http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Article SE0539

## Implementation of Section Federal Funding of Emergency Health Services Furnished to Undocumented Aliens

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

### Provider Types Affected

Hospitals, physicians and ambulance providers

### Provider Action Needed

#### STOP – Impact to You

This special edition article summarizes the Centers for Medicare & Medicaid Services (CMS) policy regarding section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) regarding the Federal Funding of Emergency Health Services furnished to undocumented aliens.

#### CAUTION – What You Need to Know

On May 9, 2005, CMS announced its policy regarding section 1011, Federal Funding of Emergency Health Services Furnished to Undocumented Aliens, of the MMA. This new program will provide \$1 billion over four years to help hospitals, certain physicians, and ambulance providers recoup the costs of providing needed emergency medical care to undocumented aliens and certain other aliens. Since this provision of the MMA is not part of the Medicare program, CMS will designate a single contractor for the purposes of enrolling providers, receiving claims, calculating provider payment amounts, and effectuating payments. As soon as CMS awards a contract to perform this workload, you will be notified. CMS’ policy notice and related documents may be found be viewed on the CMS website at: <http://www.cms.hhs.gov/providers/section1011>.

#### GO – What You Need to Do

See the *Background* and *Additional Information* sections of this special edition article to find out further details regarding the CMS policy for Section 1011 of the MMA

#### Background

Section 1011 provides \$250 million per year for the fiscal years (FY) 2005 – 2008 for payments to eligible providers for emergency health services provided to undocumented and other specified aliens. Two-thirds of the funds will be divided among all 50 states and the District of

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Columbia based on their relative percentages of undocumented aliens. One-third will be divided among the six states with the largest number of undocumented alien apprehensions.

From the respective state allotments, payments will be made directly to hospitals, certain physicians, and ambulance providers for some or all of the costs of providing emergency health care required under section 1867 and related hospital inpatient, outpatient, and ambulance services to eligible individuals. Eligible providers may include an Indian Health Service facility, whether operated by the Indian Health Service or by an Indian tribe or tribal organization. A Medicare critical access hospital (CAH) is also a hospital under the statutory definition. Payments under section 1011 may only be made to the extent that care was not otherwise reimbursed (through insurance or otherwise) for such services during that fiscal year.

Payments may be made only for services furnished to certain individuals described in the statute as:

- 1) Undocumented aliens
- 2) Aliens who have been paroled into the United States at a United States port of entry for the purpose of receiving eligible services.
- 3) Mexican citizens permitted to enter the United States for not more than 72 hours under the authority of a biometric machine-readable border crossing identification card (also referred to as a “laser visa”) issued in accordance with the requirements of regulations prescribed under a specific section of the Immigration and Nationality Act.

#### Additional Information

Additional information can be found be viewed on the CMS website at

<http://www.cms.hhs.gov/providers/section1011>.

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Article SE0535

## Claim Adjustment on Payment for Emergency Medical Treatment and Labor Act–Mandated Screening and Stabilization Services

On February 22, 2005, First Coast Service Options, Inc. (FCSO) issued an article addressing additional information on handling claims for Emergency Medical Treatment and Labor Act (EMTALA) mandated screens and stabilization services. In that article we advised acute and critical care hospitals to resubmit the claim as an adjustment indicating in the “Remarks” field “Adjustment due to CR 3437,” or take no action since FCSO was going to adjust the affected claims that were processed since November 22, 2004.

As of June 17, 2005, FCSO has performed adjustments to all affected claims that were processed on or after November 22, 2004. The affected claims were for items and services provided in emergency departments (EDs) that were considered reasonable and necessary based on EMTALA regulations and that were denied incorrectly.

EMTALA coverage guidelines are effective for services provided **on or after January 1, 2004**.

An article addressing regulations on payments for EMTALA mandated screens and stabilization services was published in the *First Quarter 2005 Medicare A Bulletin* (page 42).

Source: CMS Pub. 100-8, Transmittal 86, CR 3437

**New HCPCS Codes and System Edits for Supplies and Accessories for Ventricular Assist Devices—Full Replacement of CR 3761**

*CMS has issued the following “Medlearn Matters... Information for Medicare Providers” article.*

**Note:** The Medlearn Matters article MM3761, addressing guidelines for change request (CR) 3761, was originally posted to the provider education website [www.floridamedicare.com](http://www.floridamedicare.com) on May 10, 2005. Since then, CMS has rescinded CR 3761 and issued CR 3931 as a replacement.

**Provider Types Affected**

Providers and suppliers who bill Medicare carriers or fiscal intermediaries (FIs) for supplies and accessories for ventricular assist devices

**Provider Action Needed  
STOP – Impact to You**

This instruction and related CR 3761 announce new Healthcare Common Procedure Coding System (HCPCS) codes and implement related Medicare system edits for replacement accessories and supplies for implanted ventricular assist devices (VADs) that are covered under the prosthetic device benefit in section 1834(h) of the Social Security Act.

**CAUTION – What You Need to Know**

Providers and suppliers furnishing replacement accessories and supplies for VADs should be aware of the new codes that are being added, effective October 1, 2005.

**GO – What You Need to Do**

Be sure your billing staff is aware of these changes that affect billing for these services on or after October 1, 2005.

**Background**

The fee schedules that Medicare uses to pay for durable medical equipment, prosthetics, and orthotics (DMEPOS), are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise, as necessary, any fee schedule amounts for existing codes. The Social Security Act (Sections 1834 (a), (h)(i)), requires that payment for DMEPOS be made on a fee schedule basis.

This article provides the new codes that are being added to HCPCS edits for replacement accessories and supplies for (VADs), effective October 1, 2005. Instructions regarding the implementation of the fee schedule amounts for these codes will be included in the October quarterly DMEPOS fee schedule update instructions.

Following are the codes that describe replacement accessories and supplies for VADs that are being added to the HCPCS effective October 1, 2005:

**Code Description of Code**

- Q0480 Driver for use with pneumatic ventricular assist device, replacement only
- Q0481 Microprocessor control unit for use with electric ventricular assist device, replacement only
- Q0482 Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only
- Q0483 Monitor/display module for use with electric ventricular assist device, replacement only
- Q0484 Monitor/display module for use with electric electric/pneumatic ventricular assist device, replacement only
- Q0485 Monitor control cable for use with electric ventricular assist device, replacement only

- Q0486 Monitor control cable for use with electric/pneumatic ventricular assist device, replacement only
- Q0487 Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device, replacement only
- Q0488 Power pack base for use with electric ventricular assist device, replacement only
- Q0489 Power pack base for use with electric/pneumatic ventricular assist device, replacement only
- Q0490 Emergency power source for use with electric ventricular assist device, replacement only
- Q0491 Emergency power source for use with electric/pneumatic ventricular assist device, replacement only
- Q0492 Emergency power supply cable for use with electric ventricular assist device, replacement only
- Q0493 Emergency power supply cable for use with electric/pneumatic ventricular assist device, replacement only
- Q0494 Emergency hand pump for use with electric or electric/pneumatic ventricular assist device, replacement only

**Note:** Replacement filters described by Q0500 are furnished in boxes of varying quantities by different manufacturers. Thus, the base unit for code Q0500 for billing purposes is per each filter.

- Q0495 Battery/power pack charger for use with electric or electric/pneumatic ventricular assist device, replacement only
- Q0496 Battery for use with electric or electric/pneumatic ventricular assist device, replacement only
- Q0497 Battery clips for use with electric or electric/pneumatic ventricular assist device, replacement only
- Q0498 Holster for use with electric or electric/pneumatic ventricular assist device, replacement only
- Q0499 Belt/vest for use with electric or electric/pneumatic ventricular assist device, replacement only
- Q0500 Filters for use with electric or electric/pneumatic ventricular assist device, replacement only
- Q0501 Shower cover for use with electric or electric/pneumatic ventricular assist device, replacement only
- Q0502 Mobility cart for pneumatic ventricular assist device, replacement only
- Q0503 Battery for pneumatic ventricular assist device, replacement only, each
- Q0504 Power adapter for pneumatic ventricular assist device, replacement only, vehicle type
- Q0505 Miscellaneous supply or accessory for use with ventricular assist device

***New HCPCS Codes and System Edits for Supplies and Accessories for Ventricular Assist Devices (continued)***

Medicare payment for VADs is made under Medicare Part A, since they are implanted in the beneficiary in an inpatient setting. Payment for supplies and accessories, including all the accessories necessary for the VAD to function, that are provided in the inpatient setting, are included in the Part A payment made by the Medicare FI.

Medicare payment can be made under Medicare Part B by carriers or FIs, for the medically necessary supplies and replacement accessories after the patient is discharged from the hospital. Claims for replacement of supplies and accessories used with the VAD that are furnished by suppliers should be billed to the local carriers. Claims for replacement of supplies and accessories that are furnished by providers (e.g., hospitals outpatient departments) should be billed to the FIs.

Based on information provided to the Centers for Medicare & Medicaid Services (CMS) by VAD manufacturers, CMS has determined that the lifetime of the batteries is six months and the lifetime of all other accessories is one year. Thus, CMS will implement edits to deny claims for replacement supplies and accessories before the lifetime of the item has expired (six or 12 months following discharge from the hospital or previous Part B payment for replacement of the item).

There are instances where replacement supplies and accessories HCPCS should be covered before the lifetime of the item has expired (i.e. cases where the item is lost, stolen, or irreparably damaged). In these situations, the local carrier or FI is responsible for determining if this item should be covered before the lifetime of the item has expired. Suppliers and hospitals are required to add HCPCS modifier "RP" (replacement and repair) to the claim with codes Q0480 thru Q0499 and Q0501 thru Q0504, in those instances where replacement is needed before the lifetime of the item has expired.

Also, Medicare will process claims for replacement of supplies and accessories in instances where the VAD was not covered by Part A, for example, where the patient did not

have Medicare Part A coverage, but does have Part B. In these cases, the provider should bill under code L9900 and your Medicare carrier or FI will determine if payment is warranted.

**Note:** Hospitals must bill HCPCS codes Q0480 through Q0505 with revenue code 274.

**Implementation Date**

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

**Additional Information**

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

The official instruction issued to your FI/carrier regarding this change may be found at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

Once at that site, scroll down the CR NUM column on the right and click on the file for CR 3761.

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

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

Related Change Request (CR) Number: 3931

Related CR Release Date: July 22, 2005

Related CR Transmittal Number: 613

Effective Date: October 1, 2005

Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 613, CR 3931

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## **Teaching Adjustment for the Inpatient Psychiatric Facility Prospective Payment System**

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

**Provider Types Affected**

Inpatient psychiatric facilities (IPF) paid under prospective payment system (PPS)

**Provider Action Needed****STOP – Impact to You**

This instruction includes information from Change Request (CR) 3809, which seeks to create a separate output from the Medicare claims processing system for the teaching adjustment for IPFs in order that the teaching amounts may be settled at cost report.

**CAUTION – What You Need to Know**

Affected providers should note that teaching IPF claims submitted between January 1, 2005 and October 1, 2005 will

be reprocessed, so that the information will flow correctly to the cost report.

**GO – What You Need to Do**

Please refer to the Background section of this article for details regarding these changes.

**Background**

To help offset the higher costs for inpatient psychiatric facilities (IPFs) that train interns and residents the Centers for Medicare & Medicaid Services (CMS) provides a teaching adjustment. The adjustment is calculated by taking the ratio of the number of interns and residents to the average daily census (ADC), adding 1, and raising that sum to the 0.5150 power.



*Teaching Adjustment for the Inpatient Psychiatric Facility Prospective Payment System (continued)*

Currently, the teaching adjustment is treated in the same manner as the rest of the facility-level and patient-level adjustments and is multiplied by the Federal per diem base rate to compute the federal per diem payment.

The data needed to compute an accurate teaching adjustment (the number of interns and residents and average daily census) comes from the cost report itself. There is no way to reconcile the teaching amount with the most current data on the cost report itself unless the teaching payments are distinct from the per diem payment because the PRICER:

- Computes the teaching adjustment using data from the provider-specific file, and then
- Applies the adjustment along with the other patient-level and facility-level adjustments.

For example, if the number of patient days for an IPF changes, there is no way to compute an accurate teaching adjustment on the cost report.

Based on recent feedback from CMS cost reporting staff and FIs, CMS will modify the PRICER software and Fiscal Intermediary Standard System (FISS) used by FIs to process claims so that the portion of the federal payment attributable to the teaching adjustment can be settled appropriately on the cost report. CR 3809 seeks to create a separate output from the PRICER for the teaching adjustment for IPF in order that the teaching amounts may be settled at cost report.

Basically, the teaching adjustment is calculated as follows:

1. Take the product of the wage adjusted base rate and the applicable teaching, rural, DRG (diagnosis related group), comorbidity, and age adjustments.
2. Take the product of the wage adjusted base rate and the applicable rural, DRG, comorbidity, and age adjustments.
3. Take the difference of these two products (Step 1 minus Step 2).
4. Calculate and sum the variable per diem amounts for the product in Step 2 to calculate the federal payment net of the teaching adjustment amount.
5. Calculate and sum the variable per diem amounts for the difference in Step 3 to calculate the portion of the federal payment attributable to the teaching adjustment.
6. To obtain the total federal payment necessary for outlier calculations, etc., add Steps 4 and 5 together.

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Step 5 alone is the teaching adjustment portion of the federal payment, and can be separately identified and reconciled on the cost report.

**Note:** PIP (periodic interim payment) providers, the teaching adjustment is paid on a per claim basis.

Additionally, as stated in CR 3752, remember that there is no authority to pay Indirect Medical Education to IPFs for Medicare Advantage beneficiaries, as is done under the acute inpatient prospective payment system.

### Implementation

The implementation date for this instruction is October 3, 2005. Once the system changes are implemented, FIs will mass adjust teaching IPF claims submitted between January 1, 2005 and October 1, 2005 so that the teaching amounts may flow to the Provider Statistical & Reimbursement processes and the amounts will be settled at cost report. The FIs will complete these mass adjustments by December 15, 2005.

### Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change.

That instruction may be viewed at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3809 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3809

Related CR Release Date: April 29, 2005

Related CR Transmittal Number: 545

Effective Date: Cost reporting periods beginning on or after January 1, 2005

Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 545, CR 3809

# LOCAL COVERAGE DETERMINATIONS

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

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

## Effective and Notice Dates

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

## Electronic Notification

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

## More Information

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

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

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**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 Website at <http://www.floridamedicare.com>.**

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## ADDITIONS/REVISIONS TO LMRPs/LCDs

### A70544: Magnetic Resonance Angiography (MRA)—Revision to Policy

The local medical review policy (LMRP) for magnetic resonance angiography (MRA) was last revised on January 5, 2004. Since that time, it was determined the following ICD-9-CM code ranges should be added to the policy for magnetic resonance angiography (MRA) of the abdomen, i.e. procedure codes 74185, C8900, C8901 and C8902:

401.0 – 401.9 Essential hypertension  
402.00 – 402.91 Hypertensive heart disease

The Indication and Limitations of Coverage and/or Medical Necessity, ICD-9 Codes that Support Medical Necessity and Source of Information sections have been revised accordingly.

In addition, the LMRP has been converted to local coverage determination (LCD) format.

Italicized lettering has been used to identify national coverage information.

#### Effective Date

This revision is effective for services provided **on or after June 23, 2005**.

The revised full-text for this policy is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

### A72192: Computed Tomography of the Pelvis—Addition to Policy

The local coverage determination (LCD) for computed tomography of the pelvis – A72192 was previously revised on November 18, 2004. At that time, ICD-9-CM code 592.0 was inadvertently left out of the ICD-9-CM additions. Therefore, ICD-9-CM 592.0 has been added to the policy.

#### Effective Date

This addition is effective for services provided **on or after November 18, 2004**.

The revised full-text for this policy is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

### A76070: Bone Mineral Density Studies—Revision to Policy

The local medical review policy for bone mineral density studies was last updated on January 1, 2005. Since that time the policy has been revised to convert the policy to local coverage determination (LCD) format and make changes based upon the Medicare Claims Processing Manual, the Medicare National Coverage Database and CR 3719 dated March 11, 2005.

All national guideline language throughout the LCD was italicized. Under the ICD-9-CM code list, E932.0 was identified as a secondary diagnosis and that it should not be billed as a primary diagnosis code.

Type of bill code 21x was removed and types of bill codes 71x and 72x were added to the Type of Bill Code section of the LCD.

Revenue codes 32x and 34x were taken out and replaced with revenue code 320.

#### Effective Date

This revision is effective for services processed **on or after June 9, 2005**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

### A85651: Sedimentation Rate, Erythrocyte—Revision to Policy

The local medical review policy (LMRP) for sedimentation rate, erythrocyte – A85651 was previously revised on October 17, 2002. Since that time, the indications and limitations of coverage and/or medical necessity has been updated to include “inflammatory disorders caused by infection, or connective tissue diseases.”

In addition, the “ICD-9 Codes that Support Medical Necessity” section of the policy has been updated to include diagnosis ranges 201.00-201.28 (Hodgkin’s disease) and 410.80-410.92 (Acute myocardial infarction).

The LMRP has been converted to local coverage determination (LCD) format.

#### Effective Date

This revision is effective for services provided **on or after June 16, 2005**.

The revised full-text for this policy is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

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**AEPO: Epoetin alfa—Revision to Policy**

The local coverage determination (LCD) for epoetin alfa was last revised June 1, 2004. A revision to this LCD was made to add the following additional diagnosis codes under the “ICD-9 Codes that Support Medical Necessity” for the following category:

- Under Renal Diagnosis (ESRD, not on dialysis – Q0136) added diagnosis codes:
  - 403.01 Malignant hypertensive renal disease with renal failure
  - 403.11 Benign hypertensive renal disease with renal failure
  - 403.91 Unspecified hypertensive renal disease with renal failure
  - 404.02 Malignant hypertensive heart and renal disease with renal failure
  - 404.03 Malignant hypertensive heart and renal disease with heart failure and renal failure
  - 404.12 Benign hypertensive heart and renal disease with renal failure
  - 404.13 Benign hypertensive heart and renal disease with heart failure and renal failure
  - 404.92 Unspecified hypertensive heart and renal disease with renal failure
  - 404.93 Unspecified heart and renal disease with heart failure and renal failure

**Effective Date**

This revision is effective for services processed **on or after May 9, 2005**, for services provided **on or after May 2, 2005**.

The revised full-text for this LCD is available on the provider education website <http://www.floridamedicare.com> on or after these effective dates. ❖

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**AG0030: Positron Emission Tomography (PET) Scans—Revision to Policy**

The local medical review policy (LMRP) for positron emission tomography (PET) scans – G0030 was previously revised on January 1, 2004. Since that time, the policy has been revised per change requests (CRs) 3726, 3741 and 3640. The policy has been revised to include myocardial indications only. All G-codes in the policy have been removed and replaced with the corresponding CPT codes of 78459, 78491 and 78492 for myocardial imaging.

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

In addition the policy number and policy title have been changed to A78459: Myocardial Imaging, Positron Emission Tomography (PET) Scan.

This information can be found in the CMS online manual Pub. 100-3, Medicare National Coverage Determinations Manual, Chapter 1, Part 4, Section 220.6.

**Effective Date**

This revision is effective for services provided **on or after January 28, 2005**.

The revised full-text for this policy is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

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**AG0237: Respiratory Therapeutic Services—Revision to Policy**

The local medical review policy (LMRP) for respiratory therapeutic services – AG0237 was previously revised on January 5, 2004. Since that time, it has been determined that revenue code 46x (pulmonary function) and 730 (EKG/EGG [electrocardiogram] general classification) are not applicable revenue codes for these services. Therefore, revenue code 46x and 730 have been removed from the policy.

In addition, the LMRP has been converted to local coverage determination (LCD) format.

**Effective Date**

This revision is effective for services processed **on or after June 9, 2005**.

The revised full-text for this policy is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

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**AJ2820: Sargramostim (GM-CSF, Leukine®)—Revision to Policy**

The local medical review policy for sargramostim (GM-CSF, Leukine®) was last updated on September 23, 2002. This policy was converted into the local coverage determination (LCD) format. References were updated with addition of new and deletion of old references. ICD-9-CM codes were removed from the LCD.

**Effective Date**

This revision is effective for services processed **on or after May 26, 2005**.

The full-text for this policy may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖



**AJ3487: Zoledronic Acid (Zometa®)—Revision to Policy**

The local medical review policy for zoledronic acid (Zometa®) was last updated on January 1, 2003. This policy was converted into the local coverage determination (LCD) format. References were updated with addition of new and deletion of old references. In addition, under the “Indications and Limitations of Coverage and/or Medical Necessity” section the definition of bone metastases sites was expanded based on the United States Pharmacopeia Drug Information (USP DI) indications. The FDA approved indication for this now reads as follows:

- Documented bone metastases from solid tumors in conjunction with standard antineoplastic therapy, including bone metastases from multiple myeloma, breast carcinoma, prostate carcinoma, and other solid tumors.

**Effective Date**

This revision is effective for services provided **on or after July 7, 2005**.

The full-text for this policy may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**AJ9000: Antineoplastic Drugs—Addition to Policy**

The local coverage determination (LCD) for antineoplastic drugs was last updated on February 1, 2005. A revision to this LCD was made to add diagnosis code 230.1 (Carcinoma in situ of esophagus) under the “ICD-9 Codes that Support Medical Necessity” section for porfimer (J9600).

**Effective Date**

This addition is effective for services provided on or after **June 16, 2005**.

The revised full-text for this policy may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**AJ9293: Mitoxantrone Hydrochloride—Revision to Policy**

The local medical review policy for mitoxantrone hydrochloride was last updated on August 9, 2001. This policy was converted into the local coverage determination (LCD) format. References were updated with addition of new and deletion of old references. Under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the policy, the indications were expanded to match the United States Pharmacopeia Drug Information (USP DI) verbiage.

**Effective Date**

This revision is effective for services processed **on or after April 14, 2005**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**ANESP: Darbepoetin Alfa (Aranesp®)—Revision to Policy**

The local coverage determination for darbepoetin alfa (Aranesp®) was last updated on January 1, 2004. Since that time this coverage determination has been revised.

The indications and limitations section was revised to include indications for the use of Aranesp® to treat MDS (myelodysplastic syndrome). In addition, dosage recommendations for the treatment of MDS with Aranesp® are given. The separate coding guideline attachment was updated to identify that ICD-9-CM code 238.7 should be billed when using Aranesp® to treat MDS.

**Effective Date**

This revision is effective for services processed **on or after June 9, 2005**.

The full-text for this policy may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

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**Multiple Policies Being Revised—Revision to Policies**

The “Documentation Requirements” section of the local coverage determinations (LCDs) listed below have been revised due to change request (CR) 3457 – Psychotherapy Notes, and updated CMS national coverage policy. This change request states contractors may not request psychotherapy notes from providers as they may contain protected health information. However, it also states the provider is responsible for extracting the required information to support the services as reasonable and necessary. Psychotherapy notes **may** be submitted with the patients’ authorization.

**Policy Number Policy Name**

A90804	Individual Psychotherapy
A90810	Interactive Individual Psychotherapy
A90847	Family Psychotherapy
A90853	Group Psychotherapy
A90857	Interactive Group Psychotherapy
APHPPROG	Psychiatric Partial Hospitalization Program

Additional information is also available on the Medlearn Matters article MM3604 at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3457.pdf>.

**Effective Date**

These revisions are effective for services provided **on or after February 22, 2005**.

The revised full-text for this policy is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**RETIREMENT OF EXISTING LMRPs/LCDs****A33216: Implantation of Automatic Defibrillators—Retirement of Policy**

The local coverage determination (LCD) for implantation of automatic defibrillators – A33216 has been retired. The decision to retire this policy was based on data analysis and Change Request 3604. CMS has revised the national coverage determination for implantation of automatic defibrillators, which expanded coverage to include primary prevention of sudden cardiac arrest. CMS has defined ICD-9-CM codes for the new non-primary (secondary) indications:

427.1	ventricular tachycardia
427.41	ventricular fibrillation
427.42	ventricular flutter
427.5	cardiac arrest
427.9	cardiac dysrhythmia, unspecified

The primary prevention population is identifiable on claims through the absence of the above ICD-9-CM codes.

This revision is effective for services provided **on or after January 27, 2005**.

Coverage guidelines for implantation of automatic defibrillators are provided by a national coverage determination (NCD). The NCD is available via the Online CMS Manual System, Pub 100-3, *Medicare National Coverage Determinations Manual*, Section 20.4. The NCD manual may be viewed at [http://www.cms.hhs.gov/manuals/103\\_cov\\_determ/ncd103index.asp](http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp).

Additional information is also available on the Medlearn Matters article MM3604 at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3604.pdf>.

**Effective Date**

The retirement of this policy is effective for services provided **on or after January 27, 2005**.

The full-text for this retired policy is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

## A94760: Noninvasive Ear or Pulse Oximetry for Oxygen Saturation—Retirement of Policy

The local medical review policy (LMRP) for noninvasive ear or pulse oximetry for oxygen saturation – A94760 was previously revised on October 1, 2003. Since that time, it has been determined that all procedure codes in the policy (94760, 94761, and 94762) have an “N” status indicator, which means these codes are packaged into payment for other services. For that reason, this policy has been retired.

In addition, these codes are not billable codes in a comprehensive outpatient rehabilitation facility (CORF); therefore, type of bill 75x is being removed from the policy.

### Effective Date

The retirement of this policy is effective for services provided **on or after June 17, 2005**.

The full-text for this retired policy is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

## AG0245: Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes—Retirement of Policy

The local medical review policy (LMRP) peripheral neuropathy with loss of protective sensation (LOPS) in people with diabetes has been retired.

Types of bill 74x and 75x were removed from the LMRP prior to retiring. It was determined that these types of bill were erroneously placed in the policy.

Coverage guidelines for diabetic peripheral neuropathy are provided by a national coverage determination (NCD). The NCD is available via the Online CMS Manual System, Pub 100-3, *Medicare National Coverage Determinations Manual*, Section 70.2.1. The NCD manual may be viewed at [http://www.cms.hhs.gov/manuals/103\\_cov\\_determ/ncd103index.asp](http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp).

### Effective Date

The retirement of this policy is effective for services provided **on or after April 14, 2005**.

The full-text for this retired policy is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

## AG0248: Home Prothrombin Time International Normalized Ratio (INR) Monitoring—Retirement of Policy

The local medical review policy (LMRP) for home prothrombin time international normalized ratio (INR) monitoring has been retired.

Coverage guidelines for home prothrombin INR monitoring are provided by a national coverage determination (NCD). The NCD is available via the Online CMS Manual System, Pub 100-3, *Medicare National Coverage Determinations Manual*, Section 190.11. The NCD manual may be viewed at [http://www.cms.hhs.gov/manuals/103\\_cov\\_determ/ncd103index.asp](http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp).

### Effective Date

The retirement of this policy is effective for services provided **on or after May 9, 2005**.

The full-text for this retired policy is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

## ADDITIONAL MEDICAL INFORMATION

## AJ1950: Leuprolide Acetate—Retirement of Coding Guidelines

The coding guidelines for the local coverage determination (LCD) for leuprolide acetate – has been retired. Change request 1967 dated November 28, 2001 removed J9217 – Leuprolide acetate (for depot suspension), per 7.5 mg, from the list of non-reportable procedures, effective August 1, 2000.

However, the coding guidelines contained in the LCD reported that this code was a noncovered code under the outpatient prospective payment system implementation and instructed providers to bill using J1950. Therefore, the coding guidelines attachment for this policy has been retired. ❖

# CRITICAL ACCESS HOSPITAL SERVICES

## July 2005 Update to the Medicare Outpatient Code Editor for Hospitals Not Paid Under the Outpatient Prospective Payment System

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

### Provider Types Affected

Providers billing services to Medicare fiscal intermediaries (FIs) for outpatient services that are **not** subject to the outpatient prospective payment system (OPPS)

### Provider Action Needed

#### STOP – Impact to You

This article includes information from Change Request (CR) 3867 which informs your FI that changes have been made to the non-OPPS outpatient code editor (OCE) software used to process claims from hospitals not paid under the OPPS.

#### CAUTION – What You Need to Know

The non-OPPS OCE has been updated with new additions, deletions, and changes to ensure proper payment of your non-OPPS claims.

#### GO – What You Need to Do

See the *Background* section of this article to find out further details regarding these changes.

### Background

Change Request 3867 informs your FI that the non-OPPS OCE has been updated with new additions, changes, and deletions to Healthcare Common Procedure Coding System/Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4) codes.

The following are changes made to version 20.3 of the non-OPPS OCE:

#### Changes Retroactive to April 1, 2004

L0960 Post surgical support pads was **removed** from the nonreportable list.

#### Changes Retroactive to January 1, 2005

The following new HCPCS codes were **added** to the list of valid codes.

G0375 Smoke/Tobacco counseling 3-10  
G0376 Smoke/Tobacco counseling >10

The following *CPT* code was **added** to the nonreportable list:

0065T *Ocular photoscreen with interpretation and report, bilateral*

The following code was **added** to the ambulatory surgical center (ASC) list and payment group:

<b>CPT Code</b>	<b>Payment Group</b>
66711	2

The following HCPCS codes were **removed** from the nonreportable list:

E0950 Tray  
E0951 Loop heel

E0952 Toe loop/holder, each  
G0345 IV infuse hydration, initial  
G0346 Each additional infuse hour  
G0347 IV infusion therapy/diagnost  
G0348 Each additional hr up to 8hr  
G0349 Additional sequential infuse  
G0350 Concurrent infusion  
G0351 Therapeutic/diagnostic inje  
G0353 IV push, single original drug  
G0354 Each addition sequential IV  
G0355 Chemo adminisrate subcut/IM  
G0356 Hormonal anti-neoplastic  
G0357 IV push single/initial subst  
G0358 IV push each additional drug  
G0359 Chemotherapy IV one hr initi  
G0360 Each additional hr 1-8 hrs  
G0361 Prolong chemo infuse>8hrs pu  
G0362 Each add sequential infusion  
G0363 Irrigate implanted venous de  
G0368 EKG interpret & report preve  
G0369 Pharm fee 1st month transpla  
G0370 Pharmacy fee oral cancer etc

#### Changes Retroactive to April 1, 2005

The following new HCPCS codes were **added** to the list of valid codes:

K0730 Ctrl dose inh drug deliv sys  
K0731 Lith ion batt cid, on body  
K0732 Lith ion batt cid behind ear

The following HCPCS code was **added** to the nonreportable list:

K0730 Ctrl dose inh drug deliv sys

#### Changes Effective July 1, 2005

The following new HCPCS codes were **added** to the list of valid codes:

C9129 Inj clofarabine  
Q9958 HOCM <=149 mg/ml iodine, 1ml  
Q9959 HOCM 150-199 mg/ml iodine, 1ml  
Q9960 HOCM 200-249 mg/ml iodine, 1ml  
Q9961 HOCM 250-299 mg/ml iodine, 1ml  
Q9962 HOCM 300-349 mg/ml iodine, 1ml  
Q9963 HOCM 350-399 mg/ml iodine, 1ml  
Q9964 HOCM >= 400 mg/ml iodine, 1ml  
S0118 Ziconotide intrathecal 1 mcg  
S0133 Histerlin implant  
S0145 Peg interferon alfa-2B/10  
S0146 Peg interferon alfa-2B/10  
S0198 Inj pegaptanib 0.3 mg  
S0265 Genetic counsel 15 mins  
S0613 Ann breast exam  
S2900 Robotic surgical system  
S8270 Enuresis alarm



*July 2005 Update to the Medicare Outpatient Code Editor for Hospitals Not Paid Under the OPPTS (continued)*

The following HCPCS code was **deleted** from the list of valid HCPCS:

C9126 Injection, natalizumab

The following CPT/HCPCS codes were **added** to the nonreportable list:

- 59050 *Fetal monitor during labor by consulting physician (ie, non-attending physician) with written report, supervision and interpretation*
- C9129 Inj clofarabine
- G0250 MD review interpret of test
- L8620 Repl lithium ion battery
- S0118 Ziconotide intrathecal 1 mcg
- S0133 Histerlin implant
- S0145 Peg interferon alfa-2B/10
- S0146 Peg interferon alfa-2B/10
- S0198 Inj pegaptanib 0.3 mg
- S0265 Genetic counsel 15 mins
- S0613 Ann breast exam
- S2900 Robotic surgical system
- S8270 Enuresis alarm

The following code was **removed** from the nonreportable list:

59510 *Routine obstetric care including antepartum care, cesarean delivery, and postpartum care*

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**Implementation**

The implementation date for this instruction is July 5, 2005.

**Additional Information**

For complete details, please see the official instruction issued to your intermediary regarding this change.

That instruction may be viewed by going to [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3867 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at:

<http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3867

Related CR Release Date: May 20, 2005

Related CR Transmittal Number: 564

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 564, CR 3867

**Supply Codes and Payments for Immunosuppressive Drugs**

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

**Provider Types Affected**

Pharmacies, hospitals not subject to the outpatient prospective payment system (OPPS), and dialysis facilities in the State of Washington billing Medicare for immunosuppressive drugs

**Provider Action Needed**

**STOP – Impact to You**

Effective January 1, 2005, Medicare pays a supplying fee for immunosuppressive drugs, oral anticancer chemotherapeutic drugs, and oral anti-emetic drugs used as part of an anti-cancer chemotherapeutic regimen in accordance with Section 303(e) (2) of the Medicare Modernization Act (MMA).

**CAUTION – What You Need to Know**

Most supplies of immunosuppressive drugs are billed to the Medicare durable medical equipment regional carriers (DMERCs). However, Medicare fiscal intermediaries (FIs) will also pay for 30-day supplies of immunosuppressive drugs when provided by a dialysis facility in the State of Washington, or by hospital outpatient departments not subject to OPPTS. **When billing Medicare, both the drug and the supply fee must be billed on the same claim. If the supply fee is billed alone on the claim, the FIs rejects the service since the common working file will deny the**

**supply fee if is not billed with the drug on the same claim.**

Furthermore, you may only submit a claim for G0369 once per beneficiary per transplant.

**GO – What You Need to Do**

To ensure accurate claims processing, review the information included here and stay current with instructions for Medicare dispensing/supply fees.

**Background**

Section 303(e) (2) of the MMA implements a supplying fee for immunosuppressive drugs. Beginning January 1, 2005, Medicare pays a separately billable supplying fee of \$24.00 to a pharmacy or other entity providing an immunosuppressive drug to a Medicare beneficiary.

These payments are generally made by the DMERC to the pharmacy. However, in the state of Washington, FIs pay the supplying fee to the dialysis facility that supplies immunosuppressive drugs to kidney transplant beneficiaries. In addition, FIs will pay this \$24.00 supplying fee to non-OPPS hospitals supplying 30-day supplies of immunosuppressive drugs. The code for this supplying fee is G0370. The code description is as follows:

G0370 Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s)

*Supply Codes and Payments for Immunosuppressive Drugs (continued)*

Effective January 1, 2005, Medicare pays a supplying fee of \$50.00 to a pharmacy for the initial supplied prescription of immunosuppressive drugs to the patient during the first month following the transplant. The code for this supplying fee is G0369. This is a one-time payment per beneficiary, **per transplant**. The code description is as follows:

**G0369** Pharmacy supply fee for initial immunosuppressive drug(s) first month following transplant

Effective October 1, 2005 for claims submitted to DMERCs, edits will apply to the G0369 to ensure that only one such claim is paid per beneficiary for each transplant received by that beneficiary.

**Note:** You cannot bill both the G0369 and G0370 with the first prescription. G0369 must be billed within one year of the date of the patient’s discharge from the hospital stay during which the transplant was performed.

**Implementation**

The implementation date for this instruction is October 3, 2005

**Additional Information**

Beneficiaries are required to pay the normal co-pay and deductible on both the drug and the supplying fee.

Your FI will process any adjustment requests you submit for immunosuppressive drugs with dates of service on and after January 1, 2005 and pay the supplying fee to the dialysis facility or non-OPPS hospital.

For complete details of CR 3830, on which this article is based, please see the official instruction issued to your

intermediary regarding this change. That instruction may be viewed at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3830 in the CR NUM column on the right, and click on the file for that CR.

Additional information may also be found in Medlearn Matters Article MM3620, and the related CR 3620, which that addresses New Dispensing/Supply Fee Codes for Oral Anti-Cancer, Oral Anti-Emetic, Immunosuppressive, and Inhalation Drugs when billed to DMERCs.

MM3620 may be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3620.pdf>.

CR 3620 may be found at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

Once at that site, look for CR 3620 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions regarding this issue, please contact your FI or DMERC at their toll free number, which you will find at:

<http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3830

Related CR Release Date: April 29, 2005

Related CR Transmittal Number: 551

Effective Date: January 1, 2005 for editing claims submitted to Medicare FIs and October 1, 2005 for editing claims submitted to DMERCs

Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 551, CR 3830

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**Inpatient Social Admissions and Outpatient Services Rendered at a Separate Facility**

*CMS has issued the following “Medlearn Matters... Information for Medicare Providers” article.*

**Note:** CMS has re-issued change request (CR) 3452 on June 24, 2005. The Medlearn Matters article was revised to reflect changes to the CR reissued date and the transmittal number. No other changes were made to the article. This article was published in the [Third Quarter 2005 Medicare A Bulletin](#) (page 82).

**Provider Types Affected**

Indian health services (IHS) or tribal hospitals, including critical access hospitals (CAHs)

**Provider Action Needed**

This instruction clarifies the IHS or tribal hospitals, including CAHs, payment methodology for social admissions and outpatient services rendered at separate facilities.

**Background**

IHS or tribal hospitals (including CAHs) often submit a type of bill (TOB) 12x for social admissions. This TOB is denied by the designated fiscal intermediary (FI) if a separate facility subsequently bills TOB 13x for outpatient services or TOB 72x for dialysis services rendered during a social admission at an IHS/Tribal/CAH.

It should be noted that:

- There may be situations when a beneficiary is admitted to an IHS/Tribal facility for social reasons. If these social admissions are for patient and family convenience, they are not billable to Medicare.
- Social admission stays do not qualify for any payment on either a TOB 11x or 12x.
- For admissions before surgery, only the scheduled surgery and related services may be:
  - ♦ Billed on a TOB 83x, if the surgery is performed on an outpatient basis; and
  - ♦ Billed on a TOB 11x, if the surgery is performed on an inpatient basis.

*Inpatient Social Admissions and Outpatient Services Rendered at a Separate Facility (continued)*

- Social admissions occurring after an inpatient discharge may not be billed to Medicare.
- For patients in a social admission status requiring outpatient services at another facility, Medicare FIs will reject the TOB 12x if submitted.
- A duplicate payment would be created if a TOB 12x from the admitting facility occurred with 1) a TOB 13x from another hospital, or 2) a TOB 72x from a renal dialysis facility. This is inappropriate.

Because there is a significant number of social admissions in IHS/Tribal facilities, Medicare has decided to disallow payment for inpatient Part B services during a social admission stay when there is another bill from a different facility for an outpatient service.

The following represents the Centers for Medicare & Medicaid Services (CMS) policy:

- When a TOB 12x from an IHS/ Tribal facility (including CAHs) covers the same time period as 1) a TOB 13x received from another hospital, or 2) a TOB 72x received from a renal dialysis facility:
  - ♦ TOB 12x is presumed to represent a social admission and is disallowed; and
  - ♦ TOBs 13x and 72x will be paid.
- A social admission stay does not qualify for any payment for the TOBs 11x or 12x.
- A social admission cannot be used to satisfy the three-day prior stay for skilled nursing facilities.

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**Implementation**

The implementation date for this instruction is April 4, 2005.

**Related Instructions**

The official instruction issued to your FI may be viewed at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3452 in the CR NUM column on the right, and click on the file for that CR.

**Additional Information**

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

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

Related Change Request (CR) Number: 3452

Related CR Release Date: June 24, 2005

Related CR Transmittal Number: 596

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 596, CR 3452

**New Health Professional Shortage Area Modifier**

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

**Provider Types Affected**

Physicians and critical access hospitals (CAHs) (which must be located in a HPSA) that provide services in health professional shortage area (HPSA) and bill Medicare carriers and intermediaries for those services

**Provider Action Needed****STOP – Impact to You**

For dates of service on or after January 1, 2006, a new modifier **AQ** replaces the two existing modifiers, **QB** and **QU**, for physician services provided in HPSAs.

**CAUTION – What You Need to Know**

Make certain that all HPSA service claims filed for dates of service on or after January 1, 2006 and where a HPSA modifier is required, use the correct **AQ** modifier. There will no longer be a distinction between physicians providing HPSA services in a rural area (**QB**) and physicians providing services in an urban HPSA (**QU**).

**GO – What You Need to Do**

See the Background and Additional information sections of this article for further details regarding this Medicare Modernization Act (MMA) update.

**Background**

The two modifiers, **QB** and **QU**, currently used on claims qualifying for the HPSA bonus payments, will be deleted on January 1, 2006 and **one new modifier created, AQ, for HPSA**. Claims with dates of service prior to January 1, 2006 must continue to use the current modifiers **QB** and **QU**.

Thus, for services rendered in ZIP code areas: 1) that do not fall within a designated full county HPSA; 2) are not considered to fall within the county based on a determination of dominance made by the United States Postal Service; or 3) are partially within a non-full county HPSA, the physician or CAH must still submit a **QB** or **QU** modifier to receive payment **for claims with dates of service prior to January 1, 2006**.

**Effective for similar claims with dates of service on or after January 1, 2006, the modifier AQ, "Physician providing a service in a Health Professional Shortage Area (HPSA)," must be submitted.**

**Implementation**

The implementation date for this instruction is January 3, 2006.

*New Health Professional Shortage Area Modifier (continued)*

**Additional Information**

Within the official instructions issued by CMS are detailed instructions regarding services eligible for HPSA and physician scarcity bonus payments, HPSA incentive payments for services rendered in a critical access hospital (CAH), as well as HPSA designations and information regarding zip codes. The official instruction issued to your carrier and intermediary regarding this change may be found by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3935 in the CR NUM column on the right, and click on the file for the desired CR.

Additional information on the HPSA bonus and the physician scarcity area bonus is on the CMS website. The Guide for Using the HPSA/PSA Web Page may be viewed by going to:

<http://www.cms.hhs.gov/providers/bonuspayment/guide.pdf>.

For additional information relating to this issue, please refer to your carrier/intermediary. To find their toll free phone numbers go to:

<http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3935

Related CR Release Date: July 22, 2005

Related CR Transmittal Number: 608

Effective Date: January 1, 2006

Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 608, CR 3935

**Health Professional Shortage Area Listing**

The following are counties/area names/parts designated as geographic HPSAs (and therefore eligible for the bonus payment), as of April 12, 2005.

**Primary Care**

County/Area Name	Census Tracts (C.T.)	Type
Clay/Keystone Heights division		Urban
Collier/Imokalee/Everglades		Rural
Dixie		Rural
Escambia	0038.00, 0039.00, 0040.00	Rural
Gadsden		Urban
Glades		Rural
Hamilton		Rural
Hardee		Rural
Hendry/Labelle	9604.00, 9603.00	Rural
Holmes		Rural
Lafayette		Rural
Liberty		Rural
Madison		Rural
Martin/Indiantown/Indiantown division		Urban
Sumter		Rural
Suwannee		Rural
Wakulla		Rural
Walton (terminated January 1, 2005)		Rural
Washington		Rural

**Mental Health**

County	Type
Bradford	Rural
Columbia	Rural
Dixie	Rural
Gilchrist	Rural
Hamilton	Rural
Holmes	Rural
Jackson	Rural
Lafayette	Rural
Monroe	Rural
Putnam	Rural
St Johns	Urban
Suwannee	Rural
Union	Rural
Walton	Rural
Washington	Rural

Source: CMS Atlanta Regional Office Memorandum, May 23, 2005



## **Billing for the Administration of Drugs and Biologicals (specifically Low Osmolar Contrast Material in a Method II CAH)**

*CMS has issued the following “Medlearn Matters... Information for Medicare Providers” article.*

### **Provider Types Affected**

Method II critical access hospitals (CAHs) billing Medicare fiscal intermediaries (FIs) for low osmolar contrast material (LOCM)

### **Provider Action Needed**

#### **STOP – Impact to You**

This article is based on information from change request (CR) 3911, which revises a prior instruction in CR 3748 requiring providers to bill their FI for LOCM with Healthcare Common Procedure Coding System (HCPCS) codes A4644-A4646 instead of Q9945-Q9951 for LOCM.

The Centers for Medicare & Medicaid Services (CMS) determines that HCPCS codes Q9945-Q9951 are reportable for physician involvement in the administration of LOCM in a Method II CAH.

#### **CAUTION – What You Need to Know**

HCPCS codes A4644-A4646 will continue to be reported by method II CAHs for the technical component of the LOCM. CR3911 also provides coding guidance for method II CAHs billing for physician involvement in the administration of other drugs and biologicals.

#### **GO – What You Need to Do**

Be sure billing staff are aware of these changes, which are effective for claims for services on or after April 1, 2005.

### **Background**

Change request 3911 provides clarification on the billing requirements for physician involvement (professional component) in the administration of drugs and biologicals in the outpatient department of a method II (optional method) CAH.

Previously, CR 3748 instructed FIs to continue to accept provider claims with HCPCS codes A4644-A4646.

CR3748 also stated that providers should not report HCPCS codes Q9945-Q9951 for LOCM. CR3748 did not specifically address what HCPCS codes should be used to bill the technical or professional components of the LOCM for services furnished in the outpatient department of a method II CAH.

**Note:** You can review CR 3478 (transmittal 502, dated March 11, 2005, subject: “New Contrast Agents Healthcare Common Procedure Coding System (HCPCS) Codes”) on the CMS website at:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R502CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R502CP.pdf).

The *Code of Federal Regulation* (CFR 42 Section 413.70) provides regulations governing how physician involvement in the administration of drugs and biologicals (other than LOCM) should be billed by a method II CAH.

Both method I (standard method) and method II CAHs bill for technical services furnished in the outpatient department.

However, only method II CAHs bill the FI for physician services furnished in the outpatient department.

Method II CAHs should bill for the outpatient physician involvement (the professional component) for the administration of LOCM with revenue code 96x, 97x or 98x on type of bill (TOB) 85x. Bills must include one of the following HCPCS codes as appropriate:

<b>HCPCS Code</b>	<b>Short Descriptor</b>	<b>Long Descriptor</b>
Q9945	LOCM <=149 mg/ml iodine, 1ml	Low osmolar contrast material, up to 149 mg/ml iodine concentration, per ml
Q9946	LOCM 150-199mg/ml iodine, 1ml	Low osmolar contrast material, 150-199 mg/ml iodine concentration, per ml
Q9947	LOCM 200-249mg/ml iodine, 1ml	Low osmolar contrast material, 200-249 mg/ml iodine concentration, per ml
Q9948	LOCM 250-299mg/ml iodine, 1ml	Low osmolar contrast material, 250-299 mg/ml iodine concentration, per ml
Q9949	LOCM 300-349mg/ml iodine, 1ml	Low osmolar contrast material, 300-349 mg/ml iodine concentration, per ml
Q9950	LOCM 350-399mg/ml iodine, 1ml	Low osmolar contrast material, 350-399 mg/ml iodine concentration, per ml
Q9951	LOCM >= 400 mg/ml iodine, 1ml	Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml

***Billing for the Administration of Drugs and Biologicals (specifically Low Osmolar Contrast Material ... (continued)***

The Medicare physician fee schedule (MPFS) payment for these HCPCS codes is based upon the facility specific visit rate. Facility-specific visit rates apply to professional services performed in a facility other than the professional’s office and do not accommodate the overhead and indirect expenses a physician incurs by operating their own facility.

The **technical component** for LOCM is billed by both method I and method II CAHs with revenue code 636 on TOB 85x and one of the following HCPCS codes as appropriate:

<b>HPCP Code</b>	<b>Short Description</b>	<b>Long Description</b>
A4644	Contrast 100-199 MGs iodine	Supply of low osmolar contrast material (100-199 mgs of iodine)
A4645	Contrast 200-299 MGs iodine	Supply of low osmolar contrast material (200-299 mgs of iodine)
A4646	Contrast 300-399 MGs iodine	Supply of low osmolar contrast material (300-399 mgs of iodine)

Outpatient physician involvement for 1) hydration; 2) therapeutic or diagnostic injections and intravenous (IV) infusions (other than hydration); and 3) chemotherapy administration in a method II CAH is included in the physicians evaluation and management (E & M) services. Bills must include an appropriate outpatient hospital visit E & M *Common Procedure Terminology (CPT)* code with revenue code 96x, 97x or 98x on TOB 85x.

In regard to this Medicare requirement, FIs will accept *CPT* codes 99201-99205 or 99211-99215 with revenue code 096x, 097x or 098x on TOB 85x from a method II CAH billing for physician involvement for hydration; therapeutic or diagnostic injections and intravenous (IV) infusions (other than hydration); or chemotherapy administration.

**Implementation**

The implementation date for the instruction in CR3911 is October 24, 2005. However, note that the changes are effective for dates of service on or after April 1, 2005. Your Medicare FI will not search their files to either retract payment or retroactively pay claims processed before October 24, 2005. They will adjust claims after that date only if the CAH brings such claims to their attention.

**Additional Information**

For complete details, please see the official instruction issued to your intermediary regarding this change.

That instruction may be viewed on the CMS website by going to [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3911 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your intermediary at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

**CAH Services – Methods of Payment**

The Social Security Act provides for two methods of payment for outpatient CAH services. A CAH will be paid under 1) a reasonable cost method unless it elects payment under 2) an optional method, also known as method II.

Under the method II option, a CAH submits bills for both facility and professional services to an FI. Medicare makes payment for the facility services at the same level that would apply under the reasonable cost method (increasing to 101 percent for cost reporting periods beginning on or after January 1, 2004), but services of professionals to outpatients are paid at 115 percent of the amount that would have otherwise been paid under the Medicare physician fee schedule.

Also, note that the Medicare Modernization Act of 2003 (MMA, Section 405) amended the Social Security Act by specifying that the Centers for Medicare & Medicaid Services (CMS) may not require, as a condition for a CAH to make an election of the optional method of payment (method II), that each physician or other practitioner providing professional services in the CAH must assign billing rights to the CAH with respect to the services.

However, the optional payment method does not apply to those physicians and practitioners who have not assigned such billing rights.

Related Change Request (CR) Number: 3911

Related CR Release Date: July 22, 2005

Related CR Transmittal Number: 617

Effective Date: April 1, 2005

Implementation Date: October 24, 2005

Source: CMS Pub. 100-4, Transmittal 617, CR 3911

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# ESRD SERVICES

## Guidelines for Payment of Vaccines (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) and their Administration at Renal Dialysis Facilities)

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

### Provider Types Affected

Freestanding and provider-based renal dialysis facilities (RDFs) that bill Medicare fiscal intermediaries (FI) for vaccines and vaccine administration

### Provider Action Needed

#### STOP – Impact to You

Change request (CR) 3936 clarifies Medicare processing and payment of claims by Medicare FIs to RDFs for virus and pneumococcal pneumonia vaccines and their administration. **FIs pay** for PPV, influenza, and hepatitis B virus vaccines provided by freestanding RDFs based on the lower of the actual charge or 95 percent of the average wholesale price (AWP). Provider-based RDF payment is based on reasonable cost. Deductible and coinsurance do not apply. Vaccine administration payments to freestanding RDFs are based on the Medicare physician fee schedule according to its rate associated with CPT code 90782 for services provided prior to March 1, 2003 and on CPT code 90471 for services provided on or after March 1, 2003. Payments to provider-based RDFs are made on a reasonable cost basis.

#### CAUTION – What You Need to Know

Be cognizant of the applicable HCPCS codes and their definitions. Also, these clarifications apply to affected services provided on or after January 1, 2006.

#### GO – What You Need to Do

Use the appropriate codes when billing for the vaccines, see information listed within this article.

### Background

The goal for CR 3936 is to clarify payment rules for vaccines furnished to end-stage renal disease (ESRD) patients (PPV, influenza virus, and hepatitis B virus) and its administration provided by RDFs (type of bill 72x). The Medicare program covers **influenza virus and pneumococcal pneumonia vaccines and their administration** when furnished to eligible beneficiaries in accordance with coverage rules. Payment may be made for both the **vaccine** and the **administration**. The costs associated with the syringe and supplies are included in the administration fee and thus **HCPCS code A4657 should not be billed for these vaccines**.

Vaccines and their administration are reported using separate codes. The following codes are for reporting the vaccines only:

#### CPT Codes Descriptor

90655 *Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use*

90656	<i>Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use</i>
90657	<i>Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use</i>
90658	<i>Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use</i>
90659	<i>Influenza virus vaccine, whole virus, for intramuscular or jet injection use (<b>Discontinued December 31, 2003</b>)</i>
90732	<i>Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older; for subcutaneous or intramuscular use</i>
90740	<i>Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use</i>
90743	<i>Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use</i>
90744	<i>Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use</i>
90746	<i>Hepatitis B vaccine, adult dosage, for intramuscular use</i>
90747	<i>Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use</i>

The following codes are for reporting administration of the vaccines only:

#### HCPCS Codes Definition

G0008	Administration of influenza virus vaccine
G0009	Administration of pneumococcal vaccine
G0010	Administration of hepatitis B vaccine

One of the following diagnosis codes must be reported as appropriate. If the sole purpose for the visit is to receive a vaccine or if a vaccine is the only service billed on a claim, the applicable following diagnosis code may be used.

#### Diagnosis Code Description

V03.82	PPV
V04.8	Influenza
V04.81	Influenza
V05.3	Hepatitis B

#### Implementation

The implementation date for this instruction is January 3, 2006.

*Guidelines for Payment of Vaccines ...and their Administration at Renal Dialysis Facilities (continued)*

**Additional Information**

The revised portions of the Medicare Claims Processing Manual are attached to CR 3936, which is the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to:  
[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3936 in the CR NUM column on the right and click on the file for that CR. If you have any questions, please contact your intermediary at their toll free number which may be found at:  
<http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3936

Related CR Release Date: July 22, 2005

Related CR Transmittal Number: 610

Effective Date: January 1, 2006

Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 610, CR 3936

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**Discontinued Use of Level III HCPCS Codes for Part A Services**

The Consolidated Appropriations Act of 2001, Public Law 106-554 (enacted December 21, 2000), instructs Medicare contractors to maintain and continue the use of level III codes of the HCPCS coding system (also known as local codes) through December 31, 2003. The Healthcare Insurance and Portability and Accountability Act requires that all level III HCPCS codes will be discontinued and providers to use the appropriate level II HCPCS codes (national codes) to report the services furnished.

Effective for claims processed on or after May 21, 2005, for services provided on or after January 1, 2004, and reported using a HCPCS level III code will be returned to the provider.

Below is a list of level III HCPCS codes that were in effect on December 31, 2003. A crosswalk to a level II CPT/HCPCS code is provided where appropriate.

<b>Level III HCPCS Code</b>	<b>Level II CPT/ HCPCS Codes</b>
W4991	A4913
X0094	86803
X0091	86689
X0057	J3490 (provide the national drug code)
X0107	J2916
X0038	J3490 (provide the national drug code)
W0233	J1756
X0089	86901
X0080	No code to cover combined services
X0093	86706
X0088	86920
X0087	86850
X0086	86850
X0081	86905
X0079	86903
X0063, X0062, and X0078	J2405 Zofran 1 mg/cc

No descriptor has been established for level III codes X0063, X0062, and X0078 – Zofran 2mg/cc that is what the unlisted code describes.

When billing for J3490 –Unclassified drugs – please follow the billing guidelines for unlisted procedure code instructions published in the [Third Quarter 2005 Medicare A Bulletin](#) (page 18).

Providers are responsible to provide the fiscal intermediary with valid information and codes that best represent the service or procedure provided and billed. ❖

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## New Case-Mix Adjusted End Stage Renal Disease Composite Payment Rates and New Composite Rate Exceptions Window for Pediatric ESRD Facilities

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

The Centers for Medicare & Medicaid Services (CMS) has advised Medicare contractors that instructions issued with Medlearn Matters article MM3572 based on change request (CR) 3527 has been fully replaced by CR 3720 (Transmittal 477; dated February 18, 2005 – New Case-Mix Adjusted End Stage Renal Disease Composite Payment Rates and New Composite Rate Exceptions Window for Pediatric ESRD Facilities (Full Replacement of Change Request 3572). The original Medlearn Matters article MM3572 was published in the [Second Quarter 2005 Medicare A Bulletin](#) (pages 46-47). The Medlearn Matters article MM3720 was published in the [Third Quarter 2005 Medicare A Bulletin](#) (pages 86-87).

You may see CR 3720 (Transmittal 477) on CMS website at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R477CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R477CP.pdf).

Also, see the Medlearn Matters article related to CR 3720 (Transmittal 477) at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3720.pdf>.

Related Change Request (CR) Number: 3572  
Related CR Release Date: November 19, 2004  
Related CR Transmittal Number: 370  
Effective Date: April 1, 2005  
Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 370, CR 3572

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# CORF SERVICES

## Outpatient Rehabilitation Therapy Services

### Revisions to the Medicare Benefit Policy Manual (Pub 100-02), Chapter 15, Sections 220 and 230

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

**Note:** CMS has revised this article on July 25, 2005, to reflect that portions of CR 3648 relating to the qualifications required for staff providing services billed as physical therapy and occupational therapy services incident to the services of a physician or nonphysician practitioner must be implemented immediately. The United States District Court for the Northern District of Texas has dismissed the lawsuit brought by the National Athletic Trainer’s Association (NATA). That lawsuit had challenged the requirements for qualifications for staff providing services billed as physical and occupational therapy services incident to a physician or nonphysician practitioner. The Centers for Medicare & Medicaid Services (CMS) had previously delayed implementation of these requirements as a result of an agreement made with NATA and contained in a June 3, 2005 order issued by the court. The agreement to delay implementation has expired and the court has dismissed the litigation, so CMS is implementing immediately the challenged requirements. All other information in the article remains unchanged from the June 27 version of this article. This article continues to replace the special edition Medlearn Matters article SE0533 that was posted to provider education website www.floridamedicare.com on May 13, 2005 and later removed from the website on July 7, 2005, per CMS request.

#### Provider Types Affected

Physicians and other providers who bill fiscal intermediaries (FIs) and carriers for therapy services lawyer

#### Provider Action Needed

##### STOP – Impact to You

This manual revision re-organizes sections 220 and 230 in Chapter 15 of the Medicare Benefit Policy Manual; it adds reference information and clarifies current policy concerning physician visits and certification. In addition, it defines the qualifications of therapists.

##### CAUTION – What You Need to Know

Please note that to ensure payments for therapy services you must meet the conditions and standards for therapy services described in the manuals. In addition, the qualified therapy service must be furnished by qualified professionals/personnel as defined in the Medicare Benefit Policy Manual.

##### GO – What You Need to Do

To ensure accurate and timely processing of therapy claims, be familiar with instructions and requirements described in the Centers for Medicare & Medicaid Services (CMS) Manual System related to such claims. Read the detailed policies in the manuals and contact your intermediary or carrier if you have any questions about these changes.

#### Background

In summary, this revision to the Medicare Benefit Policy Manual (Pub 100-02), Chapter 15, Sections 220 and 230, does the following:

- Clarifies policies concerning orders, visits, plans of care, delayed certification, and private practice; and
- Incorporates the information in the *Final Rule* of November 15, 2004 concerning the definition of therapy services, the qualifications of therapists, therapy services provided incident to a physician, and supervision in private practice settings.

Some key points in this modification include:

- Medicare carriers and FIs will pay for services only when the services meet the conditions and standards described in the Medicare Benefit Policy Manual. This includes requirements regarding the qualifications of the person who provides the service as detailed in that manual.
- Medicare carriers/FIs will not deny therapy claims based only on the absence of an order or referral for therapy services. However, claims will be denied if there is no certification of the plan of care for each 30 day interval of treatment. The certification indicates the patient was under the care of a physician, and needed the treatment that was approved by the physician or nonphysician practitioner who certified the plan.
- On prepay or postpay review, if the carrier/FI finds there is no documentation indicating a physician or nonphysician practitioner certification of a therapy plan of care for treatment for the first 30 days of treatment or finds there is no certified plan of care for treatment for each interval of 30 days from the last certified interval of treatment, the claim will be denied, unless there is a delayed certification. On review, the carrier/FI will count the days from the first date treated by the therapist to determine if the certification of the plan is delayed.
- Medicare carriers/FIs will accept delayed certification of services that would otherwise be covered unless the claim, the justification, or any accompanying documentation indicates the treatment was not clinically necessary, i.e., the service does not meet the patient’s need.
- Medicare does not require a physician visit prior to certification, but the physician or nonphysician practitioner who certifies the plan may require a visit prior to certification.

*Revisions to the Medicare Benefit Policy Manual (Pub 100-02), Chapter 15, Sections 220 and 230 (continued)*

**Additional Information**

This manual change does not require a change in the way therapy services are currently provided. You may continue to obtain an order, send the plan of care promptly to the physician, obtain certification as soon as you can and recommend a visit to the physician when needed. However, in the case where a physician does not promptly return a certification of the plan of care for a patient under his/her care, this change provides some flexibility in obtaining the certification. Also, a physician retains the authority to require that a patient under his/her care must return for a visit prior to certification, and the physician may limit the length of time for which the plan is certified, or may chose to certify an interval in advance if it is medically appropriate.

The revised sections of the Medicare Benefit Policy Manual are attached to the official instruction issued to your carrier/FI regarding this change. That instruction, CR 3648, may be found at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

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On the above page, scroll down the CR NUM column on the right to find the link for CR 3648. Click on the link to open and view the file for the CR.

If you have questions regarding this issue, you may also contact your FI or carrier at their toll free number, which may be found at:

<http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3648

Related CR Release Date: June 24, 2005

Related CR Transmittal Number: 36

Effective Date: June 6, 2005

Implementation Date: June 6, 2005

Source: CMS Pub. 100-2, Transmittal 36, CR 3648

# SKILLED NURSING FACILITY SERVICES

## July 2005 Quarterly Update to the Consolidated Billing Enforcement

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

### Provider Types Affected

Physicians, providers, and suppliers billing services to carriers and fiscal intermediaries (FIs)

### Provider Action Needed

#### STOP – Impact to You

This article is based on information from Change Request (CR) 3873, which corrects the effective date of excluded HCPCS L5781 for skilled nursing facility (SNF) consolidated billing (CB).

#### CAUTION – What You Need to Know

The correct effective date of excluded HCPCS L5781 for SNF CB should be January 1, 2003.

#### GO – What You Need to Do

See the Background section of this article to find out further details regarding this change.

### Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the CB provision of the SNF PPS. Claims for services appearing on this list (which are submitted to Medicare FIs and carriers, including durable medical equipment regional carriers [DMERCs]) will not be paid by Medicare to providers, other than an SNF, when **included** in SNF CB.

- For non-therapy services, SNF CB applies only when the services are furnished to an SNF resident during a covered Part A stay.
- For physical and occupational therapies and speech-language pathology services, SNF CB applies whenever they are furnished to an 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 an SNF stay.

Separate instructions are published for FIs and carriers/DMERCs for the annual notice on SNF CB each January. The 2005 annual update may be found on the following CMS websites for:

- FIs at [http://www.cms.hhs.gov/manuals/pm\\_trans/R360CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R360CP.pdf) (Transmittal R360CP, CR3542, dated November 5, 2004).
- Carriers at <http://www.cms.hhs.gov/medlearn/snfcode.asp>.

**Quarterly updates now apply to both FIs and carriers/DMERCs.** An April 2005 quarterly update for FIs and carriers has been published subsequent to the 2005

annual update, and it is available at the CMS website for 2005 transmittals (transmittal R449CP, CR3683 dated January 21, 2005) at [http://www.cms.hhs.gov/manuals/pm\\_trans/R449CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R449CP.pdf).

CR3873 provides one HCPCS correction under Major Category III. D. Customized Prosthetic Devices.

HCPCS L5781 was previously excluded under the 2005 annual update to SNF CB with an incorrect effective date of January 1, 2005. The effective date for excluded HCPCS L5781 should be January 1, 2003.

Suppliers may bill L5781 retroactively to January 1, 2003. However, there may be situations in which an SNF has already reimbursed a supplier for L5781. Providers and suppliers cannot collect money from an SNF and Medicare Part B twice for the same service, equipment, or device for the same date of service.

Suppliers that now receive payment from Medicare Part B are expected in all cases to refund any money they received from the SNF for the same item.

Effective for claims with dates of service on or after January 1, 2003 to December 31, 2004, your Medicare carrier and FI will reopen and reprocess claims with the code L5781 and override timely filing when necessary. The carrier/FI will only do this, however, when you bring such claims to their attention.

### Implementation

The implementation date for this instruction is July 5, 2005.

### Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3873 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3873  
 Related CR Release Date: May 27, 2005  
 Related CR Transmittal Number: 568  
 Effective Date: July 1, 2005  
 Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 568, CR 3873

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## **Edit Modification for Colorectal Cancer Screening Services Furnished at Skilled Nursing Facilities**

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

### **Provider Types Affected**

Skilled nursing facilities (SNFs) submitting claims for the subject HCPCS codes to Medicare fiscal intermediaries (FIs)

### **Provider Action Needed**

#### **STOP – Impact to You**

Effective October 1, 2005 for covered Part A stay beneficiaries, you may submit (or re-submit), on a type of bill (TOB) 22x, colorectal cancer screening claims for:

- HCPCS codes G0104, G0106, G0107, and G0120 with dates of service back to April 1, 2002; and
- HCPCS code G0328 with dates of service back to January 1, 2004.

#### **CAUTION – What You Need to Know**

Effective October 1, 2005, this instruction (CR 3763) modifies the Medicare claims processing systems to accept colorectal cancer screening service claims for HCPCS codes G0104, G0106, G0107, and G0120 with dates of service back to April 1, 2002; and for HCPCS code G0328 back to January 1, 2004.

#### **GO – What You Need to Do**

Make sure that your billing staffs are aware of these modifications.

### **Background**

**Note:** Coverage of screening and preventive services rendered to SNF beneficiaries in a covered Part A stay remains subject to consolidated billing, and must be billed separately under Part B on a TOB 22x. Remember not to include claims for these services as part of your global Part A bill.

CR 2874 (February 6, 2004) extended skilled nursing facility coverage to include colorectal cancer screening procedures: 1) HCPCS codes G0104 (flexible sigmoidoscopy), 2) G0106 (barium enema, as an alternative to G0104, screening sigmoidoscopy), 3) G0107 (fecal-occult blood test), and 4) G0120 (barium enema, as an alternative to G0105, screening colonoscopy) for dates of service on or

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after July 1, 2004. However, Medicare's Fiscal Intermediary Shared System (FISS) rejected claims for such services with dates of service prior to this date. (FISS is the system used by FIs to process their claims.)

This instruction (CR 3763) modifies current FISS edits for colorectal cancer screenings services to allow claims for these HCPCS codes with dates of service on or after April 1, 2002.

It further instructs FIs to allow claims for colorectal cancer screening services (HCPCS code G0328 (fecaloccult blood test [immunoassay-based]) with dates of service on or after January 1, 2004.

### **Implementation Date**

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

### **Additional Information**

You can find more information about these changes at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3763 in the CR NUM column on the right, and click on the file for that CR.

You might also want to look at the revision to the Medicare Claims Processing Manual, Chapter 18 (Preventive and Screening Services), Section 60.2.1, Common Working Files (CWF) edits attached to CR 3763.

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

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

Related Change Request (CR) Number: 3763

Related CR Release Date: April 29, 2005

Related CR Transmittal Number: 544

Effective Date: October 1, 2005

Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 544, CR 3763

## **New Expedited Review Process for Disputed Terminations of Medicare-Covered Services in SNFs, HHAs, CORFs, and Hospices**

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

### **Provider Types Affected**

Skilled nursing facilities (SNFs), home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs), and hospices treating Medicare patients

### **Provider Action Needed**

Be sure staff is aware of the new requirements regarding notification of Medicare patients about the cessation of Medicare coverage of their services. The new rules are effective on July 1, 2005.

### **Background**

Beginning July 1, 2005, beneficiaries in original Medicare will have access to a new fast-track, expedited review process when Medicare coverage of their SNF, HHA, CORF, or hospice services is about to end. The requirement for these expedited reviews stems from section 1869(b)(1)(F) of the Social Security Act (the Act), as amended by section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000

*New Expedited Review Process for Disputed Terminations of Medicare-Covered Services ... (continued)*

(BIPA), Public Law 106—554. The Centers for Medicare & Medicaid Services (CMS) published the final regulations needed to implement the new process on November 26, 2004 (69 FR 69252). The regulation may be viewed at: <http://a257.g.akamaitech.net/7/257/2422/06jun20041800/edocket.access.gpo.gov/2004/04-26133.htm>.

As a result of the new regulations, the review process for Medicare beneficiaries in the original Medicare will essentially parallel the expedited review process that has been in effect for Medicare managed-care enrollees since January 1, 2004.

**New Regulations**

Based on the provisions of the November 2004 final rule, SNFs, HHAs, CORFs, and hospices must provide the Notice of Medicare Provider Non-Coverage (generic notice) to Medicare beneficiaries no later than two days before the effective date of the end of the coverage that their Medicare coverage will be ending. If the beneficiary does not agree that coverage should end, the beneficiary may request an expedited review of the termination decision by the quality improvement organization (QIO) in that state. The provider then must furnish the Detailed Explanation of Non-Coverage (detailed notice) to the beneficiary explaining why services are no longer covered. Generally, the QIO's review will be completed within 72 hours of the QIO's receipt of the beneficiary's request for a review.

The new SNF, HHA, CORF, and hospice notification and review requirements distribute responsibilities under the new process among three parties:

- 1) The provider is responsible for delivering the generic notice to all beneficiaries no later than two days before their covered services end and for delivering the detailed notice to the QIO and the beneficiary by close of business of the day the beneficiary requests a review.
- 2) The beneficiary (or authorized representative) is responsible for acknowledging receipt of the generic notice and for contacting the QIO within the specified timeframes if he/she wishes to pursue an expedited review.
- 3) The QIO is responsible for immediately contacting the provider if a beneficiary requests an expedited review and then making a decision no later than 72 hours after receipt of the beneficiary's request.

**What Do the New SNF, HHA, and CORF Notification Requirements Mean for Providers?****Notice of Medicare Provider Noncoverage (Generic)**

The generic notice is a short and straightforward notice that simply informs the beneficiary of the date that coverage of services is going to end and describes what should be done if the beneficiary wants the decision to be reviewed or if the beneficiary needs more information about the decision. CMS has designed the generic notice so that its delivery is as simple and burden-free as possible for the provider.

The generic notice includes only three variable fields (patient name, Medicare number, and last date of coverage) that the provider will have to fill in before delivering it to the beneficiary. There is also space for the provider to enter additional inform if desired.

**When to Deliver the Generic Notice**

Generally, the provider is responsible for delivering the generic notice no later than two days before covered services will end. If services are expected to last fewer than two days, the generic notice should be delivered upon admission. If there is more than a two-day span between services (e.g., in the home health setting), the generic notice should be issued the next to last time services are furnished.

**How to Deliver the Generic Notice**

To ensure "valid delivery" of the generic notice, the provider must provide the completed notice to the beneficiary (or authorized representative) so that the beneficiary can sign and date the notice. If the beneficiary refuses to sign the notice, the provider must make a notation on the generic notice that the beneficiary was provided with the notice but did not sign it. An authorized representative may be notified by telephone if personal delivery is not immediately available. In this case, the authorized representative must be informed of the content of the notice, and the provider must document the call and then mail the notice to the representative.

Providers that deliver the generic notice must insert the following patient-specific information:

- The beneficiary's name and Medicare number, and
- The date that coverage of services ends.

The generic notice also should identify the appropriate QIO. It also includes space for additional information as necessary or required.

**Expedited Review Process and the Detailed Notice**

If the beneficiary decides to appeal the provider's decision that Medicare coverage should end, he/she must contact the QIO by no later than noon of the day before services are to end (as indicated in the generic notice) to request a review. The QIO will inform the provider of the request for a review. The provider is responsible for providing the QIO and the beneficiary with a detailed explanation of why coverage is ending. The provider may need to present additional information to the QIO for the QIO to use in making a decision. Based on the timeframes associated with the expedited review process, the QIO decision should take place 72 hours after receipt of the beneficiary's request for a review.

**Importance of Timing/Need for Flexibility**

Although the regulations and accompanying instructions do not require action until two days before the planned termination of covered services, the generic notice may be given as soon as the provider can reasonably determine the discharge date. This will provide beneficiaries with more time to consider their options, including whether to pursue an expedited review of the decision. This also would allow more time for the review process to occur while Medicare coverage is still in place. Similarly, SNF providers may want to consider how they can assist patients who wish to be discharged in the evening or on weekends in the event that they receive an unfavorable decision from the QIO review process and want to minimize any additional liability. Tasks such as ensuring that arrangements for follow-up care are in place, scheduling equipment to be delivered (if needed), and

*New Expedited Review Process for Disputed Terminations of Medicare-Covered Services ... (continued)*

writing orders or instructions can be done in advance to facilitate a more efficient discharge. We strongly encourage providers to structure their notice delivery and discharge patterns to make the new process work as smoothly as possible.

CMS intends to continue to work together with all involved parties to identify problems, publicize best practices, and implement needed refinements to these procedures; thus we welcome all suggestions for fine-tuning the expedited review process.

**Additional Information**

Further information on the new expedited review process, including the generic notice, detailed notice, and related instructions, may be found on CMS' Beneficiary Notices Initiative Web page at:

<http://www.cms.hhs.gov/medicare/bni>.

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The BNI Web page includes a link to frequently asked questions about the expedited review process. CMS is also in the process of incorporating these procedures into the CMS Medicare Claims Processing Manual, Chapter 30.

To view the official instruction (CR3903) issued to your Medicare intermediary on this process, visit the CMS website at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

Once at that site, scroll down the CR NUM column on the right looking for CR 3903 and click on the file for that CR.

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Article SE0538  
CMS Pub. 100-4, Transmittal 594, CR 3903

**Editing of Hospital and Skilled Nursing Facility Part B Inpatient Services**

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

The Centers for Medicare & Medicaid Services (CMS) has advised Medicare contractors that instructions issued with Medlearn Matters article MM3366 based on change request (CR) 3366 has been fully replaced by CR 3531 (Transmittal 351; dated October 29, 2004 – Editing of Hospitals and Skilled Nursing Facilities Part B Inpatient Services (Full Replacement of Change Request 3366). The original Medlearn Matters article MM3366 was published in the [First Quarter 2005 Medicare A Bulletin](#) (pages 67-68).

The Medlearn Matters article MM3531 was published in the [January 2005 Medicare A Bulletin Special Edition](#) (page 47).

You may see CR 3531 (Transmittal 351) on CMS website at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R351CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R351CP.pdf).

Also, see the Medlearn Matters article related to CR 3531 (Transmittal 351) at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3531.pdf>.

Related Change Request (CR) Number: 3366  
Related CR Release Date: September 17, 2004  
Related CR Transmittal Number: 301  
Effective Date: January 1, 2005  
Implementation Date: January 1, 2005

Source: CMS Pub. 100-4, Transmittal 301, CR 3366

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**Billing Edits for Ambulance Transports to or from a Diagnostic or Therapeutic Site**

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

The Centers for Medicare & Medicaid Services (CMS) has advised Medicare contractors that instructions issued with Medlearn Matters article MM3427 based on change request (CR) 3427 has been fully replaced by CR 3676 (Transmittal 459; dated February 4, 2005 – Billing Edits for Ambulance Transports to or from a Diagnostic or Therapeutic Site (Full Replacement of Change Request 3676). The original Medlearn Matters article MM3427 was published in the [Second Quarter 2005 Medicare A Bulletin](#) (pages 55-56). The Medlearn Matters article MM3676 was published in the [Third Quarter 2005 Medicare A Bulletin](#) (pages 34-35).

You may see CR 3676 (Transmittal 459) on CMS website at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R459CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R459CP.pdf).

Also, see the Medlearn Matters article related to CR 3676 (Transmittal 459) at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3676.pdf>.

Related Change Request (CR) Number: 3427  
Related CR Release Date: October 29, 2004  
Related CR Transmittal Number: 342  
Effective Date: April 1, 2005  
Implementation Date: April 1, 2005

Source: CMS Pub. 100-4, Transmittal 342, CR 3427

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## Message to Nursing Home Administrators on Medicare Prescription Drug Coverage

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

*The Sixth article in a series of: Information for Providers, Physicians, Pharmacies and their Staff About Medicare Prescription Drug Coverage*

### Provider Types Affected

Skilled nursing facilities – This article contains important information for nursing home staff about the impact of the new prescription drug coverage on people who receive both Medicare and Medicaid.

### Information for Nursing Home Administrators

The Centers for Medicare & Medicaid Services (CMS) released the following information via the minimum data set (MDS) submission system’s Welcome Page on July 6, 2005:

- Starting January 1, 2006, Medicare prescription drug coverage will be available to everyone with Medicare. Also starting January 1, 2006, state Medicaid programs will no longer provide drug coverage for people also covered by Medicare (also known as full benefit dual eligibles or FBDEs); instead, Medicare will provide prescription drug coverage for people in this group. Since two thirds of residents in nursing homes fall into this category, this federal program will be critically important. State Medicaid coverage for **health care** coverage is not affected.
- All Medicaid beneficiaries who are eligible to receive benefits through both Medicare and Medicaid must enroll in a Medicare Prescription Drug Plan to get this coverage. They will receive information from Medicare and from the plans in their area this fall and they will need to choose and enroll in a plan that meets their needs. However, if they haven’t joined a plan by December 31, 2005, Medicare will enroll them in a plan to make sure they don’t miss a day of coverage. People in this group can switch to another plan at any time.
- The Centers for Medicare & Medicaid Services (CMS) will use the minimum data set (MDS) distribution system to keep nursing home administrators informed about Medicare prescription drug coverage as it applies to nursing home residents.
- All Medicare prescription drug plans will provide at least a standard level of coverage to all enrollees. Coverage will be available through both Medicare “Prescription Drug Plans” (PDPs), and as part of Medicare Advantage plans or other Medicare health plans (MA-PDs). All plans will be required to cover enrollees in all nursing homes in their regions. They will also be required to meet specific service and performance criteria to ensure safe prescription drug administration in the nursing home setting. While plans may offer different formularies (lists of covered drugs), CMS will require plans to cover a range of drugs in the most commonly prescribed classes to make sure that people with different medical conditions can get the treatment they need.

An “exceptions and appeals” process will be in place to ensure access to non-formulary drugs. The plans will

arrange for medications to be packaged and made available to nursing homes through long-term care pharmacy providers. These will most likely include current pharmacy providers to nursing homes, as well as new organizations that are able to meet the CMS long-term care pharmacy standards. Nursing homes will be able to select from these pharmacy vendors to ensure that all of the residents have appropriate drug coverage.

- People who receive both Medicare and Medicaid and reside in a nursing home will receive continuous prescription drug coverage, with no premiums, no deductibles, and no co-payments.
- People with limited income and resources, who are **not** eligible for full Medicaid benefits, may qualify for extra help paying for Medicare prescription drug coverage. If they qualify, they will receive extra help to pay for premiums, deductibles, and co-payments. They **will** have to pay a copayment or coinsurance amount, depending on their income and resources.
- More information concerning Medicare prescription drug coverage as it applies to the long-term care population, and operational steps that will be necessary to ensure a seamless transition in 2006, will be forthcoming through the MDS distribution system. Additional information and resources are also available on the CMS website at: <http://www.cms.hhs.gov>.

### Additional Information

More information on provider education and outreach regarding Medicare prescription drug coverage can be found on the CMS website at:

<http://www.cms.hhs.gov/medlearn/drugcoverage.asp>.

Detailed drug coverage information for CMS partners and beneficiary advocates can be found on the CMS website at

<http://www.cms.hhs.gov/partnerships/news/mma/default.asp>.

You can also find additional information regarding prescription drug plans on the website at

<http://www.cms.hhs.gov/pdps/>.

### Important Points to Remember

- On January 1, 2006, new prescription drug coverage will be available to your Medicare residents. It will cover brand name and generic drugs.
- Starting January 1, 2006, state Medicaid programs will no longer provide drug coverage for people also covered by Medicare.
- All Medicaid beneficiaries who are eligible to receive benefits through both Medicare and Medicaid **must** enroll in a Medicare Prescription Drug Plan to get continuous coverage of their prescription drug costs.
- If Medicaid beneficiaries who are eligible to receive benefits through both Medicare and Medicaid do not



*Message to Nursing Home Administrators on Medicare Prescription Drug Coverage (continued)*

enroll in a Medicare Prescription Drug Plan by December 31, 2005, Medicare will enroll them in a plan automatically to make sure they do not miss a day of coverage.

- Medicaid beneficiaries who live in a nursing home will pay nothing out of their pocket for Medicare prescription drug coverage.

- If your Medicare patients ask you questions about the new coverage, you can refer them for additional information and assistance to 1-800-MEDICARE and to <http://www.medicare.gov>.

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

Source: CMS Special Edition Medlearn Article SE0544

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**Inpatient Part A Billing: SNF Prospective Payment System PRICER Software—Addition to the Medicare Claims Processing Manual Chapter 6**

*CMS has issued the following “Medlearn Matters... Information for Medicare Providers” article.*

**Provider Affected**

Skilled nursing facilities (SNFs) and swing bed facilities billing Medicare fiscal intermediaries

**Provider Action Needed**

**STOP – Impact to You**

This article is informational only as CR 3774 is placing information in its Medicare Claims Processing Manual concerning the SNF PRICER. Effective for cost reporting periods beginning on or after July 1, 1998 all skilled nursing services billed on a type of bill (TOB) 21x are reimbursed based on calculations made with the SNF PRICER. Effective for cost reporting period beginning on or after July 1, 2002, all swing bed facility claims billed on a TOB 18x are reimbursed on calculations made by the SNF PRICER.

**CAUTION – What You Need to Know**

This instruction adds the SNF PRICER logic used to make payment determinations for SNF and swing bed prospective payment system (PPS) to Chapter 6, Section 30.6 (SNF PPS P PRICER Software) of the Medicare Claims Processing Manual.

**GO – What You Need to Do**

Review Chapter 6, Section 30.6 of the Medicare Claims Processing Manual if you for details regarding the SNF PRICER. Note that a PC-based version of the SNF PRICER program may be found at <http://www.cms.hhs.gov/providers/pricer/default.asp>.

**Background**

The Balanced Budget Act (BBA) of 1997 (Public Law 105-33) mandated the implementation of a per diem prospective payment system (PPS) for skilled nursing facilities that covers all costs (routine, ancillary, and capital) of covered SNF services furnished to beneficiaries under Part A of the Medicare program, effective for cost reporting periods beginning on or after July 1, 1998. Such claims are submitted on (TOB) 21x.

The Centers for Medicare & Medicaid Services (CMS) has previously developed an SNF PRICER program that calculates the Medicare payment rate for skilled nursing and

swing bed facility services. (For cost reporting periods beginning on or after July 1, 2002, swing bed facility claims (TOB 18x) are reimbursed based on the calculations made by the SNF PRICER.)

The SNF PRICER is available electronically to the Medicare claim processing system and is updated at least annually. The SNF PPRICER program may be found at: <http://www.cms.hhs.gov/providers/pricer/default.asp>.

The purpose of CR 3774 is to revise Chapter 6 “Skilled Nursing Facility Inpatient Part A Billing,” of the Medicare Claims Processing Manual to add Section 30.6 “Skilled Nursing Facility Prospective Payment System PRICER Software.”

**Implementation**

The implementation date for this instruction is August 1, 2005.

**Additional Information**

The revisions to Chapter 6 of the Claims Processing Manual are included in CR 3774.

For complete details, please see the official instruction issued to your intermediary regarding this change.

That information may be found by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3774 in the CR NUM column on the right, and then click on the file for that CR.

If you have questions regarding this issue, contact your intermediary on their toll free number, which is available at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3774  
 Related CR Release Date: April 29, 2005  
 Related CR Transmittal Number: 540  
 Effective Date: April 29, 2005  
 Implementation Date: August 1, 2005

Source: CMS Pub. 100-4, Transmittal 540, CR 3774

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## **An Algorithmic Approach to Determine if Mobility Assistive Equipment Is Reasonable and Necessary**

*CMS has issued the following “Medlearn Matters... Information for Medicare Providers” article.*

### **Provider Types Affected**

Providers billing Medicare durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs) for mobility assistive equipment (MAE)

### **Provider Action Needed**

#### **STOP – Impact to You**

This article includes information from Change Request (CR) 3791, in which the Centers for Medicare & Medicaid Services (CMS) addresses numerous items that it has termed mobility assistive equipment (MAE).

#### **CAUTION – What You Need to Know**

MAE includes (but is not limited to) canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters. CMS determines that MAE is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.

Determination of the presence of a mobility deficit will be made by an algorithmic process (as outlined in the Clinical Criteria for MAE Coverage included in this article) to provide the appropriate MAE to correct the mobility deficit.

#### **GO – What You Need to Do**

You should sequentially consider specific questions in CR 3791 that provide clinical guidance for the coverage of equipment (of appropriate type and complexity) to restore the beneficiary’s ability to participate in Mobility-Related Activities of Daily Living (MRADLs) (toileting, feeding, dressing, grooming, bathing, etc.) in customary locations in the home. These questions correspond to the numbered decision points on the Clinical Criteria for MAE Coverage flow chart in CR3791. That chart is also included in this article.

### **Background**

Recently, considerable public interest has been focused on the provision of wheelchairs under the Medicare benefit. The agency has responded with a multi-faceted plan to ensure the appropriate prescription of wheelchairs to beneficiaries who need them. One facet of this plan is the delineation of suggested clinical conditions of wheelchair coverage. The Centers for Medicare & Medicaid Services (CMS) solicited public comment through a number of open door forums and other methods. Many advocacy groups suggested that the agency adopt a function-based interpretation of its historical “bed or chair confined” criterion for wheelchair coverage.

CMS believes that an algorithmic process that sequentially considers the appropriate “Mobility Assistive Equipment” (MAE) that corrects the mobility deficit is the appropriate process to follow in covering MAEs. CMS believes that the Clinical Criteria for MAE Coverage, in Section 280.3, Chapter 1, of Medicare Publication 100-03 (Medicare National Coverage Determinations), sufficiently describes this process.

Utilizing such a process will ensure that the beneficiary (or caregiver) is able to maintain as much independence as physically and mentally possible, thereby ensuring the beneficiary’s Mobility-Related Activities of Daily Living (MRADLs) are maintained.

CMS is extending national coverage regarding MAE for beneficiaries who have a personal mobility deficit sufficient to impair their participation in MRADLs such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. Determination of the presence of a mobility deficit will be made by an algorithmic process, as outlined in the Clinical Criteria for MAE Coverage, to provide the appropriate MAE to correct the mobility deficit. MAE includes, but is not limited to, canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters.

CR 3791 instructs Medicare carriers, DMERCs, and RHHIs to:

- Disregard the “bed- or chair- confined” criterion that has been historically used to determine if a wheelchair is reasonable and necessary as defined by the Social Security Act (Section 1862(A)(1)(a)).
- Use the algorithmic approach as outlined in the Medicare National Coverage Determinations Manual (Pub. 100-03, Section 280.3), Clinical Criteria for MAE Coverage (and included below) to determine coverage eligibility of MAE. MAE includes, but is not limited to, canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters.

As in other cases, if data analysis indicates potentially aberrant billing, Medicare DMERCs and FIs will use these standards when performing medical review of claims.

Medicare beneficiaries may require mobility assistance for a variety of reasons and for varying durations because the etiology of the disability may be due to a congenital cause, injury, or disease. Thus, some beneficiaries experiencing temporary disability may need mobility assistance on a short-term basis, while in contrast, those living with chronic conditions or enduring disabilities will require mobility assistance on a permanent basis.

In addition, Medicare beneficiaries who depend upon mobility assistance are found in varied living situations. Some may live alone and independently while others may live with a caregiver or in a care facility. The beneficiary’s environment is relevant to the determination of the appropriate form of mobility assistance that should be employed.

For many patients, a device of some sort is compensation for the mobility deficit. However, some beneficiaries experience co-morbid conditions that can impact their ability to safely utilize MAE independently or to successfully regain independent function even with mobility assistance.

The functional limitation (as experienced by a beneficiary) depends on:

- The beneficiary’s physical and psychological function,
- The availability of other support, and
- The beneficiary’s living environment.

*An Algorithmic Approach to Determine if Mobility Assistive Equipment Is Reasonable and Necessary (continued)*

A few examples include muscular spasticity, cognitive deficits, the availability of a caregiver, and the physical layout, surfaces, and obstacles that exist in the beneficiary's living environment.

**Nationally Covered Indications**

Effective May 5, 2005, CMS finds that the evidence is adequate to determine that MAE is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their performance of mobility-related activities of daily living (MRADL) such as toileting, feeding, dressing, grooming, and bathing in customary areas in the home. **Determination of the presence of a mobility deficit will be made by an algorithmic process, Clinical Criteria for MAE Coverage, to provide the appropriate MAE to correct the mobility deficit.**

**Clinical Criteria for MAE Coverage**

The beneficiary, the beneficiary's family or other caregiver, or a clinician, will usually initiate the discussion and consideration of MAE use. **Sequential consideration of the questions below provides clinical guidance for the coverage of equipment of appropriate type and complexity to restore the beneficiary's ability to participate in MRADLs such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.** These questions correspond to the numbered decision points on the accompanying flow chart.

1. Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs in the home? A mobility limitation is one that:
  - a) Prevents the beneficiary from accomplishing the MRADLs entirely, or,
  - b) Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to participate in MRADLs, or,
  - c) Prevents the beneficiary from completing the MRADLs within a reasonable time frame.
2. Are there other conditions that limit the beneficiary's ability to participate in MRADLs at home?
  - a) Some examples are significant impairment of cognition or judgment and/or vision.
  - b) For these beneficiaries, the provision of MAE might not enable them to participate in MRADLs if the comorbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with MAE.
3. If these other limitations exist, can they be ameliorated or compensated sufficiently such that the additional provision of MAE will be reasonably expected to significantly improve the beneficiary's ability to perform or obtain assistance to participate in MRADLs in the home?
  - a) A caregiver, for example a family member, may be compensatory, if consistently available in the beneficiary's home and willing and able to safely operate and transfer the beneficiary to and from the wheelchair and to transport the beneficiary using the wheelchair. The caregiver's need to use a wheelchair to assist the beneficiary in the MRADLs is to be considered in this determination.
- b) If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of wheelchair coverage if it results in the beneficiary continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of MAE.
4. Does the beneficiary or caregiver demonstrate the capability and the willingness to consistently operate the MAE safely?
  - a) Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.
  - b) A history of unsafe behavior in other venues may be considered.
5. Can the functional mobility deficit be sufficiently resolved by the prescription of a cane or walker?
  - a) The cane or walker should be appropriately fitted to the beneficiary for this evaluation.
  - b) Assess the beneficiary's ability to safely use a cane or walker.
6. Does the beneficiary's typical environment support the use of wheelchairs including scooters/power-operated vehicles (POVs)?
  - a) Determine whether the beneficiary's environment will support the use of these types of MAE.
  - b) Keep in mind such factors as physical layout, surfaces, and obstacles, which may render MAE unusable in the beneficiary's home.
7. Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair in the home to participate in MRADLs during a typical day? The manual wheelchair should be optimally configured (seating options, wheelbase, device weight, and other appropriate accessories) for this determination.
  - a) Limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities are relevant.
  - b) A beneficiary with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, i.e. light weight, etc., should be determined based on the beneficiary's physical characteristics and anticipated intensity of use.
  - c) The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.

***An Algorithmic Approach to Determine if Mobility Assistive Equipment Is Reasonable and Necessary (continued)***

- d) Assess the beneficiary's ability to safely use a manual wheelchair.

**Note:** If the beneficiary is unable to self-propel a manual wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair may be appropriate.

8. Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?
  - a) A POV is a three or four-wheeled device with tiller steering and limited seat modification capabilities. The beneficiary must be able to maintain stability and position for adequate operation.
  - b) The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a POV.
  - c) Assess the beneficiary's ability to safely use a POV/scooter.
9. Are the additional features provided by a power wheelchair needed to allow the beneficiary to participate in one or more MRADLs?
  - a) The pertinent features of a power wheelchair compared to a POV are typically control by a joystick or alternative input device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.
  - b) The type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments.
  - c) The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a power wheelchair.
  - d) Assess the beneficiary's ability to safely use a power wheelchair.

**Note:** If the beneficiary is unable to use a power wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair is appropriate. A caregiver's inability to operate a manual wheelchair can be considered in covering a power wheelchair so that the caregiver can assist the beneficiary.

**Nationally Noncovered Indications**

Medicare beneficiaries not meeting the clinical criteria for prescribing MAE as outlined, and as determined by the beneficiary's physician, would not be eligible for Medicare coverage of the MAE.

**Note:** All other durable medical equipment (DME) not meeting the definition of MAE as described in this instruction will continue to be covered, or noncovered, as is currently described in the NCD Manual, section 280, Medical and Surgical Supplies.

Also note that CR 3791 revises the Medicare National Coverage Determinations Manual (Pub. 100-03, Section 280.3), and this revision is a national coverage determination (NCD) made under the Social Security Act (section 1862[a][1]).

NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (see the *Code of Federal Regulations* (CRF), Title 42, Sections 405.732, 405.860). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an administrative law judge may not review an NCD. See the Social Security Act (Section 1869(f)(1)(A)(i)).

**Implementation**

The implementation date for this instruction is July 5, 2005. Your DMERC or FI will adjust claims affected by this change, but processed before July 5, 2005, if you bring such claims to the attention of the DMERC/FI.

**Additional Information**

For complete details, please see the official instruction issued to your DMERC or FI regarding this change. That instruction includes the complete section 280.3 and the instruction may be viewed by going to:

[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3791 in the CR NUM column on the right, and click on the files for that CR. You will note two files for CR 3791. The file reflecting transmittal number 37 contains the revisions to the Medicare National Coverage Determinations Manual and the file with transmittal number 574 contains the Medicare claims processing business requirements/instructions.

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

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

Related Change Request (CR) Number: 3791

Related CR Release Date: June 3, 2005

Related CR Transmittal Number: 37 and 574

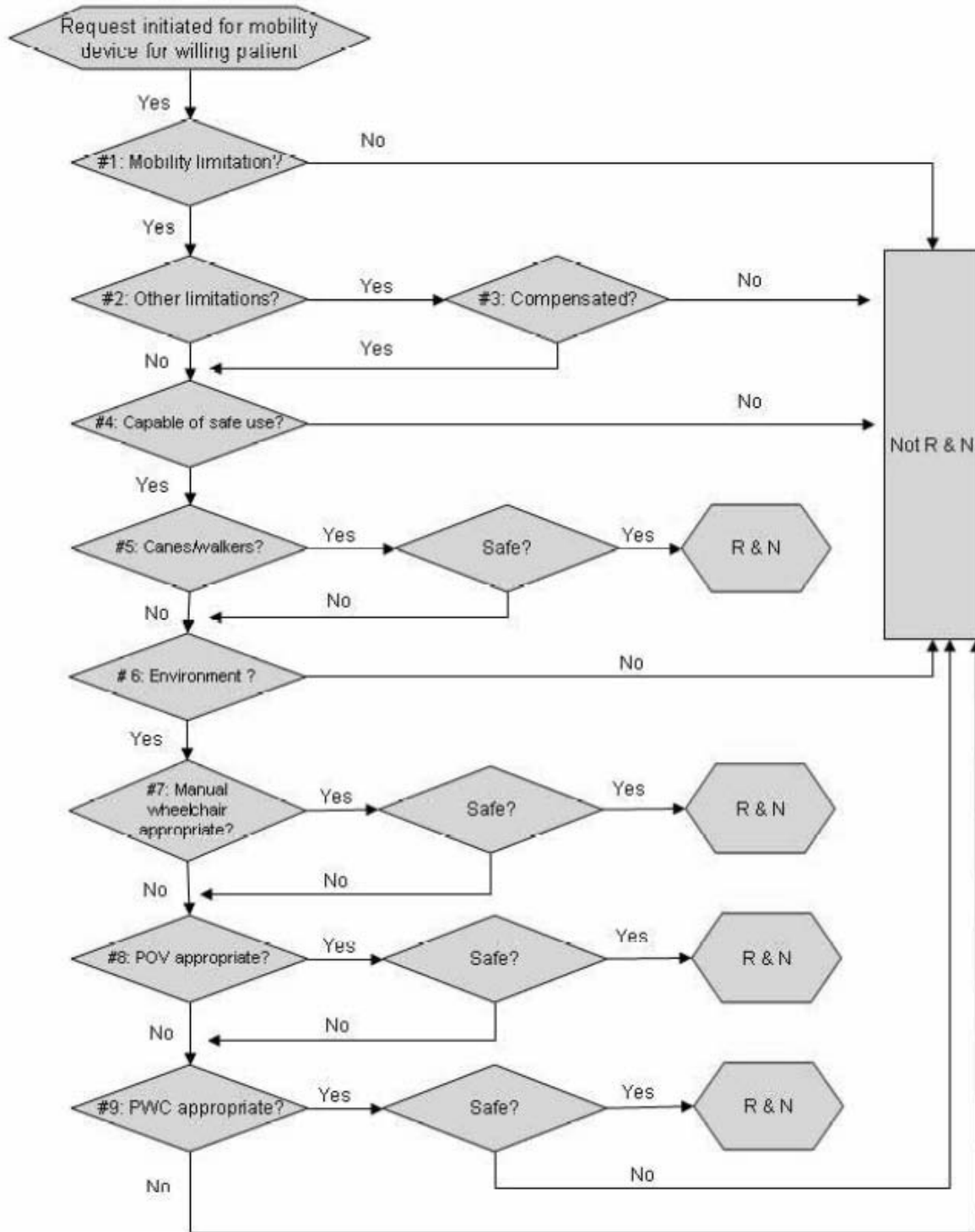
Effective Date: May 5, 2005

Implementation Date: July 5, 2005



*An Algorithmic Approach to Determine if Mobility Assistive Equipment Is Reasonable and Necessary (continued)*

**Clinical Criteria for MAE Coverage**



Source: CMS Pub. 100-4, Transmittal 574, CR 3791

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**Nonphysician Practitioner Questions and Answers as It Relates to SNF CB**

*CMS has issued the following “Medlearn Matters... Information for Medicare Providers” article.*

**Note:** This article is provided as informational for skilled nursing facilities.

**Provider Types Affected**

Nonphysician practitioners (NPPs), physicians, suppliers, and providers

**Provider Action Needed**

Be sure to understand the policies related to services for skilled nursing facilities (SNF) and nursing facilities (NF) as they relate to nonphysician practitioners.

**Background**

The Balanced Budget Act of 1997 modified the way the Medicare program pays for Nonphysician practitioner (NPP) services. Prior to January 1, 1998, these services were reimbursed by Medicare Part B only in certain geographical areas and health care settings. The Balanced Budget Act removed the restrictions on settings and effective January 1998, payment is allowed for nonphysician practitioner services in all geographic areas and health care settings permitted under state licensing laws.

On November 13, 2003, CMS issued the Survey & Certification letter (S&C-04-08), which addresses the differences in requirements concerning the delegation of physician tasks in SNFs and NFs from a survey and certification perspective. Please note that reimbursement requirements for NPPs may differ from the survey and certification requirements. The following questions (Q1 through Q17) have been asked by NPPs, and each question has been answered (A1 through A17) by the Centers for Medicare & Medicaid Services (CMS).

**Q1. Why do new regulations from CMS governing physician delegation of services differ between skilled nursing facilities (SNFs) and nursing facilities (NFs)?**

**A1.** The requirements addressing physician delegation of services are not new. The distinction made between the delegation of physician visits and tasks between SNFs and NFs is mandated by Congress in the law. The original authority for 42 *Code of Federal Regulations* (CFR) section 483.40 was the sentence in section 1819(b)(6)(A) of the Social Security Act requiring that every SNF resident’s medical care be under the supervision of a physician (the same sentence appeared in section 1919(b)(6)(A) of the Social Security Act for NFs). The requirements contained in 42 CFR, section 483.40, include a prescribed visit schedule and the requirement for the physician to perform the initial visit personally. Section 483.40 of the CFR originally applied these same standards uniformly in both SNFs and NFs. However, in section 4801(d) of the Omnibus Budget Reconciliation Act of 1990 (OBRA ‘90), Congress subsequently amended the Medicaid provisions of the law (section 1919(b)(6)(A) of the Social Security Act) to allow, at the option of the state, all physician tasks (including the initial visit) to be delegated to physician extenders who are not employed by the facility but who are working in collaboration with the physician. In response, CMS amended the regula-

tions to reflect this broader authority for delegating physician tasks in NFs (see section 483.40(f)). Since Congress declined to make a similar change in the statutory requirements for SNFs at section 1819(b)(6)(A) of the Social Security Act, the corresponding SNF requirements in section 483.40(c) and (e) remain unchanged.

**Q2. When may nonphysician practitioners (NPPs) begin to bill for medically necessary visits that occur prior to the initial comprehensive visit in an SNF and in a NF?**

**A2.** CMS defined “initial comprehensive visit” in the November 13, 2003 S&C-04-08 and stated that NPPs may perform any medically necessary visits even if they occur prior to the initial comprehensive visits in both SNFs and NFs. Medically necessary visits that NPPs perform on or after November 13, 2003, may be billed to the carrier when collaboration and billing requirements are met in the SNF and NF setting. The Survey & Certification letter S&C-04-08, may be found at: <http://www.cms.hhs.gov/medicaid/survey-cert/letters.asp>.

**Q3. If State regulations require a physician co-signature for orders and/or notes written by an NPP, may the physician bill for this action?**

**A3.** No. CMS only pays for medically necessary face-to-face visits by the physician or NPP with the resident. Since the NPP is performing the medically necessary visit, the NPP would bill for the visit.

**Q4. If State regulations require more frequent visits than those that are federally mandated, are NPPs able to bill for those visits?**

**A4.** CMS only reimburses physicians and NPPs for medically necessary visits and federally prescribed visits. Visits required to fulfill or meet state requirements are considered administrative requirements and are not medically necessary for the resident. Medicare pays for services that are reasonable and medically necessary for the treatment of illness or injury only, as stated in the Social Security Act, section 1862(a)(1)(A).

**Q5. May NPPs who are employed by the facility bill for medically necessary visits?**

**A5.** Payment may be made for the services of nurse practitioners (NPs) and clinical nurse specialists (CNSs) who are employed by an SNF or NF when their services are rendered to facility residents. If NPs and CNSs employed by a facility opt to reassign payment for their professional services to the facility, the facility can bill the appropriate Medicare Part B carrier under the NPs’ or CNSs’ UPINs for their professional services. Otherwise, the NPs or CNSs who are employed by an SNF or NF bill the carrier directly for their services to facility residents.

*Nonphysician Practitioner Questions and Answers as It Relates to SNF CB (continued)*

On the other hand, physician assistants (PAs) who are employed by an SNF or NF cannot reassign payment for their professional services to the facility because Medicare law requires the employer of a PA to bill for the PA's services. Hence, the facility must always bill the Part B carrier under the PA's UPIN for the PA's professional services to facility residents.

- Q6. May NPPs employed by the NF perform the initial comprehensive visit, sign initial orders, or perform other federally required visits in NFs?**
- A6.** No. The statute specifies that the NPPs are prohibited from providing these services when **employed** by the facility. The Social Security Act states at section 1919(b)(6)(A) that the health care of every resident must be provided under the supervision of a physician or under the supervision of an NPP **not** employed by the facility who is working in collaboration with a physician.
- Q7. May NPPs perform the initial comprehensive visit in SNFs?**
- A7.** No. The Social Security Act states at Section 1819(b)(6)(A) "that the medical care of every resident must be provided under the supervision of a physician." Congress did not extend this benefit to NPPs in an SNF as was done under 1919(b)(6)(A).
- Q8. When may NPPs sign the initial orders for an SNF resident?**
- A8.** NPPs may not sign initial orders for an SNF resident. However, they may write initial orders for a resident (only) when they review those orders with the attending physician in person or via telephone conversation and have the orders signed by the physician.
- Q9. Must a physician verify and sign orders written by an NPP who is employed by the NF?**
- A9.** Yes. The regulation at 42 CFR, § 483.40(b)(3) states, the physician must "Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications."  
In accordance with 42 CFR, Section 483.40(f), required physician tasks, such as verifying and signing orders in an NF, can be delegated under certain circumstances to a physician assistant, nurse practitioner, or clinical nurse specialist who is **not** an employee of the facility but who is working in collaboration with a physician. Therefore, in order to comply with survey and certification requirements, the physician must sign all orders written by an NPP who is employed by the NF.
- Q10. Why must a physician verify and sign orders written by an NPP in the SNF?**
- A10.** In SNFs, depending on state law and the facility's policy, physicians do NOT have to verify and sign orders written by an NPP after the initial comprehensive visit. Nonetheless, the ultimate responsibility for

delegated tasks remains with the physician, as indicated in § 483.40(e)(1)(iii). For a NF, depending upon state law, NPPs not employed by the facility but who are working in collaboration with a physician are not required to have their orders (initial or ongoing) cosigned by a physician.

- Q11. Referring to S&C –04-08 issued on November 13, 2003, the chart under the "Other Medically Necessary Visits and Orders" column, it specifies the ability of the NPP to perform AND sign but in the column for "Other Required Visits" it does not address signing. Does CMS require a physician's signature in such cases?**
- A11.** 'Other Required Visits' refers to the federally required visits. During these required visits, it is not always necessary to write orders. However, during a "Medically Necessary Visit," which is when the resident's condition may have changed, thus, warranting a visit outside the federally required schedule, the resident is exhibiting signs and/or symptoms that require medical attention. In these cases, CMS believes orders will often be required and, thus, expect orders to address the resident's change in condition. Therefore, an NPP may sign the medically required orders. Please remain mindful that the survey and certification requirement that the physician must sign and date all orders remains in effect. (See Q & As 9 & 10.)
- Q12. Why can't a PA, regardless of employment, sign certifications/re-certifications for SNF residents?**
- A12.** Congress amended section 1814(a)(2) of the Social Security Act in 1989. The Social Security Act **specifies** that NPs and CNSs who are not employed by the facility may certify (and recertify) that the services the beneficiary requires may only be performed in the SNF. They did not extend this benefit to PAs. Therefore, by statute, PAs may not sign SNF certifications/re-certifications.
- Q13. If a physician extender is not employed by the NF but is employed by an organization related to the NF, may he/she still provide services in the nursing home?**
- A13.** The requirement in 42 CFR, section 483.40(f), is specific in that the physician tasks may be performed by a NP, PA, or CNS "who is not an employee of the facility." In this case, the NPP is not an employee of the NF and, thus, can perform physician tasks as long as they work in collaboration with the physician.
- Q14. If an NP or CNS is not employed by the SNF but is employed by an organization related to the SNF, may he/she sign the certification and re-certifications?**
- A14.** The requirement in 42 CFR section 424.20(e) is specific in that an NP or CNS "neither of whom has a direct or indirect employment relationship with the facility" may sign the certifications and re-certifications.

## Nonphysician Practitioner Questions and Answers as It Relates to SNF CB (continued)

In this case, the NP or CNS is not an employee, but has an indirect employment relationship and, thus, are not permitted to sign the certifications and recertifications. (Social Security Act section 1814(a)(2)).

**Q15. If physician delegation responsibilities are based on payment source, what are the physician delegation responsibilities for private pay resident, VA contracts or managed care?**

**A15.** If the resident's stay is being paid for by a source other than Medicare or Medicaid AND the resident is residing in a Medicare/Medicaid dually-certified facility, follow the most stringent requirement. If the resident is residing in a Medicare only or a Medicaid only certified facility, then follow the requirements for that specific certified facility.

**Q16 Are NPPs allowed to certify/recertify therapy plans of care under Medicare Part B?**

**A16.** Regulation 42 CFR section 424.24(c)(3) states that if a physician or NPP establishes the plan of care, he/she must also certify the plan of care. If the plan of care is established by a physical or occupational therapist or speech language pathologist, a physician or NPP who has knowledge of the case must sign the plan of care. (This Q & A was **not** addressed in the November 13, 2003, Survey & Certification letter, S&C-04-08.)

Should you have any questions concerning this article, please submit your inquiry via the CMS website as follows:

- 1) Click on Feedback in top tool bar of <http://www.cms.hhs.gov> (from the home page or any page on cms.hhs.gov).
- 2) Select and click "Site Feedback" in last paragraph.
- 3) User should:
  - a) Enter his/her email address.
  - b) At Category, select "Providers" from the drop down menu.
  - c) At the subcategory, select Nursing Home Quality Initiative.
  - d) Enter feedback in space provided.
  - e) Submit feedback.

### Related Instructions

The CMS website contains considerable information regarding SNF billing procedures and NPP billing processes. Some of the specific sites are as follows:

The *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 7 – SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule) may be found at the following

CMS website: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c07.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c07.pdf).

The *Skilled Nursing Facility Manual*, Chapter V (Billing Procedures) is located at the following CMS website: [http://www.cms.hhs.gov/manuals/12\\_snf/sn500.asp](http://www.cms.hhs.gov/manuals/12_snf/sn500.asp).

The *Home Health Agency Manual*, Chapter IV (Billing Procedures) website is located at: [http://www.cms.hhs.gov/manuals/11\\_hha/hh400.asp](http://www.cms.hhs.gov/manuals/11_hha/hh400.asp).

### Additional Information

The CMS Quarterly Provider Update Websites for NPPs for 2004 may be found at: <http://www.cms.hhs.gov/providerupdate/january2004/nonphys.asp>

<http://www.cms.hhs.gov/providerupdate/april2004/nonphys.asp>

<http://www.cms.hhs.gov/providerupdate/July2004/nonphys.asp>

<http://www.cms.hhs.gov/providerupdate/october2004/nonphys.asp>

In addition, the CMS Quarterly Provider Update Websites for NPPs for 2003 may be found at: <http://www.cms.hhs.gov/providerupdate/january2003/nonphys.asp>

<http://www.cms.hhs.gov/providerupdate/april2003/nonphys.asp>

<http://www.cms.hhs.gov/providerupdate/july2003/nonphys.asp>

<http://www.cms.hhs.gov/providerupdate/october2003/nonphys.asp>

### Acronyms

**CFR** – Code of Federal Regulations

**CMS** – Centers for Medicare & Medicaid Services

**CNS** – Clinical nurse specialist

**NF** – Nursing facility

**NP** – Nurse practitioner

**NPP** – Nonphysician practitioner (NPs, CNSs, and PAs are considered NPPs)

**OBRA '90** – Omnibus Budget Reconciliation Act of 1990

**PA** – Physician assistant

**S&C** – Survey & certification

**SNF** – Skilled nursing facility

**VA** – Veterans Administration

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Effective Date: N/A – This is informational only.

Source: CMS Special Edition Medlearn Article SE0418

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# **HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM**

## **July 2005 Update of the Hospital Outpatient Prospective Payment System**

*CMS has issued the following “Medlearn Matters... Information for Medicare Providers” article.*

### **Provider Types Affected**

Providers billing Medicare fiscal intermediaries (FIs) for services paid under the hospital outpatient prospective payment system (OPPS)

### **Provider Action Needed**

#### **STOP – Impact to You**

This article is based on information contained in change request (CR) 3915, which describes changes to the OPPS to be implemented in the July 2005 OPPS update.

#### **CAUTION – What You Need to Know**

Unless otherwise noted, all changes addressed in CR 3915 are effective for services furnished on or after July 1, 2005.

#### **GO – What You Need to Do**

Please see the *Background* and *Additional Information* sections of this instruction for further details regarding the July 2005 OPPS update.

### **Background**

This article is based on information contained in change request (CR) 3915, which describes changes to the OPPS implemented in the July 2005 OPPS update. The July 2005 OPPS outpatient Code Editor (OCE) and OPPS PRICER will reflect additions, changes, and deletions to the following:

- The Healthcare Common Procedure Coding System (HCPCS)
- Ambulatory payment classification (APC)
- HCPCS modifier
- Revenue codes.

Key OPPS changes for July 2005 (unless another date is specified) are described below.

**Note:** July 2005 revisions to the OPPS OCE data files, instructions, and specifications are provided in CR 3871 (Transmittal 572, dated June 1, 2005, subject: “July 2005 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 6.2.”). A Medlearn Matters article (MM3871) is available regarding those changes on the CMS website at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3871.pdf>.

### **1. Smoking and Tobacco-Use Cessation Counseling Services**

CMS determined (effective March 22, 2005) that the evidence is adequate to conclude that smoking and tobacco-use cessation counseling is reasonable and necessary for:

- A patient who has a disease or an adverse health effect that has been found by the U.S. Surgeon General to be linked to tobacco use; or
- A patient taking a therapeutic agent whose metabolism or dosing is affected by tobacco use as based on FDA-approved information.

These individuals will be covered under Medicare Part B when certain conditions of coverage are met, subject to certain frequency and other limitations.

**Note:** Conditions of Medicare Part A and Medicare Part B coverage for smoking and tobacco-use cessation counseling services are summarized in a Medlearn Matters article (MM3834), which is available on the CMS website at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3834.pdf>.

For services furnished on or after March 22, 2005, hospitals should report the following HCPCS codes when billing for smoking and tobacco-use cessation counseling service:

# OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

## July 2005 Update of the Hospital Outpatient Prospective Payment System (continued)

HCPCS	SI	Descriptor	APC
G0375	S	Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes <b>Short Descriptor:</b> Smoke/Tobacco counseling 3-10	1501
G0376	S	Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes <b>Short Descriptor:</b> Smoke/Tobacco counseling greater than 10	1501

**Note:** The above G codes will **not** be active in Medicare systems until July 5, 2005.

### 2. Drugs and Biologicals

#### a. Drugs with Payments Based on Average Sales Price (ASP) Effective July 1, 2005

CR3915 contains an extensive table of the drugs and biologicals whose payments under the OPSS will be established in accordance with the average sales price (ASP) methodology that is used to calculate payment for drugs and biologicals in the physician office setting. To view the table, access CR 3915 on the CMS website by visiting [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

Once at that page, scroll down the CR NUM column on the right and select CR 3915.

The 2005 OPSS Final Rule (Federal Register, Volume 69, Number 219, page 65777 at: <http://edocket.access.gpo.gov/2004/04-24759.htm>, stated that payments for drugs and biologicals based on ASP will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary, CMS will incorporate changes to the payment rates in an appropriate quarterly release of the OPSS PRICER and will not be publishing the updated payment rates in the program instructions implementing the associated quarterly update of the OPSS. However, the updated payment rates can be found in the July update of OPSS Addendum A and Addendum B on the CMS website at <http://www.cms.hhs.gov/providers/hopps/>.

Single-indication orphan drugs payable under OPSS are also listed below. The methodology used to establish payment rates for these drugs is discussed in the 2005 OPSS Final Rule which can be found in Volume 69 of the Federal Register, Number 219, page 65807 (69 FR 65807) on the CMS website at [http://www.cms.hhs.gov/providerupdate/regs/cms1427fc\\_3.pdf](http://www.cms.hhs.gov/providerupdate/regs/cms1427fc_3.pdf).

#### b. Updated Payment Rates for Certain Drugs, Biologicals and Services Effective April 1, 2005 through June 30, 2005

The payment rate for HCPCS J0135 (APC of 1083, Injection, adalimumab, 20mg) was incorrect in the April 2005 OPSS PRICER. The corrected payment rate of \$294.63 will be installed in the July 2005 OPSS PRICER, effective for services furnished on April 1, 2005 through June 30, 2005. Your FI will automatically adjust any claims that were processed to payment between April 1, 2005 and July 1, 2005 that contained J0135 using the corrected payment rate.

#### c. Newly-Approved Drugs and Biologicals Eligible for Pass-Through Status

The following drugs and biologicals have been designated as eligible for pass-through status under the OPSS effective July 1, 2005. Payment rates for these items can be found in the July update of OPSS Addendum A and Addendum B on the CMS website at <http://www.cms.hhs.gov/providers/hopps/>.

HCPCS	APC	SI	Long Description
C9127	9127	G	Injection, paclitaxel protein bound particles, per 1 mg
C9128	9128	G	Injection, pegaptamib sodium, per 0.3 mg
C9129	9129	G	Injection, clofarabine, per 1 mg
J8501*	0868	G	Aprepitant, oral, 5 mg

\*J8501 was approved for pass-through status effective April 6, 2005.

### 3. Medical Nutrition Therapy Services

If a medical nutrition therapy service is provided in the hospital outpatient department, hospitals should bill their local FI using the UB-92 for an evaluation and management code. Hospitals should be reporting CPT codes 97802, 97803, and 97804 for medical nutrition therapy services to Medicare FIs using the UB-92 or its electronic equivalent.

### 4. Reprocessing of OPSS Claims Containing Certain Surgical Procedures

CMS discovered an error in the 2005 OPSS PRICER that miscalculates certain outlier payments. The error has been corrected in the July 2005 version of the OPSS PRICER. To correct prior payments, by September 15, 2005, FIs will reprocess claims that meet **all** of the following criteria using the July 2005 OPSS PRICER:

- Claims processed using the January or April 2005 OPSS PRICER
- Claims with one or more surgical procedure lines (lines with a status indicator of "T" (any HCPCS) or "S" with HCPCS codes greater than 09999 and less than 70000) that contain no surgical procedure lines with charges less than \$1.01
- Claims with dates of service January 1, 2003 or later.

*July 2005 Update of the Hospital Outpatient Prospective Payment System (continued)*

**5. No-Cost Device Coding**

Effective for services furnished on or after April 1, 2005, all hospitals paid under the OPSS must report a code for a device when reporting the code for inserting the device. (See Medlearn Matters article MM3606 on the CMS site at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3606.pdf>.)

If an OPSS hospital fails to report a device code, edits installed in the outpatient code editor (OCE) for services furnished on or after April 1, 2005 will not allow the claim to be processed to payment. For example, if a hospital doesn't report the code for a pacemaker with the CPT code for the procedure performed to insert the pacemaker, OCE edits will cause the claim to be returned to the provider. However, there are occasions when a hospital may furnish a device for surgical insertion for which it incurs no cost. These cases include, but are not limited to, devices replaced under warranty, due to recall, or due to defect in a previous device; devices provided in a clinical trial; or devices provided as a sample. The hospital charge for a device furnished to the hospital at no cost should equal \$0.00.

Some hospitals paid under the hospital outpatient prospective payment system (OPSS) might ordinarily report neither a code nor a charge for a device for which it incurred no cost, which would result in the claim failing the device edits installed in the OCE. Other hospitals have billing systems, which require that a charge be reported for separately payable codes in order for the claim to be submitted for payment, even items for which the hospital incurs no cost.

Hospitals paid under the OPSS have asked that CMS clarify how devices furnished to beneficiaries for whom the hospital incurs no cost should be reported. CMS advises hospitals as follows **for services furnished on or after April 1, 2005:**

- Hospitals paid under the OPSS that surgically implant a device furnished at no cost to the hospital must report the appropriate HCPCS code for the device on TOB 13x.
- Hospitals paid under the OPSS that surgically implant a device furnished at no cost to the hospital must report a charge of zero for the device, or, if the hospital billing system requires that a charge be entered, the hospital must submit a token charge (e.g. \$1.00) on the line with the device code.

Showing a token charge in this circumstance will allow claims for reasonable and necessary services to be paid.

**Implementation**

The implementation date for this instruction is July 5, 2005.

**Additional Information**

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3915 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3915

Related CR Release Date: June 30, 2005

Related CR Transmittal Number: 599

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 599, CR 3915

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**Correction to Termination Date for HCPCS Codes G0297 and G0337**

The Centers for Medicare & Medicaid Services has notified fiscal intermediaries that the July 2005 release to the PPS outpatient code editor (OCE) issued under Change Request 3871, Transmittal 572, on June 1, 2005, assigned OCE edit 69, "Services provided outside of approval period," and lists January 28, 2005, as the termination date for the following two HCPCS codes:

- G0297 Insertion of single chamber pacing cardioverter defibrillator pulse generator
- G0337 Hospice evaluation and counseling services, pre-election

Termination of these codes in the July 2005 release of the OPSS OCE is incorrect. HCPCS code G0297 is a valid code that is recognized under the OPSS. HCPCS code

G0337 is not paid under the OPSS, but may be payable when submitted to regional home health intermediaries by hospice providers.

CMS will correct this error in the October 2005 update of the OPSS OCE.

**No Action Required by Providers Regarding Workaround**

As mandated by CMS, FIs are implementing a workaround **not** to reject claims that contain HCPCS codes G0297 and G0337 with dates of service **on or after January 28 2005**, until the successful implementation of the October 2005 OCE release. ❖

Source: CMS Joint Signature Memorandum 05408, July 7, 2005

## July 2005 Outpatient Prospective Payment System Update to the Outpatient Code Editor

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

### Provider Types Affected

All providers billing outpatient services to Medicare fiscal intermediaries (FIs) that are paid under the outpatient prospective payment system (OPPS)

### Provider Action Needed

This instruction is based on information contained in Change Request (CR) 3871 which 1) informs FIs that the July 2005 OPPS OCE specifications have been updated with new additions, changes, and deletions, and 2) insures that FIs install the updated July 2005 OPPS OCE (Version 6.2) into their systems.

### Background

Full details of version 6.2 of the OPPS OCE are contained in CR 3871 and will not be repeated in this article, especially since many of the details are not changing, and providers paid under the OPPS are likely familiar with these details. The modifications of the outpatient code editor/ambulatory patient classification (OCE/APC) for the July 2005 release (V6.2) are summarized in the following table:

	Mod. Type	Effective Date	Edit	Description
1.	Logic	7/1/05	73	New edit 73 “Incorrect billing of blood and blood products” – RTP (Reason code W7073)  If blood products are billed with revenue code (RC) 39x and modifier BL without a corresponding line billed with RC 38x (same HCPCS, modifier and units), the claim will be returned to the provider unprocessed.
2.				New Payment Adjustment Flags (PAFs)  PAF #5 – Blood/blood product used in blood deductible calculation (Apply to blood product billed with RC 38x and modifier BL)  PAF #6 – Blood processing/storage not subject to blood deductible (Apply to blood product billed with RC 39x and modifier BL).
3.				Make HCPCS/APC/SI and modifier changes, as specified by CMS.
4.	Content		19, 20, 39, 40	Implement version 11.1 of the NCCI file, removing all code pairs which include: anesthesia (00100-01999), E&M (92002-92014, 99201-99499), MH (90804-90911) or drug admin (96400-96450; 96542-96549; 90780,90781)
5.	Content	8/1/00	19, 20, 39, 40	Reinstate CAD codes in NCCI files
6.	Content	7/1/05	22	Add new modifier BL

**Note:** With regard to the new edit 73 (item 1 in the above table), please note that in some circumstances, in order for Medicare to correctly allocate payment for blood processing and storage, providers are required to submit two lines with different revenue codes for the same service when blood products are billed. One line is required with revenue code 39x and an identical line (same HCPCS, modifier, and units) with revenue code 38x. For more details on billing blood products, see the Medlearn Matters article MM3681 on the CMS website at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3681.pdf>.

You should also read through the specifications in the official instruction (CR 3871) issued to your intermediary, and note the highlighted sections, which also indicate changes from the prior release of the software. Some OCE/ APC modifications in the release may also be retroactively added to prior releases.

If so, the retroactive date appears in the “Effective Date” column in the above table.

Attachment B of CR3871 provides a summary of July 2005 data changes that are effective July 1, 2005. It summarizes all of the modifications made to the APC’s, *Current Procedural Terminology (CPT)* codes, APC assignments, status indicators, modifiers, revenue codes and edits to update the OPPS OCE for the July 1, 2005 quarterly release. Key changes are as follows:

### APC Changes

#### Added APC

The following APC of 09129 (Inj clofarabine) with a status indicator of K was added to the OCE/APC, **effective July 1, 2005.**



*July 2005 Outpatient Prospective Payment System Update to the Outpatient Code Editor (continued)*

**APC Description Changes**

The following APCs had description changes, **effective July 1, 2005:**

APC	Old Description	New Description
00769	Ondasetron hcl oral	Ondansetron hcl oral
00869	IVIG lyophil 1G	IVIG lyophil 1g
00870	IVIG lyophil 10 MG	IVIG lyophil 10 mg
00871	IVIG non-lyophil 1G	IVIG non-lyophil 1g
00872	IVIG non-lyophil 10 MG	IVIG non-lyophil 10 mg
09436	Azathioprine parenteral,brnd	Azathioprine parenteral,brand

**APC Status Indicator Changes**

The following APCs had status indicator changes, **effective July 1, 2005:**

APC	Old SI	New SI
09126	G	K
09127	K	G
09128	K	G

**HCPCS/CPT Procedure Code Changes**

Added HCPCS/CPT Procedure Codes

The following new HCPCS codes were added to the OCE/APC, **effective January 1, 2005:**

HCPCS	Code Description	SI	APC	Edit	Activ Date	Term Date
G0375	Smke/Tobacco counseling 3-10	S	01501	68	03/22/2005	
G0376	Smoke/Tobacco counseling >10	S	01501	68	03/22/2005	

The following new HCPCS codes were added to the OCE/APC, **effective April 1, 2005:**

HCPCS	Code Description	SI	APC	Edit	Active Date	Termination Date
K0730	Ctrl dose inh drug deliv sys	Y	00000	61		
K0731	Lith ion batt cid, on body	A	00000	nada		
K0732	Lith ion batt cid behind ear	A	00000	nada		

The following new HCPCS codes were added to the OCE/APC, **effective July 1, 2005:**

HCPCS	Code Description	SI	APC	Edit	Activ Date	Term Date
C9129	Inj clofarabine	K	09129			
Q9958	HOCM <=149 mg/ml iodine, 1ml	B	00000	62		
Q9959	HOCM 150-199mg/ml iodine, 1ml	B	00000	62		
Q9960	HOCM 200-249mg/ml iodine, 1ml	B	00000	62		
Q9961	HOCM 250-299mg/ml iodine, 1ml	B	00000	62		
Q9962	HOCM 300-349mg/ml iodine, 1ml	B	00000	62		
Q9963	HOCM 350-399mg/ml iodine, 1ml	B	00000	62		
Q9964	HOCM >= 400 mg/ml iodine, 1ml	B	00000	62		
S0118	Ziconotide intrathecal 1mcg	E	00000	28		
S0133	Histerlin implant	E	00000	28		
S0145	Peg interferon alfa-2B/10	E	00000	28		
S0146	Peg interferon alfa-2B/10	E	00000	28		
S0198	Inj pegaptanib 0.3 mg	E	00000	28		
S0265	Genetic counsel 15 mins	E	00000	28		
S0613	Ann breast exam	E	00000	28		
S2900	Robotic surgical system	E	00000	28		
S8270	Enuresis alarm	E	00000	28		

**Deleted HCPCS/CPT Procedure Codes**

The following HCPCS/CPT code(s) were deleted from the OCE/APC, **effective July 1, 2005:**

HCPCS	Code Description	Status Indicator	APC
C9126	Injection, natalizumab	E	0

# OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

July 2005 Outpatient Prospective Payment System Update to the Outpatient Code Editor (continued)

## HCPCS Description Changes

The following code descriptions were changed, **effective July 1, 2005**:

HCPCS	Old Description	New Description
C9724	EPS gast cardia plic	EPS gast cardia plic
G9017	Amantadine HCL, oral	Amantadine HCL 100mg oral
G9018	Zanamivir, inh pwdr	Zanamivir, inhalation pwd 10m
G9019	Oseltamivir phosp	Oseltamivir phospate 75mg
G9020	Rimantadine HCL	Rimantadine HCL 100mg oral
G9034	Zanamivir, inh pwdr, brand	Zanamivir powder via inhaler
G9035	Oseltamivir phosp, brand	Oseltamivir phospate 75mg o
G9036	Rimantadine HCL, brand	Rimantadine HCL 100mg
G9043	Low vision rehab therapist	Low vision rehab therapist
Q4079	Injection, natalizumab	Injection, Natalizumab, 1 MG
Q9941	IVIG lyophil 1G	IVIG lyophil 1g
Q9942	IVIG lyophil 10 MG	IVIG lyophil 10 mg
Q9943	IVIG non-lyophil 1G	IVIG non-lyophil 1g
Q9944	IVIG non-lyophil 10 MG	IVIG non-lyophil 10 mg
Q9955	Inj perflexane lip micros, ml	Inj perflexane lip micros,ml
Q9957	Inj perflutren lip micros, ml	Inj perflutren lip micros,ml

## HCPCS Changes- APC, Status Indicator and/or Edit Assignments

The following codes had an APC and/or SI and/or edit change, **effective January 1, 2004 \*\***, and a blank in the field indicates no change:

HCPCS	Code Description	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
J8521	Capecitabine, oral, 500 mg			E	B	28	62

The following codes had an APC and/or SI and/or edit change, **effective April 1, 2004 \*\***, and a blank in the field indicates no change:

HCPCS	Code Description	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
L0960	Post surgical support pads			E	A	28	N/A

The following codes had an APC and/or SI and/or edit change, **effective January 1, 2005 \*\***, and a blank in the field indicates no change:

CPT/ HCPCS	Code Description	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
0064T	Spectroscop eval expired gas	00000	00367	A	X		
0065T	Ocular photoscreen bilat			A	E	N/A	50
E0950	Tray			E	A	13	N/A
E0951	Loop heel			E	A	13	N/A
E0952	Toe loop/holder, each			E	A	13	N/A
K0630	SIO flex pelvisacral prefab			Y	A	61	N/A
K0631	SIO flex pelvisacral custom			Y	A	61	N/A
K0632	SIO panel prefab			Y	A	61	N/A
K0633	SIO panel custom			Y	A	61	N/A
K0634	LO flexibl L1-below L5 pre			Y	A	61	N/A
K0635	LO sag stays/panels pre-fab			Y	A	61	N/A
K0636	LO sagitt rigid panel prefab			Y	A	61	N/A
K0637	LO flex w/o rigid stays pre			Y	A	61	N/A
K0638	LSO flex w/rigid stays cust			Y	A	61	N/A
K0639	LSO post rigid panel pre			Y	A	61	N/A
K0640	LSO sag-coro rigid frame pre			Y	A	61	N/A
K0641	LSO sag-cor rigid frame cust			Y	A	61	N/A
K0642	LSO flexion control prefab			Y	A	61	N/A

# OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

## July 2005 Outpatient Prospective Payment System Update to the Outpatient Code Editor (continued)

CPT/ HCPCS	Code Description	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
K0643	LSO flexion control custom			Y	A	61	N/A
K0644	LSO sagit rigid panel prefab			Y	A	61	N/A
K0645	LSO sagittal rigid panel cus			Y	A	61	N/A
K0646	LSO sag-coronal panel prefab			Y	A	61	N/A
K0647	LSO sag-coronal panel custom			Y	A	61	N/A
K0648	LSO s/c shell/panel prefab			Y	A	61	N/A
K0649	LSO s/c shell/panel custom			Y	A	61	N/A

The following codes had an APC and/or SI and/or edit change, **effective July 1, 2005** \*\*A blank in the field indicates no change:

CPT/ HCPCS	Code Description	Old APC	New APC	Old SI	New SI	Old Edit	New Edit
0017T	Photocoagulat macular drusen	00000	00235	E	T	28	N/A
38204	Bl donor search management			E	N	28	N/A
48554	Transpl allograft pancreas			E	C	14	N/A
59050	Fetal monitor w/report			E	M	14	72
59510	Cesarean delivery			E	B	14	62
93010	Electrocardiogram report			A	B	N/A	62
96549	Chemotherapy, unspecified	00000	00116	N	S		
C9127	Paclitaxel protein pr			K	G		
C9128	Inj pegaptamib sodium			K	G		
E0203	Therapeutic lightbox tabletp			E	A	9	N/A
G0179	MD recertification HHA PT			E	M	14	72
G0180	MD certification HHA patient			E	M	14	72
G0181	Home health care supervision			E	M	14	72
G0182	Hospice care supervision			E	M	14	72
G0250	MD review interpret of test			E	M	28	72
L8620	Repl lithium ion battery			A	E	N/A	28
Q4079	Injection, Natalizumab, 1 G			G	K		

### Units of Service Changes

The following codes were assigned to the following “units of service”, **effective July 1, 2005**:

CPT/	Old Max Units	New Max Units
36430	0	1

### Edit Assignments

The following code was added to edit 67, 68, or 69 **effective October 1, 2003**:

HCPCS	Edit#	Active Date	Termination Date
G0297	69	10/01/2003	01/28/2005

The following code was added to edit 67, 68, or 69 **effective January 1, 2005**:

HCPCS	Edit#	Active Date	Termination Date
G0337	69	01/01/2005	01/28/2005

The following CPT/HCPCS codes were deleted as blood products, **effective July 1, 2005**:

86890 P9041 P9045 P9046 P9047

The HCPCS code C9129 was added to edit 55 “Non Reportable for Site of Service”, **effective July 1, 2005**:

### Modifiers

Modifier BL was added to the list of valid modifiers, **effective July 1, 2005**.

### Implementation

The implementation date for this instruction is July 5, 2005.

## July 2005 Outpatient Prospective Payment System Update to the Outpatient Code Editor (continued)

### Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change.

That instruction may be viewed on the CMS website by going to

[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3871 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your intermediary at their toll-free number found on the CMS website at:

<http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3871

Related CR Release Date: June 1, 2005

Related CR Transmittal Number: 572

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 572, CR 3871

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## Expansion of Various Alpha and Numeric Fields Within the Outpatient Prospective Payment System Outpatient Code Editor

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

### Provider Types Affected

Providers billing fiscal intermediaries (FIs)

### Provider Action Needed

#### STOP – Impact to You

Providers should note that this instruction is based on information contained in Change Request (CR) 3767, which informs FIs that the field byte size for edits, status indicator (SI), payment adjustment flag, and payment indicator in the outpatient prospective payment system (OPPS) outpatient code editor (OCE) are currently limited.

#### CAUTION – What You Need to Know

The OPPS OCE edit, SI, payment adjustment flag, and payment indicator fields will be expanded.

#### GO – What You Need to Do

Please see the Background and Additional Information sections of this instruction for further details regarding these changes.

### Background

The OPPS and non-OPPS OCEs were established to ensure correct payment and implementation of policy decisions related to outpatient institutional provider payments. Due to 1) limited space, 2) the increasing need for additional edits and SIs in the OPPS OCE, the following fields will be expanded/incorporated into the OPPS OCE to accommodate the following:

- The OPPS OCE status indicator (SI) (an alpha field) will be expanded to two bytes.
- The OPPS OCE edit field (a numeric field) will be expanded to three bytes.

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- The OPPS OCE payment indicator (a numeric field) will be expanded to two bytes.

- The OPPS OCE payment adjustment flag numeric field will be a two-position field.

### Implementation

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

### Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change.

That instruction may be viewed at:

[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3767 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at:

<http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3767

Related CR Release Date: July 12, 2005

Related CR Transmittal Number: 602

Effective Date: October 1, 2005

Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 602, CR 3767



## Clarifying Manual Instructions for Coding and Payment for Drug Administration Under the Hospital Outpatient Prospective Payment System

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

### Provider Types Affected

Physicians and providers billing services paid under the OPPTS to Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs)

### Provider Action Needed

#### STOP – Impact to You

This article includes information from Change Request (CR) 3848, which implements revisions to the Medicare Claims Processing Manual (Pub 100-04), Chapter 4 (Part B Hospital [Including Inpatient Hospital Part B and OPPTS]), Section 230 (Billing and Payment for Drugs and Biologicals).

#### CAUTION – What You Need to Know

It is important to note that there are no new instructions being communicated with CR 3848. The Centers for Medicare & Medicaid Services (CMS) has only clarified information in existing policies related to drug administration.

#### GO – What You Need to Do

See the Background and Additional Information sections of this article for further details regarding the Medicare manual update.

### Background

CR 3848 clarifies portions of Section 230 in the Medicare Claims Processing Manual, Pub 100-04, Chapter 4, titled “Billing and Payment for Drugs and Biologicals”. Various subsections have been revised or created for this manual update as listed in the following table:

Revised (R) & New (N)	Chapter/Section/Sub-Section/Title
R	4/Table of Contents
R	4/230/Billing and Payment for Drugs and Drug Administration
R	4/230.1/Coding and Payment for Drugs and Biologicals
N	4/230.1.1/Separately Payable Drugs
N	4/230.1.2/Packaged Drugs
N	4/230.1.3/Pass-Through Drugs
N	4/230.1.4/Non-Pass Through Drugs
N	4/230.2/Coding and Payment for Drug Administration
N	4/230.2.1-General
N	4/230.2.2/Administration of Chemotherapy Drugs by Infusion
N	4/230.2.3/Administration of Chemotherapy Drugs by a Route Other Than Infusion
N	4/230.2.4/Administration of Non-Chemotherapy Drugs by Infusion
N	4/230.2.5/Administration of Non-Chemotherapy Drugs by a Route Other Than Infusion
N	4/230.2.6/Use of Modifier 59
N	4/230.2.7/Billing for Infusion Hours

CR 3848 instructs FIs and RHHIs to follow the reorganized instructions in Pub. 100-04, Chapter 4, Section 230.

**Note:** There are no new instructions being communicated with CR 3848.

### Implementation

The implementation date for this instruction is June 1, 2005.

### Additional Information

In addition to the clarifications, CMS has provided some examples to help providers better understand the drug administration policies. The examples further explain the following:

- Administration of Chemotherapy Drugs by Infusion (Section 230.2.2)
- Administration of Non-Chemotherapy Drugs by Infusion (Section 230.2.4)
- Use of Modifier 59 (Section 230.2.6)
- Billing for Infusion Hours (Section 230.2.7)

The revised portions of the Medicare Claims Processing Manual are attached to CR 3848, which is the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to:

[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3848 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3848

Related CR Release Date: June 3, 2005

Related CR Transmittal Number 573

Effective Date: January 1, 2005

Implementation Date: June 1, 2005

Source: CMS Pub. 100-4, Transmittal 573, CR 3848

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# PROVIDER AUDIT ISSUES

## Inflation Factor for Reasonable Compensation

The Centers for Medicare & Medicaid Services (CMS) has added section 905.6 – Inflation Factor to the Part 1 of the *Medicare Provider Reimbursement Manual*. Section 905.6 provides the calendar year inflation factors from 1995 through 2004.

The inflation factor rates are obtained from the cost category of professional fees for non-medical in the CMS prospective payment system hospital input price index. The data in the input price index is taken from actual data for the most recent year from the employment cost index for professional and technical workers published by the Bureau of Labor Statistics.

Intermediaries apply an inflation factor to update ranges of reasonable compensation determined for previous years. CMS furnished and annual calendar year inflation factor for this purpose. Following are the CY factors for recent years:

1995 – 2.6 percent	1996 – 3.1 percent	1997 – 2.6 percent	1998 – 3.3 percent	1999 – 2.8 percent
2000 – 4.5 percent	2001 – 4.7 percent	2002 – 3.0 percent	2003 – 3.4 percent	2004 – 4.3 percent.

CMS will revise this section as new inflation factors become available. ❖

Source: Medicare Provider Reimbursement Manual – Part 1, Transmittal 428, June 2005

## Update to the Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and the Hospice PRICER for Fiscal Year 2005

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

### Provider Types Affected

Medicare hospices

### Provider Action Needed

This instruction provides hospices with information on the annual update as follows:

- The hospice payment rates for fiscal year (FY) 2005 will be the FY 2004 payment rates increased by 3.3 percentage points.
- The hospice cap amount for the cap year ending October 31, 2004 is \$19,635.67.
- The hospice wage index notice was published in the *Federal Register* on October 1, 2004 and was effective on that date.

### Background

The law governing the payment for hospice care requires annual updates to the hospice payment rates. The payments for hospice care for fiscal years after 2002 will increase by the market basket percentage increase for the fiscal year (Social Security Act, Section 1814(i)(1)(C)(ii)), and the payment methodology has been codified in regulations found at 42 CFR section 418.306(a)(b).

### Hospice Payment Rates

The **hospice payment rates** for FY 2005 will be the FY 2004 payment rates, increased by 3.3 percentage points. This is the total market basket percentage increase forecasted for FY 2005, and the payment rates are effective for care and services furnished on or after October 1, 2004 through September 30, 2005.

The national payment rates for revenue codes 0651, 0652, 0655, and 0656 for October 1, 2004 through September 30, 2005 are listed in the following table. The Medicare fiscal intermediary must adjust these revenue codes based on the beneficiary’s locality.

Code	Description	Rate	Wage Component Subject to Index	Non-weighted Amount
651	Routine Home Care	\$121.98	\$83.81	\$38.17
652	Continuous Home Care Full Rate = 24 hours of care \$29.66 hourly rate	\$711.92	\$489.16	\$222.76
655	Inpatient Respite Care	\$126.18	\$68.30	\$57.88
656	General Inpatient Care	\$542.61	\$347.32	\$195.29

**Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and the Hospice PRICER for Fiscal Year 2005 (continued)****Hospice Cap**

The **hospice cap** amount is increased or decreased, for accounting years after 1984, by the same percentage as the percentage increase or decrease, respectively, in the medical care expenditure category of the consumer price index for all urban consumers.

- The hospice cap amount for the cap year ending October 31, 2004 is \$19,635.67.

**Hospice Wage Index**

The **hospice wage index** is used to adjust payment rates to reflect local differences in wages according to the revised wage index, and it is updated annually in accordance with recommendations made by a negotiated rulemaking advisory committee. The hospice wage index notice will be effective October 1, 2004 and was published in the *Federal Register* on that date.

**Related Instructions**

The Medicare Claims Processing Manual (Pub 100-04), Chapter 11 (Processing Hospice Claims), Section 30 (Billing and Payment for General Hospice Services), Subsection 30.2 (Payment Rates) and Section 80 (Caps and Limitations on Hospice Payments), Subsection 80.2.3 (Adjustments to Cap Amount) are being revised.

The updated manual instructions are included in the official instruction issued to your contractor, and may be found by going on the CMS website to [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3386 in the CR NUM column on the right, and click on the file for that CR.

**Additional Information**

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

Related Change Request (CR) Number: 3386

Related CR Release Date: July 15, 2005

Related CR Transmittal Number: 606

Effective Date: October 1, 2004

Implementation Date: October 4, 2004

Source: CMS Pub. 100-606, Transmittal 606, CR 3386

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# **FRAUD AND ABUSE**

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## **Office of Inspector General Reports Progress Against Waste, Abuse and Fraud**

The Department of Health & Human Services (HHS) Office of Inspector General (OIG) has completed the Semiannual Report to Congress for the first half of fiscal year (FY) 2005. The report, sent to HHS and Congress, describes OIG investigations and evaluation and audit reports finalized during the reporting period. This publication is an important indicator of the progress OIG has made and the challenges the Department faces in achieving greater economy and efficiency.

For the first half of FY 2005, OIG reported savings and expected recoveries of nearly \$17 billion: \$15.6 billion in implemented recommendations and other actions to put funds to better use, \$266 million in audit receivables, and \$1.1 billion in investigative receivables.

Also for this reporting period, OIG reported exclusions of 1,695 individuals and entities for fraud or abuse of federal health care programs and/or their beneficiaries; 258 criminal

actions against individuals or entities that engaged in crimes against departmental programs; and 105 civil actions, which include False Claims Act and unjust enrichment suits filed in district court, Civil Monetary Penalties Law settlements, and administrative recoveries related to provider self-disclosure matters.

OIG continues to be an aggressive force within HHS to improve the efficiency of the Department and to punish those who defraud its programs. This office is dedicated to maintaining public credibility of our vital programs. Details of some of the activities are contained in the U.S. Department of Health & Human Services Office of Inspector General Semiannual Report to the Congress available at <http://oig.hhs.gov/publications/docs/semiannual/2005/SemiannualSpring05.pdf>. ❖

Source: Office of Inspector General News, June 13, 2005

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## **CMS Efforts to Identify Medicare and Medicaid Improper Payments**

On July 13, 2005, Tim Hill, director of the Centers for Medicare & Medicaid Services Financial Management, presented a testimony before the Senate Homeland Security and Governmental Affairs Subcommittee, Federal Financial Management, Government Information and International Security Hearing on CMS efforts to identify incorrect or erroneous payments in the Medicare and Medicaid programs. A full-text of Tim Hill testimony may be found on the CMS website at <http://www.cms.hhs.gov/media/press/release.asp?Counter=1504>. ❖

Source: CMS Office of Financial Management Testimony

*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.*



# THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

## Correction to the Use of Group Codes for the Enforcement of Mandatory Electronic Submission of Medicare Claims

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

### Provider Types Affected

All physicians, providers and suppliers who bill Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs)

### Provider Action Needed

Providers and suppliers need to be aware of the Administrative Simplification Compliance Act (ASCA) that requires all expenses for items and services billed to the Medicare program be submitted electronically.

Unless there is an exception in place for a given provider, paper claims will be denied.

### Background

Section 3 of the ASCA, PL107-105, and the implementing regulation at 42 CFR 424.32, requires you—with limited exceptions—to submit all your initial claims for reimbursement under Medicare electronically, on or after October 16, 2003. Further, ASCA amendment to Section 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare program for any expenses incurred for items or services" for which a claim is submitted in a nonelectronic form.

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## Access Process for Beneficiary Eligibility Inquiries/Replies (HIPAA 270/271 Transactions) (Extranet Only)

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

### Provider Types Affected

All physicians, providers, and suppliers billing Medicare

### Provider Action Needed

#### STOP – Impact to You

This article is based on information from Change Request (CR) 3883, which states that the Centers for Medicare & Medicaid Services (CMS) is making changes to its information technology (IT) infrastructure. The goal is to address standards for Medicare beneficiary eligibility inquiries to create the necessary database and infrastructure to provide a centralized Health Insurance Portability and Accountability Act (HIPAA) compliant 270/271 health care eligibility inquiry and response on a real-time transaction.

#### CAUTION – What You Need to Know

In June 2005, only clearinghouses, certain providers and trading partners will be permitted to send 270 transactions via the Extranet, a secure, closed, and private network used

### Additional Information

The official instruction issued to your intermediary/carrier regarding this change may be found at:

[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3815 in the CR NUM column on the right, and click on the file for the desired CR.

For additional information relating to this issue, please refer to your local FI, carrier, RHHI or DMERC.

Their toll free phone numbers may be found at:

<http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3815

Related CR Release Date: April 29, 2005

Related CR Transmittal Number: 541

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 541, CR 3815

to transmit data between Medicare carriers and intermediaries and CMS. CMS expects to provide limited access via the Internet for 270/271 transactions later this year.

### GO – What You Need to Do

See the Background and Additional Information sections of this article for further details regarding these changes and manual revisions that explain how this access will work.

### Background

Change Request (CR) 3883 states that CMS is making changes to its IT infrastructure to address standards for Medicare beneficiary eligibility inquiries. This IT change will create the necessary database and infrastructure to provide a centralized HIPAA-compliant 270/271 beneficiary health care eligibility inquiry and response in real-time.

Not only will these changes satisfy the current demand for a fully functioning HIPAA-compliant 270/271 eligibility

## ELECTRONIC DATA INTERCHANGE

### Access Process for Beneficiary Eligibility Inquiries/Replies (HIPAA 270/271 Transactions) (Extranet Only) (continued)

transaction for fee for service providers/submitters, they will also support (over time) a national provider telephone interactive voice response (IVR) as well as Internet eligibility queries.

The new infrastructure will support the 270/271 for Medicare and will use a central national Medicare eligibility database in processing these queries bypassing the current:

- Carriers,
- Durable medical equipment regional carriers (DMERCs), and
- Fiscal intermediaries (FIs).

However, Medicare plans to continue to use the provider newsletters and web sites of the carriers, DMERCs, and FIs to share information on availability, enrollment, Internet use, and other pertinent information about the 270/271 as developments warrant.

The 270/271 implementation guide adopted for national use under HIPAA can be obtained at the Washington Publishing Co. website at: <http://www.wpc-edi.com/HIPAA>.

A provider that prefers to obtain eligibility data in an electronic data interchange (EDI) format, but does not want to use the 270/271 Version 4010, may contract with a clearinghouse to translate the information on its behalf; however, that provider would be liable for those clearinghouse costs.

#### Access Process for Clearinghouses/Provider

To obtain access to the MDCN via the extranet, Clearinghouses and Providers must complete the 270/271 Access Form that can be found on the CMS website at <http://www.cms.hhs.gov/it>.

The 270/271 access form should be completed in full and submitted electronically. The electronic submitted form will be directed to both CMS staff and the CMS' Medicare Eligibility Integration Contractor (MEIC).

The CMS staff will ensure that all of the necessary information is provided on the form, as well as ensure the complete connectivity to the 270/271 application. The MEIC will be responsible for contacting the clearinghouses, providers, and trading partners to authenticate the accessing entity's identity.

Once authentication has been completed, the MEIC will provide the clearinghouses, providers, and trading partners with a submitter ID that is required to be used on all 270/271 transactions. Testing will be coordinated by the MEIC.

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After successful testing, 270 production inquiries may be sent real-time.

**Note:** To access the MDCN, an entity must on its own obtain the necessary telecommunication software from the AT&T reseller. The current AT&T resellers are:

- IVANS: <http://www.ivans.com>
- McKesson: <http://www.mckesson.com>

#### Future Requirement

CMS is developing an attestation that all clearinghouses and providers will be required to agree to provisions concerning adherence of the HIPAA Privacy and Security Rule. This attestation will be available for review through the Paperwork Reduction Act process and will be available for public comment in the near future.

#### Implementation

The implementation date for this instruction is August 22, 2005.

#### Additional Information

For complete details, including a list of data elements that will be provided in response to the 270 transaction, please see the official instruction issued to your Medicare carrier, including DMERCs, or FI regarding this change. That instruction may be viewed by going to [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3883 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3883

Related CR Release Date: June 15, 2005

Related CR Transmittal Number: 583

Effective Date: May 20, 2005

Implementation Date: August 22, 2005

Source: CMS Pub. 100-4, Transmittal 583, CR 3883

## ASCA Enforcement of Mandatory Electronic Submission of Medicare Claims—Important Information for Paper Claim Submitters

The provision of the Administrative Simplification Compliance Act (ASCA) requiring electronic submission of all initial claims with limited exceptions, for reimbursement under Medicare has been in effect since October 16, 2003. Change Request 3440 implemented the enforcement of this provision for which its amendment to Section 1862(a) of the Act, prescribes that ‘no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services’ for which a claim is submitted in a non-electronic form.

Providers who have not converted to electronic submission need to:

- Perform a self-assessment to determine if you meet one of the exceptions outlined in the related Medlearn Matters article which can be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3440.pdf>.
- If you determine you meet an exception that qualifies for submission of paper claims, no further action is necessary at this time. Please do not submit documentation supporting your determination in the absence of a request from this office.
- If you determine you do not qualify for continued submission of paper claims, free HIPAA compliant billing software for submission of Medicare claims is available from our office.

There are also commercial billing software, billing agent, and clearinghouse services available that often include services other than Medicare billing and may better meet your needs.

- When you receive a ‘Review of Paper Claims Submission Practices’ letter, you **must** respond within

30 calendar days from the date of the letter with documentation demonstrating your eligibility to continue to submit paper claims to Medicare.

- If a response to this letter is **not** received within 30 days of the date of the letter or, if you do respond and your response **does not establish** your eligibility to submit paper claims, the contractor will notify you by mail that Medicare will deny any paper claims that you submit more than 90 calendar days after the date of the initial request letter. **This Medicare decision is not subject to appeal.**
- If the response to the letter **does** establish your eligibility to submit paper claims, the contractor will notify you by mail that you meet one or more of the exception criteria to submit paper claims. If your situation changes to the point that you no longer meet the exception criteria, you will be required to start submitting your claims electronically within 90 calendar days from that change in your status.

Information regarding the free HIPAA-compliant billing software, PC-ACE Pro32® and the necessary forms to obtain the software can be found on our website at:

<http://www.fcso.com/customers/providers.shtml>.

If you are interested in commercial billing software, billing agent, or clearinghouse services, a list of HIPAA vendors can be found in the EDI section of our website at: <http://www.floridamedicare.com>.

If you have questions about electronic claim submission, you may contact Medicare EDI at (904) 791-8767, option 1. ❖

Source: CMS Pub. 100-4, Transmittal 450, CR 3440

This material provides a basic overview of the consumer privacy protection rules adopted by the United States Department of Health and Human Services in conformance with the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996. This material does not interpret these rules or attempt to apply the rules to your particular circumstances. The information provided is (1) for your information only, (2) subject to change without notice, and (3) provided “as is” without warranty of any kind, expressed or implied. FIRST COAST SERVICE OPTIONS, INC. DISCLAIMS RESPONSIBILITY FOR ANY CONSEQUENCES OR LIABILITY ATTRIBUTABLE TO OR RELATED TO ANY USE, NON-USE, OR INTERPRETATION OF INFORMATION CONTAINED OR NOT CONTAINED IN THIS MATERIAL. FIRST COAST SERVICE OPTIONS, INC. DISCLAIMS ANY LIABILITY FOR ANY DIRECT, SPECIAL, INDIRECT, INCIDENTAL, OR CONSEQUENTIAL LOSSES OR DAMAGES RELATED TO THE ACCURACY OR COMPLETENESS OF THIS MATERIAL. The information provided is no substitute for your own review and analysis of the relevant law.

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## ELECTRONIC DATA INTERCHANGE

### Standard Paper Remittance Advice

If you are currently receiving the standard paper remittance (SPR) advice, consider utilizing the technology available to increase productivity by switching to the electronic remittance advice (ERA).

Take advantage of faster communication, payment information, and reduction of paperwork by receiving the ERA.

If you are receiving both an SPR and ERA, consider canceling the SPR. Please contact our EDI department today at **1-904-791-8767, option 1**, and ask to receive the ERA, and/or cancel the SPR today. ❖

Source: Source: CMS Joint Signature Memorandum 05378, June 10, 2005

**Reporting of Add-on-Payments that Do Not Result in a Specific Increase or Decrease in the Amount Reported as Payable on a Remittance Advice**

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

**Provider Types Affected**

Providers billing Medicare fiscal intermediaries (FIs)

**Provider Action Needed**

This instruction is informational for providers so they will be aware of corrections that Medicare FIs will make generating remittance advice notices.

**Background**

Currently, FIs report add-on-payment(s) such as new technology as additional payments, in the Claim/Service Adjustment Segments (CAS) of Medicare remittance advice transactions when the additional payment is already included in the allowed amount. This results in the double counting of those amounts and creates an out-of-balance situation usually corrected by forcing the balance with an offsetting entry in the same amount with code A7 (presumptive payment adjustment).

This instruction clarifies how Medicare FIs should report add-on-payments on a remittance advice to avoid an out-of-balance situation.

Effective October 1, 2005, FIs must report add-on-payments that do not result in payment of a supplement in addition to the reported allowed amount, in the appropriate claim or service level **AMT segment**, not in a CAS segment. Data reported in any AMT segment is excluded from remittance advice balancing calculations.

Add-on payments are "Internal" adjustments, actions that factor into the adjudication of a claim. These adjustments do not result in an increase or a decrease in the payment calculated as due for a particular claim or service contained in a remittance advice, but they may affect:

- The reported allowed amount; or
- The payment issued to the provider for the claims reported upon in a remittance advice.

"Internal" adjustments (which the Medicare's Fiscal Intermediary Shared System (FISS) includes in the allowed amount) currently include the items listed below. (FISS is the system Medicare uses to process claims submitted to FIs.) The Centers for Medicare & Medicaid (CMS) now requires FIs to show the add-on payments in the appropriate AMT segment according to the following guidelines:

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- Inpatient cost outlier – qualifier ZZ
- Hemophilia – qualifier ZK
- New technology, and electroconvulsive therapy supplements – qualifier ZL

FISS will ensure that these amounts are not entered in the CAS segment and are not included in the balancing calculation.

**Additional Information**

Look for the updated companion document (including information about electroconvulsive therapy (ECT) in AMT02 field) at:

<http://www.cms.hhs.gov/providers/edi/hipaadoc1.asp>.

The flat file spreadsheet may also be found at the same website.

The wording in Medicare Claims Processing Manual, Chapter 22, Section 20 has now been revised to clarify the X12 835 implementation guide expectations and the CMS requirement for the reporting of these "internal" adjustments. That revision is attached to the official instruction (CR 3866) issued to your FI regarding this change. CR 3866 may be found at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3866 in the CR NUM column on the right, and click on the file for that CR.

For additional information relating to this issue, please refer to your local FI. Find the toll free phone number for your local FI at:

<http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3866

Related CR Release Date: May 2, 2005

Related CR Transmittal Number: 555

Effective Date: October 1, 2005

Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 555, CR 3866

**Remittance Advice Remark Code/Claim Adjustment Reason Code Update**

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

**Provider Types Affected**

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries, regional home health intermediaries [RHHIs], and durable medical equipment regional carriers [DMERCs]) for services

**Provider Action Needed****STOP – Impact to You**

The complete list, including changes made from November 1, 2004 through February 28, 2005, of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 Health Care Claim Adjustment Reason Codes may be found at:

<http://www.wpc-edi.com/codes>.



*Remittance Advice Remark Code/Claim Adjustment Reason Code Update (continued)*

**CAUTION – What You Need to Know**

Please refer to the Additional Information section of this article for remark and reason code changes approved February 28, 2005.

**GO – What You Need to Do**

Be sure your staff is aware of these changes.

**Background**

Two code sets, reason and remark code sets, must be used to report payment adjustments, appeal rights, and related information for transactions 835 (Health Care Claim Payment/Advice), 837 Coordination of Benefits (COB), and on standard paper remittance advice. Medicare contractors must use currently valid codes. An updated code list is published three times per year. Medicare contractors are informed of these changes through recurring code updates (such as this article and corresponding CR 3923), and/or through a specific CR that describes the change in policy that resulted in the code change.

**The remittance advice remark code list** is maintained by CMS. However additions, deactivations, and modifications to the code list may be initiated by Medicare and non-Medicare entities.

- Medicare contractors must use **modified codes** for codes currently used by Medicare even if the modification was initiated by an entity other than Medicare.
- Medicare contractors do not have to use **new codes** initiated by an entity other than Medicare, unless otherwise instructed by Medicare.
- Medicare contractors must stop using a code that has been deactivated either by the effective date of deactivation, or the effective date established by the code update CR.

**The health care claim adjustment reason code list** is maintained by a national code maintenance committee that meets three times a year when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes. This updated list is posted thrice per year.

- Reason code changes requested by Medicare may be included in a Medicare instruction in addition to the regular code update notification.
- Reason codes may be retired if they are no longer applicable, or if a similar code exists.
- Retirements are effective for a specified future and succeeding versions, but Medicare contractors can also discontinue use of retired codes in prior versions.
- The regular code update notification will establish the deadline for Medicare contractors to retire a reason code that could be earlier than the version specified in the Washington Publishing Company (WPC) posting.

**Remark and Reason Code Changes**

Remark and reason code changes approved by Medicare February 28, 2005 include:

<b>Code Type</b>	<b>Code</b>	<b>New/Modified/Deactivated/Retired</b>	<b>Current Narrative</b>	<b>Comment</b>
Remark	N345	New	Date range not valid with units submitted	Not Medicare Initiated
Remark	N346	New	Missing/incomplete/invalid oral cavity designation code	Not Medicare Initiated
Remark	N347	New	Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.	Medicare Initiated
Remark	MA100	Modified	Missing/incomplete/invalid date of current illness or symptoms	Modified effective as of March 30, 2005
Remark	MA128	Modified	Missing/incomplete/invalid FDA approval number	Modified effective on March 30, 2005
Reason	166	New	These services were submitted after this payer’s responsibility for processing claims under this plan ended.	New as of February, 2005

**Note:** Typographic errors were also identified and corrected in reason codes 52, 57, 70, 76 and 146. No codes were retired.

## Remittance Advice Remark Code/Claim Adjustment Reason Code Update (continued)

### Additional Information

For additional information about remittance advice, please refer to:

Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers at [http://www.cms.hhs.gov/medlearn/RA\\_Guide\\_05-27-05.pdf](http://www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf).

The official instruction issued to your FI/carrier/DMERC/RHHI regarding this change may be found by going to [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3923 in the CR NUM column on the right, and click on the file for that CR.

Please refer to your local Medicare contractor for more information about this issue. To find the toll free phone number, go to CMS website <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

Related Change Request (CR) Number: 3923

Related CR Release Date: July 22, 2005

Related CR Transmittal Number: 609

Effective Date: October 1, 2005

Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 609, CR 3923

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## Understanding the Remittance Advice Guide now Available

A reference document title *Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers and Billers* is now available on the Medicare Learning Network's (Medlearn) Web page located on the CMS website at: [http://www.cms.hhs.gov/medlearn/RA\\_Guide\\_05-27-05.pdf](http://www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf).

Chapter 1 and 2 describe a remittance advice (RA) and the components of an RA. For institutional providers, Chapter 3 includes a sample electronic remittance advice (ERA) and standard paper remittance (SPR) advice with field descriptions. Chapter 4 includes a crosswalk between ERA and SPR fields and a sample SPR with field descriptions, specifically for professional providers. At the end of Chapter 3 and 4, providers can find information on remittance balancing.

### Print the chapter that fits your needs!

The guide also includes informative resources such as an acronym list, a glossary, and important websites and phone numbers.

Finally, the guide has three comprehensive indexes for:

- 1) key terms and concepts
- 2) institutional ERA and SPR field descriptions
- 3) professional SPR field descriptions.

Check this website today. ❖

Source: CMS Joint Signature Memorandum 05378, June 10, 2005

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## CMS Releases New Educational Guide on Remittance Advice Notices

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

### Provider Types Affected

All Medicare physicians, providers, suppliers, and their billing staff who submit claims to Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs)

### Provider Action Needed

This special edition article describes the release of a national educational guide for Medicare-fee-for-service (FFS) providers, physicians, suppliers and their billing staff who may wish to use the guide to help increase their understanding of the remittance advice (RA). The Guide is available on the CMS website at [http://www.cms.hhs.gov/medlearn/RA\\_Guide\\_05-27-05.pdf](http://www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf).

### Background

The Medicare FFS program serves many of the more than 40 million Medicare beneficiaries enrolled in the Medicare program. Under this program, more than one

billion claims are submitted annually for reimbursement of health care services. The Medicare contractors, FIs, RHHIs, carriers, and DMERCs process the claims. These Medicare contractors use the standard remittance advice (RA) as their means to communicate to providers claim processing decisions regarding payments, adjustments, and denials, as well as data that was missing or incorrect on the incoming claims that need to be submitted or corrected before a payment decision can be made on a claim.

Every day Medicare FFS contractors send thousands of RAs to providers. Each of these RAs conveys information that may impact the provider's Medicare business. CMS wants to be certain that providers understand how to read and interpret the RA; therefore, CMS has developed and is pleased to announce the release of *Understanding the Remittance Advice: A Guide for Medicare Providers, Physician, Suppliers and Billers*. This educational guide has useful information that is designed to be used as a self-help tool.

***CMS Releases New Educational Guide on Remittance Advice Notices (continued)***

The Guide offers the user the following benefits:

- Easy access to general information about RAs without direct personal assistance from Medicare contractor customer service staff, thus saving valuable time.
- Increased ability to understand and interpret the reasons for claim denials and claim adjustments.
- Reduction in the resubmission of claims due to errors.
- Rapid follow-up action, resulting in quicker payment.
- A useful tool for training new staff or a refresher for experienced staff.

The Guide is comprised of four chapters each highlighting a specific aspect of the RA, an acronym list, a glossary, important websites and phone numbers, and three comprehensive indices: 1) for key terms and concepts; 2) for institutional ERA and SPR field descriptions; 3) professional SPR field descriptions. Each chapter and/or section of the Guide can be printed according to the provider's specific needs.

**Print What Fits Your Needs**

- **Chapters 1 and 2** describe a RA and its components.
- **Chapter 3** specifically targets institutional providers i.e., those who submit claims to FIs and RHHIs and includes a sample electronic remittance advice (ERA) and standard paper remittance (SPR) advice with field descriptions.

- **Chapter 4** targets providers that submit claims to carriers and DMERCs and includes a crosswalk between ERA and SPR fields and a sample SPR with field descriptions, specifically for professional providers. At the end of Chapters 3 and 4, providers can find information on remittance balancing.
- **Reference A: Acronyms**, a handy tool that contains acronyms used throughout the Guide.
- **Reference B: Glossary**, a list that contains terms used throughout this Guide.
- **Reference C: Websites and Phone Numbers**, a list of Web page references and address and phone number references that assist with submitting Medicare claims and troubleshooting denials and claim rejections.
- **Reference D: Resources**, a list of the resources that were used to compile the Guide and where to find them on the CMS website.

**Additional Information**

Print copies of the Guide will be available late summer of 2005. Until print copies are available *Understanding the Remittance Advice: A Guide for Medicare Providers, Physician, Suppliers and Billers* may be accessed electronically on the CMS website at [http://www.cms.hhs.gov/medlearn/RA\\_Guide\\_05-27-05.pdf](http://www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf).

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Article SE0540

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# EDUCATIONAL RESOURCES

## Join our FCSO eNews Electronic Mailing List and Receive Notices of Updates to [www.FloridaMedicare.com](http://www.FloridaMedicare.com)

**Note:** The following article was published in the Third Quarter 2005 Medicare A Bulletin (page 137). In that article, the name of the domain was printed incorrectly. The correct domain name is **'lb.bcentral.com'**. We apologize for any inconvenience this may have caused.

### First Time Subscribers

We encourage you to register for our *eNews* mailing lists to receive urgent, critical, and new information affecting the Medicare program.

By signing to our *eNews*, you will receive regular messages providing you with updates to the provider website ([www.floridamedicare.com](http://www.floridamedicare.com)) and key program alerts, critical program changes, seminar schedules, publications, and educational tips. Sign up today by clicking on the link below then 'FCSO eNews Lists/Interest Groups' link and select the desired interest group from the list.

[http://www.floridamedicare.com/provider/content/special/mailling\\_list.htm](http://www.floridamedicare.com/provider/content/special/mailling_list.htm)

If you have previously signed up and are not receiving regular *eNews* notices, please sign up again. If you do not receive a confirmation email and/or start to receive weekly notices the following information may assist you resolving your issues.

### Previously Signed Up but Not Receiving Regular Notices—Solutions Organizations:

Because some organizations have enhanced their firewalls or security settings, we may not be able to successfully deliver our *eNews* notices to individuals within those organizations. Please check with your organization's IT

staff to determine how they can identify our organization as an approved sender to your individual e-mail address. We recommend requesting them to ensure that mail from the **'lb.bcentral.com'** domain be permitted.

The same recommendation applies to some e-mail providers.

### Email Providers (Internet Service Providers [ISPs])

E-mail providers like AOL, Yahoo!, Hotmail, and others are constantly changing their methods to classify e-mail. Our system delivers e-mail to all accounts the same way, and the vast majority gets it in their main inbox. Some e-mail providers filter messages based on the 'From' address and may put your e-mail into the recipient's bulk or spam mail folder. We recommend that you add **'lb.bcentral.com'** domain to your 'Approved Sender' list. If your e-mail service provider does not offer such 'Approved Sender' lists, please request from them to allow notices from **'lb.bcentral.com'** domain to be delivered.

### Still Experiencing Problems

If you are still experiencing problems not receiving FCSO *eNews* notices, we ask that you please send an email to us at [providerwebsite@fcsoc.com](mailto:providerwebsite@fcsoc.com) indicating the actions you've taken and the issues you continue to experience. We will contact you to assist with resolving them.

*Please pass this information along to other interested parties.*

## CMS Quarterly Provider Update

The July 2005 *Quarterly Provider Update* is now available on the Centers for Medicare & Medicaid Services (CMS) website.

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

- Inform providers about new developments in the Medicare program.
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions.
- Ensure that providers have time to react and prepare for new requirements.

- Announce new or changing Medicare requirements on a predictable schedule.
- Communicate the specific days that CMS business will be published in the *Federal Register*.

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

The *Quarterly Provider Update* may be accessed at <http://www.cms.gov/providerupdate/main.asp>.

We encourage you to bookmark this website and visit it often for this valuable information. ❖

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

*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.



**ORDER FORM - PART A MATERIALS**

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NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
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*NOTE: The Medicare A Bulletin is available free of charge online at [www.floridamedicare.com](http://www.floridamedicare.com).*

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**Addresses****CLAIMS STATUS****Coverage Guidelines****Billing Issues Regarding****Outpatient Services, CORE, ORF, PHP**

Medicare Part A Customer Service  
P. O. Box 2711  
Jacksonville, FL 32231-0021

**PART A REDETERMINATION**

Medicare Part A Redetermination and Appeals  
P. O. Box 45053  
Jacksonville, FL 32232-5053

**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**

Auto/Liability Department – 17T  
P. O. Box 44179  
Jacksonville, FL 32231-4179

**PROVIDER EDUCATION**

Medicare Education and Outreach  
P. O. Box 45157  
Jacksonville, FL 32232-5157

**Seminar Registration Hotline**

1-904-791-8103

**ELECTRONIC CLAIM FILING “DDE Startup”**

Direct Data Entry (DDE)  
P. O. Box 44071  
Jacksonville, FL 32231-4071

**FRAUD AND ABUSE**

Complaint Processing Unit  
P. O. Box 45087  
Jacksonville, FL 32232-5087

**PART A RECONSIDERATION****Claims Denied at the Redetermination Level**

MAXIMUS  
QIC Part A East Project  
Eastgate Square  
50 Square Drive  
Victor, NY 14564-1099

**OVERPAYMENT COLLECTIONS****Repayment Plans for Part A Participating Providers****Cost Reports (original and amended)****Receipts and Acceptances****Tentative Settlement Determinations****Provider Statistical and Reimbursement (PS&R) Reports****Cost Report Settlement (payments due to provider or Program)****Interim Rate Determinations****TEFRA Target Limit and Skilled Nursing Facility Routine Cost Limit Exceptions****Freedom of Information Act Requests (relative to cost reports and audits)**

Provider Audit and Reimbursement Department (PARD)  
P.O. Box 45268  
Jacksonville, FL 32232-5268  
1-904-791-8430

**MEDICARE REGISTRATION****American Diabetes Association****Certificates**

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

**Telephone Numbers****PROVIDERS**

Customer Service Center Toll-Free  
1-877-602-8816  
Speech and Hearing Impaired  
1-877-660-1759

**BENEFICIARY**

Customer Service Center Toll-Free  
1-800-MEDICARE  
1-800-633-4227  
Speech and Hearing Impaired  
1-800-754-7820

**ELECTRONIC MEDIA CLAIMS**

EMC Start-Up  
1-904-791-8767, option 4

Electronic Eligibility  
1-904-791-8131

Electronic Remittance Advice  
1-904-791-6865

Direct Data Entry (DDE) Support  
1-904-791-8131

PC-ACE Support  
1-904-355-0313

Testing  
1-904-791-6865

Help Desk  
(Confirmation/Transmission)  
1-904-905-8880

**Medicare Websites****PROVIDERS**

Florida Medicare Contractor  
[www.floridamedicare.com](http://www.floridamedicare.com)  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)

**BENEFICIARIES**

Centers for Medicare & Medicaid Services  
[www.medicare.gov](http://www.medicare.gov)

**Other Important Addresses****REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY****Home Health Agency Claims Hospice Claims**

Palmetto Government Benefit Administrators – Gulf Coast  
34650 US Highway 19 North, Suite 202  
Palm Harbour, FL 34684-2156

**RAILROAD MEDICARE****Railroad Retiree Medical Claims**

Palmetto Government Benefit Administrators  
P. O. Box 10066  
Augusta, GA 30999-0001

**DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)****Durable Medical Equipment Claims Orthotic and Prosthetic Device Claims Take Home Supplies****Oral Anti-Cancer Drugs**

Palmetto Government Benefit Administrators  
P. O. Box 100141  
Columbia, SC 29202-3141



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***MEDICARE A BULLETIN***

*FIRST COAST SERVICE OPTIONS, INC. ❖ P.O. Box 2078 ❖ JACKSONVILLE, FL 32231-0048*

**\* ATTENTION BILLING MANAGER \***

