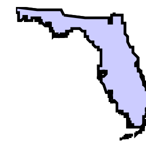
Medicare A Bulletin

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.***

**Routing Suggestions:**

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

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# 2005 HCPCS Annual Update

## Annual Procedure Code Update

### Effective for Services Furnished on or After January 1, 2005

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

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

### Description of HCPCS Coding Levels

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

### Level I – Numeric Codes (*CPT*)

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

### Level II – Alpha Numeric (HCFA-Assigned)

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

### Category III Codes – New Emerging Technology Codes

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

## The 2005 HCPCS Update

The 2005 HCPCS update is divided into the following major sections:

### Additions

The procedure/modifier codes listed under “Modifiers and Procedure Codes Added for 2005” section are newly identified *CPT*/HCPCS codes and modifiers that must be used only for services furnished **on or after January 1, 2005.**

### Revisions

The procedure/modifier codes listed under “Modifiers and Procedure Codes Revised for 2005” section include *CPT*/HCPCS codes in which the descriptor or administrative instructions have changed from 2004. When using these codes, refer to the *2005 CPT* or HCPCS coding books to ensure the correct code is billed for the service furnished.

### Reinstated Codes

The procedure/modifier codes listed under “Modifiers and Procedure Codes Reinstated for 2005” section include *CPT*/HCPCS codes that were discontinued during 2004 or for 2005; however after some reconsideration CMS has reinstated theses codes for 2005.

### Discontinued Procedures

The procedure codes listed under “Modifiers and Procedure Codes Discontinued for 2005” section may not be reported for service dates **after December 31, 2004.**

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

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

### A Word About Coverage

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

*The 2005 HCPCS Update (continued)*

### Jurisdiction

The lists of added, revised, or discontinued *CPT*/HCPCS codes for 2005 are complete with no regard to contractor jurisdiction. The majority of procedure codes in the HCPCS are processed in Florida by the local Medicare Part A fiscal intermediary, First Coast Service Options, Inc. (FCSO). However, some *CPT*/HCPCS codes listed represent services processed by the durable medical equipment regional carrier (DMERC). The DMERC that serves Florida is Palmetto Government Benefits Administratrors (*http://www.palmettogba.com*). It is the responsibility of the billing provider to submit claims to the appropriate Medicare contractor.

### Use of Unlisted *CPT*/HCPCS Codes

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

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

### Reminder for EMC Billers

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

### Questions or Concerns?

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

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

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

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

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

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

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

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

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

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## Modifiers and Procedure Codes Added for 2005

### Modifiers
AE
AF
AG
AK
AR
CD
CE
CF
CG
KC
KD
KF
RD
SW
SY

### *CPT-4* Codes
*00561*
*11004*
*11005*
*11006*
*11008*
*19296*
*19297*
*19298*
*27412*
*27415*
*29866*
*29867*
*29868*
*31545*
*31546*
*31620*
*31636*
*31637*
*31638*
*32019*
*32855*
*32856*
*33933*
*33944*
*34803*
*36475*
*36476*
*36478*
*36479*
*36818*
*37215*
*37216*
*43257*
*43644*
*43645*
*43845*
*44137*
*44715*
*44720*
*44721*
*45391*
*45392*

### *CPT-4* Codes
*46947*
*47143*
*47144*
*47145*
*47146*
*47147*
*48551*
*48552*
*50323*
*50325*
*50327*
*50328*
*50329*
*50391*
*52402*
*57267*
*57283*
*58356*
*58565*
*58956*
*63050*
*63051*
*63295*
*66711*
*76077*
*76510*
*76820*
*76821*
*78811*
*78812*
*78813*
*78814*
*78815*
*78816*
*79005*
*79101*
*79445*
*82045*
*82656*
*83009*
*83630*
*84163*
*84166*
*86064*
*86335*
*86379*
*86587*
*87807*
*88184*
*88185*
*88187*
*88188*
*88189*
*88360*
*88367*
*88368*
*90465*
*90466*
*90467*

### *CPT-4* Codes
*90468*
*90656*
*91034*
*91035*
*91037*
*91038*
*91040*
*91120*
*92620*
*92621*
*92625*
*93745*
*93890*
*93892*
*93893*
*94452*
*94453*
*95928*
*95929*
*95978*
*95979*
*97597*
*97598*
*97605*
*97606*
*97810*
*97811*
*97813*
*97814*
0500F
0501F
0502F
0503F
1000F
1001F
1002F
2000F
4000F
4001F
4002F
4006F
4009F
4011F
0062T
0063T
0064T
0065T
0066T
0067T
0068T
0069T
0070T
0071T
0072T
0073T
0074T
0075T
0076T
0077T

### *CPT-4* Codes
0078T
0079T
0080T
0081T
0082T
0083T
0084T
0085T
0086T
0087T

### CMS Assigned Codes (HCPCS)
A4223
A4349
A4520
A4605
A7040
A7041
A7045
A7527
A9152
A9153
A9180
B4102
B4103
B4104
B4149
B4157
B4158
B4159
B4160
B4161
B4162
C9218
C9399
C9400
C9401
C9402
C9403
C9404
C9405
C9410
C9411
C9413
C9414
C9415
C9417
C9418
C9419
C9420
C9421
C9422
C9423
C9424
C9425
C9426
C9427
C9428

### HCPCS Codes
C9429
C9430
C9431
C9432
C9433
C9438
C9713
C9716
D0416
D0421
D0431
D0475
D0476
D0477
D0478
D0479
D0481
D0482
D0483
D0484
D0485
D2712
D2794
D2915
D2934
D2971
D2975
D5225
D5226
D6094
D6190
D6194
D6205
D6214
D6624
D6634
D6710
D6794
D7283
D7288
D7311
D7321
D7511
D7521
D7953
D7963
D9942
E0463
E0464
E0639
E0640
E0769
E0849
E1039
E1229
E1239
E1841
E2205
E2206

***Modifiers and Procedure Codes Added for 2005 (continued)***

**HCPCS Codes**

E2291
E2292
E2293
E2294
E2368
E2369
E2370
E2601
E2602
E2603
E2604
E2605
E2606
E2607
E2608
E2609
E2610
E2611
E2612
E2613
E2614
E2615
E2616
E2617
E2618
E2619
E2620
E2621
E8000
E8001
E8002
G0329
G0336
G0337
G0341
G0342
G0343
G0344

**HCPCS Codes**

G0345
G0346
G0347
G0348
G0349
G0350
G0351
G0353
G0354
G0355
G0356
G0357
G0358
G0359
G0360
G0361
G0362
G0363
G0364
G0365
G0366
G0367
G0368
G9013
G9014
G9017
G9018
G9019
G9020
J0128
J0135
J0180
J0878
J1457
J1931
J2357
J2469
J2794

**HCPCS Codes**

J3110
J3246
J3396
J7304
J7343
J7344
J7518
J7611
J7612
J7613
J7614
J7616
J7617
J7674
J8501
J8565
J9035
J9041
J9055
J9305
K0628
K0629
K0630
K0631
K0632
K0633
K0634
K0635
K0636
K0637
K0638
K0639
K0640
K0641
K0642
K0643
K0644
K0645

**HCPCS Codes**

K0646
K0647
K0648
K0649
K0669
L1932
L2005
L2232
L4002
L5685
L5856
L5857
L6694
L6695
L6696
L6697
L6698
L7181
L8515
L8615
L8616
L8617
L8618
L8620
L8621
L8622
S0116
S0117
S0158
S0159
S0160
S0161
S0162
S0164
S0194
S0196
S0257
S0618

**HCPCS Codes**

S2082
S2083
S2152
S2348
S3890
S4042
S8301
S9482
S9976
S9977
S9988
T2049
T4521
T4522
T4523
T4524
T4525
T4526
T4527
T4528
T4529
T4530
T4531
T4532
T4533
T4534
T4535
T4536
T4537
T4538
T4539
T4540
T4541
T4542
V2702

## Modifiers and Procedure Codes Revised for 2005

**Modifiers**

FP

***CPT-4* Codes**

00560
00562
00563
19160
19162
25075
25076
26115
26116
31630
31631
32850
33930
33940

***CPT-4* Codes**

34800
34802
34804
34805
34808
36416
36568
36569
36570
36571
36580
36584
36585
36819
37205
37206
37207

***CPT-4* Codes**

37208
38242
43256
43846
43842
43843
43847
44132
46715
46716
47133
47140
48550
49505
49507
49590
50300

***CPT-4* Codes**

50320
50360
50547
50548
52234
52344
57282
59070
59072
59074
59076
59897
61885
62273
63685
64425
64590

***CPT-4* Codes**

66710
67912
70470
70482
70488
70543
70546
70549
70552
70553
70558
70559
71111
71270
74170
75960
76075

*Modifiers and Procedure Codes Revised for 2005 (continued)*

**_CPT-4_ Codes**

76076
76511
76512
76827
77418
77750
78267
78464
78465
79200
79300
79403
79440
83013
83014
83892
83893
83894
83896
83897
83898
83901
83902
83912
84165
85046
86334
87046
88313
89346
88361
88365
90471
90473
90474
90586
90655
90657
90658
90700

**_CPT-4_ Codes**

90780
90781
90782
90784
91065
91122
93741
93742
94060
94070
95971
95972
95973
96111
96150
97802
97803
97804
99293
99294
99295
99296
0040T
0055T

**CMS Assigned Codes (HCPCS)**

A4222
A4332
A5119
A5500
A5501
A5503
A5504
A5505
A5506
A5507
A5508
A5509

**HCPCS Codes**

A5510
A5511
A9517
A9525
A9530
A9532
A9534
B4150
B4152
B4153
B4154
B4155
C1716
C1717
C1718
C1719
C1720
C2616
C2633
C8918
C8919
C8920
C9211
D0350
D0415
D0480
D2710
D2910
D3332
D4210
D4211
D4240
D4241
D4260
D4261
D4273
D4276
D4341
D4381
D6056

**HCPCS Codes**

D6057
D7111
D7286
D7287
D7490
D7955
E0118
E0221
E0450
E0461
E0625
E0638
E0951
E0952
E0955
E0956
E0957
E0967
E0978
E0986
E1010
E1011
E1014
E1025
E1026
E1027
E1038
E1225
E1226
G0173
G0237
G0238
G0239
G0244
G0260
G0295
G0308
G0309
G0310
G0311

**HCPCS Codes**

G0312
G0313
G0314
G0315
G0316
G0317
G0318
G0319
G0320
G0321
G0322
G0323
J0150
J0152
J0880
J1564
J2324
L1820
L2035
L2036
L2037
L2038
L2039
L2320
L2330
L2755
L2800
L4040
L4045
L4050
L4055
L6890
L6895
L7180
Q3031
S2150
T2005
V2745

## Procedure Codes Reinstated for 2005

### CMS Assigned Codes

A4644
A4645
A4646
L0430

# Procedure Codes Discontinued for 2005

## *CPT-4* Codes

| | |
|---|---|
| 35161 | To report, use 37799 |
| 35162 | To report, use 37799 |
| 35582 | |
| 50559 | |
| 50578 | |
| 50959 | |
| 50978 | |
| 52347 | |
| 78810 | To report, see 78811-78813 |
| 78990 | |
| 79000 | To report, use 79005 |
| 79001 | To report, use 79005 |
| 79020 | To report, use 79005 |
| 79030 | To report, use 79005 |
| 79035 | To report, use 79005 |
| 79100 | To report, use 79101 |
| 79400 | To report, use 79101 |
| 79420 | To report, use 79445 |
| 79900 | |
| 88180 | To report, see 88182, 88189 |
| 91032 | To report, see 91034, 91035 |
| 91033 | To report, see 91034, 91035 |
| 92589 | |
| 97601 | To report, use 97597, 97598 |
| 97780 | To report, see 97810, 97811 |
| 97781 | To report, see 97813, 97814 |
| 0001F | To report, use 2000F |
| 0002F | To report, use 1000F |
| 0003F | To report, use 1001F |
| 0004F | To report, use 4000F |
| 0005F | To report, use 4001F |
| 0006F | To report, use 4002F |
| 0007F | To report, use 4006F |
| 0008F | To report, use 4009F |
| 0009F | To report, use 1002F |
| 0010F | |
| 0011F | To report, use 4011F |
| 0001T | To report, use 34803 |
| 0005T | To report, see 0075T, 0076T |
| 0006T | To report, see 0075T, 0076T |
| 0007T | To report, see 0075T, 0076T |
| 0009T | To report, use 58356 |
| 0012T | To report, use 29866 |
| 0013T | To report, see 29867, 27415 |
| 0014T | To report, use 29868 |
| 0057T | To report, use 43257 |

## CMS Assigned Codes (HCPCS)

| | |
|---|---|
| A4324 | See code A4349 |
| A4325 | See code A4349 |
| A4347 | |
| A4521 | |
| A4522 | |
| A4523 | |
| A4524 | |
| A4525 | |
| A4526 | |
| A4527 | |
| A4528 | |
| A4529 | |

## HCPCS Codes

| | |
|---|---|
| A4530 | |
| A4531 | |
| A4532 | |
| A4533 | |
| A4535 | |
| A4536 | |
| A4537 | |
| A4538 | |
| A4609 | See code A4605 |
| A4610 | See code A4605 |
| B4151 | |
| B4156 | |
| C9109 | See code J3246 |
| C9124 | See code J0878 |
| C9125 | See code J2794 |
| C9207 | See code J9041 |
| C9208 | See code J0180 |
| C9209 | See code J1931 |
| C9210 | See code J2469 |
| C9213 | See code J9305 |
| C9214 | See code J9305 |
| C9215 | See code J9055 |
| C9216 | See code J0128 |
| C9217 | See code J2357 |
| C9219 | See code J7518 |
| C9412 | See code J7310 |
| C9701 | |
| C9703 | |
| C9712 | See code 91035 |
| C9714 | See code 19297 |
| C9715 | See code 19296 |
| C9717 | See code 46947 |
| D2970 | |
| D6020 | See code 21248 |
| D7281 | |
| E0176 | |
| E0177 | |
| E0178 | |
| E0179 | |
| E0192 | |
| E0454 | |
| E0962 | |
| E0963 | |
| E0964 | |
| E0965 | |
| E1012 | |
| E1013 | |
| G0001 | |
| G0292 | |
| J3245 | |
| J3395 | |
| J7618 | |
| J7619 | |
| J7621 | |
| K0023 | |
| K0024 | |
| K0059 | |
| K0060 | |
| K0061 | |
| K0081 | See code E2206 |

## HCPCS Codes

| | |
|---|---|
| K0114 | |
| K0115 | |
| K0116 | |
| K0627 | See code E0849 |
| K0650 | See code E2601 |
| K0651 | See code E2602 |
| K0652 | See code E2603 |
| K0653 | See code E2604 |
| K0654 | See code E2605 |
| K0655 | See code E2606 |
| K0656 | See code E2607 |
| K0657 | See code E2608 |
| K0658 | See code E2609 |
| K0659 | See code E2610 |
| K0660 | See code E2611 |
| K0661 | See code E2612 |
| K0662 | See code E2613 |
| K0663 | See code E2614 |
| K0664 | See code E2615 |
| K0665 | See code E2616 |
| K0666 | See code E2617 |
| K0667 | |
| K0668 | See code E2619 |
| L0476 | |
| L0478 | |
| L0500 | |
| L0510 | |
| L0515 | |
| L0520 | |
| L0530 | |
| L0540 | |
| L0550 | |
| L0560 | |
| L0561 | |
| L0565 | |
| L0600 | |
| L0610 | |
| L0620 | |
| L2435 | |
| L5674 | See code L5685 |
| L5675 | See code L5685 |
| L5846 | |
| L5847 | |
| L5989 | |
| L8490 | |
| Q0182 | See code J7343 |
| Q0183 | See code J7344 |
| S0115 | |
| S0163 | |
| S0165 | |
| S0830 | |
| S2085 | |
| S2113 | |
| S2130 | |
| S2131 | |
| S2211 | |
| S2255 | |
| S8182 | |
| S8183 | |
| T1500 | |

# GENERAL INFORMATION

## Unsolicited/Voluntary Refunds

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

### Provider Types Affected

All Medicare providers

### Provider Action Needed

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

### Background

Medicare carriers and intermediaries receive unsolicited/voluntary refunds from providers. These voluntary refunds are not related to any open account receivables. Providers billing intermediaries typically make these refunds by submitting adjustment bills, but they occasionally submit refunds via check. Providers billing carriers usually send these voluntary refunds by check.

Related CR 3274 is intended mainly to provide a detailed set of instructions for Medicare carriers and intermediaries regarding the handling and reporting of such refunds. The implementation and effective dates of that CR apply to the carriers and intermediaries. But, the important message for providers is that the submission of such a refund related to Medicare claims in no way limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to those or any other claims.

### Additional Information

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

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

Related Change Request (CR) Number: 3274
Related CR Release Date: July 30, 2004
Related CR Transmittal Number: 50
Effective Date: October 1, 2004/January 1, 2005
Implementation Date: October 1, 2004/January 3, 2005

Source: CMS Pub 100-6 Transmittal 50, CR 3274

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## Timely Claim Filing Guidelines for All Medicare Providers

All Medicare claims must be submitted to the contractor within the established timeliness parameters. For timeliness purposes, services furnished in the last quarter of the calendar year are considered furnished in the following calendar year. The time parameters are:

| *Dates of Service* | *Last Filing Date* |
|---|---|
| October 1, 2002 – September 30, 2003 | by December 31, 2004 |
| October 1, 2003 – September 30, 2004 | by December 31, 2005* |
| October 1, 2004 – September 30, 2005 | by December 31, 2006* |
| October 1, 2005 – September 30, 2006 | by December 31, 2007 |

*If December 31 falls on a federal nonworking day, the last filing date is extended to the next succeeding workday. A federal nonworking day is considered a Saturday, Sunday, legal holiday, or a day declared by statute or executive order as a nonworking day for federal employees.

**Periodic interim payment (PIP) providers must submit claims by the last day of the year following the year of the discharge date.**

Claims must be submitted complete and free of errors. Any claim filed with invalid or incomplete information, and returned to provider (RTP) for correction, is not protected from the timely filing guidelines. ❖

## Hurricane Relief Changes

Hurricane season officially ended November 30, 2004. All hurricane relief processes implemented by First Coast Service Options, Inc. (FCSO) and the Center for Medicare & Medicaid Services (CMS) ended also. **Effective December 1, 2004,** normal processing was resumed.

Any outstanding problems/issues as a result of the past hurricane season will be handled on a case by case basis by contacting the appropriate Provider Customer Service Center:

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

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

## Interest Payment on Clean Claims Not Paid Timely

*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 durable medical equipment regional carriers (DMERCs)

### Provider Action Needed

Physicians, providers, and suppliers should note that this article clarifies information relating to the calculation of interest due on claims not paid in a timely manner by Medicare.

### Background

The Medicare Claims Processing Manual (Pub, 100-04, Chapter 1, Section 80.2.2) provides instructions for assessing and calculating interest due on non-periodic interim payment (PIP) claims not paid in a timely manner by fiscal intermediaries (FIs) and carriers. It states the following:

- Interest is required to be paid for clean claims not paid within 30 days after the day of receipt of a claim.
- Interest accrues until and including the day of late payment.

Related CR 3557 corrects Chapter 1, Section 80.2.2 of the Medicare Claims Processing Manual. For your convenience, the following revised language from Section 80.2.2 is provided with revisions in bold and italicized:

"Interest must be paid on clean claims if payment is not made within the applicable number of calendar days ***(i.e., 30 days)*** after the date of receipt as described above. The applicable number of days is also known as the payment ceiling. For example, a clean claim received on October 1, 1993, must have been paid before the end of business on October 31, 1993. Interest is not paid on:

- Claims requiring external investigation or development by the provider's FI ***or carrier***
- Claims on which no payment is due
- Full denials
- Claims for which the provider is receiving PIP
- Home health prospective payment system (HH PPS) requests for anticipated payment (RAPs).

Interest is paid on a per bill basis at the time of payment. Interest is paid at the rate used for section 3902(a) of title 31, U.S. Code (relating to interest penalties for failure to make prompt payments). The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department Web page *http://www.publicdebt.treas.gov/opd/opdprmt2.htm* for the correct rate. Also, the FI or carrier notifies the provider of any changes to this rate.

Interest is calculated using the following formula:

Payment amount x rate x days divided by 365 (366 in a leap year) = interest payment

The interest period begins on the day after payment is due and ends on the day of payment. Note that the example below is for one 6-month period in which the interest rate was 5.625 percent.

| Milestones | Clean Paper Claim (in calendar days) | Clean Electronic Claim (in calendar days) |
|---|---|---|
| Date Received | November 1, 2001 | November 1, 2001 |
| Payment Due | ***December 1, 2001*** | ***December 1, 2001*** |
| Payment Made | December 4, 2001 | December 4, 2001 |
| Interest Begins | December 2, 2001 | December 2, 2001 |
| Days for Which Interest Is Due | ***3*** | ***3*** |
| Amount of Payment | $100 | $100 |
| Interest Rate | 5.625 percent | 5.625 percent |

See section 80.2.1.1 for the definition of EMC and paper claims.

The following formula is used:

For the clean paper claim: $100 x .05625 x ***3*** divided by 365 = ***$0.0462*** or, ***$0.05*** when rounded to the nearest penny.

For the clean electronic claim: $100 x .05625 x ***3*** divided by 365 = ***$0.0462,*** or ***$0.05*** when rounded to the nearest penny."

When interest payments are applicable, the FI or carrier reports the amount of interest on each claim on the remittance record to the provider.

*Interest Payment on Clean Claims Not Paid Timely (continued)*

### Additional Information

The official instruction issued to your intermediary/carrier regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R416CP.pdf*.

### Implementation Date

The implementation date for this instruction is January 25, 2005

**Note:** For the period beginning January 1, 2005, and ending June 30, 2005, the interest rate applicable on clean claims not paid timely is 4.250 percent.

Related Change Request (CR) Number: 3557
Related CR Release Date: December 23, 2004
Related CR Transmittal Number: 416
Effective Date: January 25, 2005
Implementation Date: January 25, 2005

Source: CMS Pub 100-4 Transmittal 416, CR 3557

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## Drug Administration Coding Changes and Reimbursement

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

### Provider Types Affected

Physicians, providers, and suppliers

### Provider Action Needed

This article informs physicians, providers, and suppliers that the Centers for Medicare & Medicaid Services (CMS) will implement drug administration coding and payment changes recommended by the American Medical Association's (AMAs) Current Procedural Coding Terminology (CPT) Editorial Panel and Relative Value Update Committee (RUC).

CMS will also provide reimbursement that reflects the additional resource costs of multiple administrations of chemotherapy and non-chemotherapy drugs.

Additionally, this article clarifies billing procedures for services related to management of significant adverse drug reactions related to chemotherapy drugs and treatments.

### Background

### Creating New Billing Codes for Drug Administration in 2005

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 includes provisions for evaluating drug administration codes used by physicians to bill for administering drugs to patients, and if additional codes for clarifications are needed, the MMA requires a prompt process for adding these new codes.

CMS uses the *American Medical Association's (AMAs) Current Procedural Coding Terminology (CPT*) system for coding of physicians' services. The CPT Editorial Panel established a work group that recently made recommendations to the CPT Editorial Panel to adopt selected new drug administration codes and refined several existing codes.

These new codes, which address concerns that physicians have raised about the drug administration codes, will reflect the additional resources costs associated with infusing a second cancer drug. Also, in 2005, oncologists and other physicians will be able to bill Medicare for more than one administration of both non-chemotherapy and chemotherapy drugs.

Subsequent to the completion of the CPT Editorial Panel's work, the AMA's Relative Value Update Committee (RUC) met to make recommendations to CMS regarding the resource inputs for the new and refined drug administration codes.

CMS will act to implement these new codes beginning January 1, 2005. These new and refined CPT codes will be included in the CPT system and become operational in 2006, and CMS will establish G codes for 2005 to be operational in advance of their formal inclusion in the CPT system.

In addition, CMS plans to use the RUC's recommended values for the new and refined drug administration codes beginning January 1, 2005. The work and practice expense inputs for each of the new drug codes are available at CMS website *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0462.pdf*. Enclosure 1 contains the work Relative Value Units (RVUs), staff time and medical equipment practice expense inputs, and Enclosure 2 contains the medical supplies practice expense inputs for each of the codes.

**Clarifying Billing for Managing Significant Adverse Drug Reactions**

The CPT Workgroup recommended additional codes to capture services provided by physicians and their staff in conjunction with drug administration. These include physician time required to monitor and attend to patients who develop significant adverse reactions to chemotherapy drugs, or otherwise have complications in the course of chemotherapy treatment.

While the CPT Workgroup recommended new codes to recognize these services, the CPT Editorial Panel believes that existing codes can be used. However, some physicians may not be aware of their ability to bill these services using existing CPT codes, and they are not being appropriately compensated for all the services they provide in conjunction with chemotherapy administration. Physicians can bill existing codes that reflect the time, resources, and complexity of services they and their staff provide for management

*Drug Administration Coding Changes and Reimbursement (continued)*

of significant adverse drug reactions. Note that this is in addition to the billing normally allowed for the physician's care of a cancer patient. The existing codes that can and should be used include the following:

- **Bill for Doctor Visit**. If a patient has a significant adverse reaction to drugs during a chemotherapy session and the physician intervenes, the physician can bill for a visit in addition to the chemotherapy administration services.
- **Bill for Higher Level Doctor Visit**. If the patient had already seen the doctor prior to a chemotherapy session for a problem that is unrelated to the supervision of the administration of chemotherapy drugs, the doctor may bill a visit service for a significant adverse drug reaction. The total time, resources and complexity of the physician's interaction with the patient may justify a higher level of a visit service.
- **Bill for Prolonged Service**. If the patient already had a physician visit prior to the chemotherapy session and experienced a significant adverse reaction to drugs on the same day, the physician can bill a prolonged service code, in addition to the doctor visit. There are several code combinations to use, depending on the number of minutes involved. The physician must have a face-to-face encounter with the patient and must spend at least 30 minutes beyond the threshold or typical time for that level of visit for the physician to bill the prolonged service code.
- **Bill for Critical Care Service**. If the patient already had a physician visit prior to the chemotherapy session and experienced a life-threatening adverse reaction to the drugs, the physician can bill for a critical care service in addition to the visit if the physician's work involves at least 30 minutes of direct face-to-face involvement managing the patient's life-threatening condition. Examples of life threatening conditions are: central nervous failure; circulatory failure; and shock, renal, hepatic, metabolic and/or respiratory failure.

**Assuring Accuracy of Drug Payments**

CMS is continuing its work to ensure that drug pricing data under the new average sales price (ASP) system are accurate, and CMS published first-quarter ASP data for the drugs that make up over 70 percent of oncology drug expenses.

CMS revised the method manufacturers used to apply rebates and discounts in order to make the ASP prices more accurate and is awaiting the independent report from the Government Accountability Office (GAO) on the adequacy of Medicare payments for drugs under the ASP system.

CMS is also considering a number of interesting comments about payment for cancer care that were submitted on the physician fee schedule proposed rule. CMS is considering these comments carefully and will announce its decisions in the final rule in the beginning of November. CMS plans to continue to work with oncology groups to identify ways in which oncology practices, particularly small practices and practices in relatively rural areas, can obtain the most favorable drug prices possible and is taking these steps now to allow the maximum time possible for oncology practices to plan for 2005.

### Additional Information

If you have any questions, please contact your intermediary/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: N/A
Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Matters SE0462

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## Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

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

### Provider Types Affected

Physicians, providers, home health agencies (HHAs), and suppliers

### Provider Action Needed

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

This article provides the annual HH consolidated billing update effective January 1, 2005. Affected providers should be aware of these changes.

### Background

Section 1842(b)(6) of the Social Security Act requires that payment for home health services provided under a home health plan of care be made to the HHA. As a result, billing for all such items and services is to be made by a single HHA overseeing that plan. This HHA is known as the primary agency for HH PPS for billing purposes.

With the exception of therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA).

Medicare periodically publishes Routine Update Notifications, which contain updated lists of non-routine supply and therapy codes that must be included in HH

***Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement (continued)***

consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS codes that Medicare also publishes annually. This list may also be updated as frequently as quarterly if required by the creation of new HCPCS codes during the year.

## Additional Information

This notification provides the annual HH consolidated billing update effective January 1, 2005. The following table describes the HCPCS codes and the specific changes to each that this notification is implementing on January 3, 2005:

| Code | Description of Code | Type Change | Replacement Code or Code Being Replaced |
|---|---|---|---|
| **Non-Routine Supplies** | | | |
| A4347 | Male external catheter | Delete | Replacement code: A4349 |
| A4324 | Male ext cath w/adh coating | Delete | Replacement code: A4349 |
| A4325 | Male ext cath w/adh strip | Delete | Replacement code: A4349 |
| A4349 | Male ext catheter, with or without adhesive, disposable, each | Add | Replaces codes: A4347, A4324, A4325 |
| A7040 | One way chest drain valve | Add | |
| A7041 | Water seal drainage container and tubing for use with implanted chest tube | Add | |
| A7045 | Exhalation port with or without swivel used with accessories for positive airway devices, replacement only | Add | |
| A7527 | Tracheostomy/laryngectomy tube plug/stop, each | Add | |
| **Therapies** | | | |
| 97601 | Wound care selective | Delete | Replacement codes: 97597, 97598 |
| 97597 | Removal of devitalized tissue from wound(s), selective debridement; surface area less than or equal to 20 square centimeters | Add | Replaces code: 97601 |
| 97598 | Removal of devitalized tissue from wound(s), selective debridement; total wound(s) surface area greater than 20 square centimeters | Add | Replaces code: 97601 |
| 97605 | Negative pressure wound therapy(eg. vacuum assisted drainage collection); total wound(s) surface area less than or equal to 50 square centimeters | Add | |
| 97606 | Negative pressure wound therapy (eg. vacuum assisted drainage collection); total wound(s) surface area greater than 50 square centimeters | Add | |

The last update to the HH consolidated billing was issued under Transmittal 226, CR 3350. This CR can be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R226CP.pdf*.

The official instruction issued to your intermediary/carrier (including durable medical equipment carriers (DMERCs) and regional home health intermediaries (RHHIs)) regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3525 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 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: 3525
Related CR Release Date: October 29, 2004
Related CR Transmittal Number: 340
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 340, CR 3525

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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.*

## 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).

## 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
***Relevant HCPCS codes:*** A4217, A4450 and A4452

AV Item furnished in conjunction with a prosthetic device, prosthetic or orthotic
***Relevant HCPCS codes:*** A4450 and A4452

AW Item furnished in conjunction with a surgical dressing
***Relevant HCPCS codes:*** 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*.

## Additional Information

The official instruction issued to the intermediary regarding this change can be found online, referenced via CR 3300, at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

On the above online page, scroll down while referring to the CR NUM column on the right to find the link for CR 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 23, 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

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

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

### Provider Types Affected

Physicians, providers, and suppliers

### Provider Action Needed

This instruction provides specific information regarding the 2005 annual update for the durable medical equipment prosthetic, orthotics and supplies (DMEPOS) fee schedule.

### Background

The DMEPOS fee schedules are updated on an annual basis in accordance with the statute and regulations, as described in the Medicare Claims Processing Manual (Pub 100-04, Section 60, Chapter 23).

This notification provides details regarding the 2005 annual update for the DMEPOS fee schedule.

The Social Security Act (SSA) (Sections 1834(a), (h), and (i)) requires payment on a fee schedule basis for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings. In addition, the *Code of Federal Regulations* (42 CFR 414.102) requires payment on a fee schedule basis for parenteral and enteral nutrition (PEN).

The 2005 DMEPOS fee schedule update factors for items furnished from January 1, 2005 through December 31, 2005 are as follows:

- DME other than items classified as class III devices by the Food and Drug Administration (FDA) – zero percent
- DME classified as class III devices by the FDA – 3.3 percent
- Prosthetic devices, prosthetics, and orthotics – zero percent
- PEN – 3.3 percent
- Surgical dressings – zero percent

Please refer to the table below for comments and notes on several Healthcare Common Procedure Coding System (HCPCS) codes. The descriptions for the items falling under the HCPCS codes listed in the table can be obtained from the HCPCS file at *https://www.cms.hhs.gov/medicare/hcpcs/default.asp*.

### Healthcare Common Procedure Coding System Codes

**HCPCS Codes Notes**

**A4253, A4259, E0260, E0277, E0424, E0431, E0434, E0439, E0570, E1390, E1391, K0001, and K0011**

These codes are affected by the provision in Section 302 (c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requiring reductions for certain DME equal to the percentage difference between 2002 Medicare fee schedule amounts and the median 2002 price paid under federal employee health benefit (FEHB) plans surveyed by the Office of the Inspector General. The reductions take effect January 1, 2005, and will be implemented as part of this annual update to the DMEPOS fee schedules.

**A5500 (extra-depth shoe), A5501 (custom molded shoe), K0628 (direct formed insert), K0629 (custom molded insert)**

Section 627 of the MMA requires the calculation and implementation of fee schedule amounts for therapeutic shoes and inserts effective January 1, 2005. Fee schedules for these HCPCS codes have been calculated by CMS using the methodology contained in section 1834(h) of the Social Security Act for prosthetic devices, prosthetics, and orthotics. These fee schedule amounts will be implemented as part of this annual update to the DMEPOS fee schedules.

**A5503 thru A5507 (shoe modification codes), K0628 or K0629 (inserts)**

In accordance with section 1833(o)(2)(C) of the Social Security Act, the payment amounts established for shoe modification codes (A5503 thru A5507) must be established in a way that prevents a net increase in expenditures when substituting these items for inserts (codes K0628 or K0629). Therefore, the 2005 fee schedule amounts for codes A5503 thru A5507 have been calculated based on the weighted average of the fee schedule amounts for insert codes K0628 and K0629. The fees for K0628 and K0629 were weighted based on the approximate total allowed services for each code for items furnished during the second quarter of calendar year 2004. For 2006 and each subsequent year, the weighted average insert fee used to establish the fee schedule amounts for the shoe modification codes will be based on an updated weighted average (i.e., using more current allowed service data for each insert code).

**E0675**

Code E0675 was added to the HCPCS effective January 1, 2004. The fee schedule for code E0675 was calculated using retail prices for two products; however, the fee schedule is being revised effective January 1, 2005, to remove pricing for one product that was not yet an established product in the market at the time the code was added.

**E1010**

The description for code E1010 for "wheelchair accessory, addition to power seating system, including leg rest, …**each**" is changed effective January 1, 2005, to show "wheelchair accessory, addition to power seating system,……., including leg rest, **pair**" and the fee schedule for E1010 is revised to reflect this change. Suppliers should bill single leg rest power elevation systems under code K0108.

**E2320 thru E2330, and Modifier KC**

Codes E2320 thru E2330 for special power wheelchair interfaces were added to the HCPCS effective January 1, 2004. The fee schedule amounts for these codes were calculated based on pricing for the differential cost of furnishing these special interfaces over a standard interface that is paid for as part of the payment for the

*Fee Schedule Update for 2005 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (continued)*

wheelchair (e.g., K0011). However, when these items are furnished to replace existing interfaces on wheelchairs that have been in use by the patient for a period of time due to a change in the patient's medical condition or in cases where the existing interface is irreparably damaged or has exceeded its reasonable useful lifetime, the fee schedule payment should reflect payment for the full cost of the replacement special interface. Modifier KC is being added to the HCPCS effective January 1, 2005, to identify replacement of special power wheelchair interfaces in these cases. Fee schedule amounts for replacement of special power wheelchair interfaces will be established effective January 1, 2005, for use in paying claims for use Codes E2320 thru E2330 billed with the KC modifier.

**E2340 thru E2343, and K0108**

Codes E2340 thru E2343 for nonstandard power wheelchair seat frame width and depth were added to the HCPCS effective January 1, 2004. The fee schedule amounts for these codes were calculated using retail prices for some products for nonstandard seat dimensions (i.e., captain's chairs that sit on top of power wheelchair bases) as opposed to nonstandard seat frame dimensions. The base fee schedule amounts for codes E2340 thru E2343 will be adjusted to remove these products from the base fee calculations. Suppliers of nonstandard seat dimensions should bill HCPCS K0108 instead of codes E2340 thru E2343.

**K0646, K0648, and L0565**

The fee schedule amounts for codes K0646 and K0648 are being revised effective January 1, 2005, by cross walking the fee schedule amounts for previous code L0565 to both code K0646 and K0648. As a result of a court settlement, previously paid claims for K0646 and K0648 that were submitted between July 6, 2004 and January 1, 2005, shall be adjusted if such claims are resubmitted by suppliers on or after January 1, 2005, and on or before 18 months after the date the claim was originally submitted.

**E0617, E0691 thru E0694, K0606 thru K0609, and modifier KF**

A one-time notification (Transmittal 35, Change Request 3020) was issued on December 24, 2003, and listed HCPCS codes for categories of DME items identified by the FDA as class III devices. As indicated above, the fee schedule amounts for class III DME will be increased by 3.3 percent effective January 1, 2005, whereas the fee schedule amounts for items that are not classified as class III devices by the FDA will not be increased on January 1, 2005. Transmittal 35 indicated that HCPCS codes E0617, E0691 thru E0694, and K0606 thru K0609 represented codes for categories of DME items identified by the FDA as class III devices. However, some products billed under these codes are not class III devices. Therefore, effective January 1, 2005, separate fee schedules will be provided in the DMEPOS fee schedule file: one for class III products within these codes that must be billed with HCPCS modifier KF and one for products within these codes that are not class III devices that may not be billed with HCPCS modifier KF.

**A7040, A7041, L8615 thru L8618, L8620 thru L8622**

Codes A7040, A7041, L8615 thru L8618, and L8620 thru L8622 describe items that are subject to the fee schedule for prosthetics and orthotics (PO) and are being added to the HCPCS effective January 1, 2005. These codes fall under the jurisdiction of the local carriers rather than the DMERCs. CMS will be calculating the fee schedule amounts for these items using the standard gap-filling process. The description for these codes can be obtained from the 2005 HCPCS file as soon as it is available at: *http://www.cms.hhs.gov/medicare/hcpcs/default.asp*.

**A4324 thru A4325; A4347; A4609 thru A4610; B4151; B4156; E0176 thru E0179; E0192; E0454; E0962 thru E0965; E1012 thru E1013; K0023 thru K0024; K0059 thru K0061; K0081; K0114 thru K0116; K0627; L0476; L0478; L0500; L0510; L0515; L0520; L0530; L0540; L0550, L0560 thru L0561; *L0565; L0600; L0610; L0620; L2435; L5674 thru L5675; L5846 thru L5847; L5989; L8490**

These codes are being deleted from the HCPCS effective January 1, 2005, and are therefore being removed from the DMEPOS and PEN fee schedule files.

*As indicated above, the fee schedule amounts for code L0565 are being crosswalked to codes K0646 and K0648.

## Additional Information

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

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR 3574. Click on the link to open and view the file for the CR.

If you have questions regarding this issue, you may also contact your carrier, fiscal intermediary, or 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: 3574
Related CR Release Date: November 19, 2004
Related CR Transmittal Number: 369
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 369, CR 3574

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## January 2005 Quarterly Average Sale Price Medicare Part B Drug Pricing

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

### Provider Types Affected

All providers

### Provider Action Needed

No provider action is necessary. This article is informational only and explains how Medicare pays for certain drugs that are not paid on a cost or prospective payment basis, effective January 1, 2005.

### Background

According to Section 303 of the Medicare Modernization Act of 2003 (MMA), beginning January 1, 2005 drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the average sales price (ASP) plus six percent. The Centers for Medicare & Medicaid Services (CMS) will supply its carriers/intermediaries with the ASP drug-pricing file for Medicare Part B drugs. The ASP is based on quarterly drug information supplied to CMS by drug manufacturers.

Thus, 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. CMS will update the payment allowance limits quarterly.

**Exceptions**

There are exceptions to this general rule, as summarized below:

1. The payment allowance limits for blood and blood products, with certain exceptions such as blood clotting factors, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.
2. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005 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 durable medical equipment is implanted. The payment allowance limits will not be updated in 2005.
3. The payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.
4. The payment allowance limits for drugs not included in the ASP Medicare Part B Drug Pricing File are based on the published wholesale acquisition cost (WAC) or invoice pricing.

Note that the absence or presence of a HCPCS code and its associated payment limit in the ASP files does not indicate Medicare coverage of the drug. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.

### Implementation

The implementation date is January 3, 2005.

### Additional Information

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

From that Web page, look for CR 3539 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/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: 3539
Related CR Release Date: October 29, 2004
Related CR Transmittal Number: 348
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 348, CR 3539

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## 2005 Holiday Schedule

First Coast Services Options, Inc will observe the following holiday schedule in 2005:

| | |
|---|---|
| January 3, (Monday) | New Year's Day |
| January 17, (Monday) | Martin Luther King Jr. Day |
| March 25, (Friday) | Good Friday |
| May 30, (Monday) | Memorial Day |
| July 4, (Monday) | Independence Day |
| September 5, (Monday) | Labor Day |
| November 24, (Thursday) | Thanksgiving Holiday |
| November 25, (Friday) | Thanksgiving Holiday |
| December 23, (Friday) | Christmas Holiday |
| December 26, (Monday) | Christmas Holiday. |

# Implementation of Section 921 of the Medicare Modernization Act – Provider Customer Service Program

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

## Provider Types Affected

Physicians, providers, and suppliers

## Provider Action Needed

This instruction implements Section 921 of the Medicare Modernization Act (MMA). It creates the Provider Customer Service Program (PCSP) at most Medicare contractors. Collectively, fiscal intermediaries (FIs) and carriers are referred to as contractors or Medicare contractors. Because of funding limitations, the Centers for Medicare & Medicaid Services (CMS) is implementing this instruction in phases. Currently, only carriers and some FIs will be implementing this program in January 2005. Check with your FI/ carrier to see if they are participating in the first phase.

## Background

Medicare contractors are required to implement a PCSP designed to meet provider informational and educational needs.

The PCSP flows from provisions in Section 921 of the MMA that strengthen and enhance Medicare's ongoing efforts associated with provider inquiries and education. The PCSP is designed to improve accuracy, completeness, consistency, and timeliness by ensuring that providers' issues are addressed by staff with the appropriate levels of expertise.

The PCSP includes the following three principal components:

- Provider self-service technology
- Provider contact center (PCC)
- Provider outreach and education

### Provider Self-Service Technology

- Self-service technology will enable the contact centers to handle the increasing volume of provider calls by allowing providers access to certain information without direct personal assistance from Medicare contractor staff. Contractors will require providers to use the interactive voice response (IVR) systems to access information about claims status, beneficiary eligibility, and remittance advice code definitions.

### Provider Contact Center

The PCC will respond to inquiries from the following:

- Telephone calls
- Letters
- Faxes
- E-mails

Contractors will use an inquiry triage process for telephone inquiries to ensure that inquiries are answered by the staff with the appropriate expertise. Each contractor will organize its customer service representatives (CSRs) into at least two levels.

Inquiries that require even more specialized expertise or research or that just require significant additional time to resolve will be referred to a new group, the Provider Relations Research Specialists (PRRSs). The PRRS will provide clear and accurate written answers within 10 business days for at least 75 percent of cases referred by telephone CSRs, 20 business days for 90 percent of the cases referred by telephone CSRs, and 45 business days for 100 percent of all cases (referred by CSRs or from the general inquiries area). All general inquiries (letter, fax, and e-mail) will be answered within 45 business days.

### Provider Outreach and Education

This component of the PCSP includes all provider outreach, education, and training activities that your carrier/ FI currently performs, plus some additional requirements and activities. These new areas include:

- Training tailored for small providers and tailored to reduce the claims error rate
- Enhanced use of the Internet
- Local "Ask-the-Contractor" teleconferences and other new methods of communication

Small providers are defined by law as providers with fewer than 25 full-time equivalents or suppliers with fewer than 10 full-time equivalent staff. Contractors are required to identify providers meeting the definition of small providers and, beginning April 1, 2005, offer to all providers at least two educational programs tailored to the needs of the small providers/suppliers within their jurisdiction. Thereafter, contractors shall offer at least one additional event tailored to small providers per quarter with a minimum of six such events per state per federal fiscal year. (Thus, there may be more than one event in certain quarters of the year.)

## Additional Information

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

That instruction may be viewed by going to: *http://www.cms.hhs.gov/manuals/transmittals/ comm_date_dsc.asp*.

From that Web page, look for CR 3376 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions or want to take advantage of any opportunities under this expanded PCSP, visit the web site of your carrier/intermediary or call them 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: 3376
Related CR Release Date: September 10, 2004
Related CR Transmittal Number: 113
Effective Date: January 1, 2005
Implementation Date: January 5, 2005, unless otherwise indicated

Source: CMS Pub 100-20 Transmittal 113, CR 3376

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## Physician's Role in Certifying and Planning Care for Partial Hospitalization Programs

The law requires that payment from Medicare be made only if the physician certifies the need for services and establishes the plan of care for outpatient partial hospitalization services. The certification requirements follow:

### Partial Hospitalization Program (PHP) Requirements

**PHYSICIAN CERTIFICATION**

The certification by the physician identifying the patient admitted to the PHP would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided. This certification indicates that PHP is "in lieu" of continued inpatient treatment, or those patients who, would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided.

Upon admission the physician must make a certification that must be signed, and maintained in the patient's record, to include the following information:

*(It is generally expected that the physician certification will be completed within 24 hours of the patient's admission to the partial hospitalization program.)*

- A physician who is treating the patient and has knowledge of the patient's response to treatment must sign the physician certification.
- A physician trained in the diagnosis and treatment of psychiatric illness must certify that the patient being admitted to the partial hospitalization program would require inpatient psychiatric hospitalization if the partial hospitalization services are not provided.
- The certification should identify the diagnosis and psychiatric need for the partial hospitalization.
- Partial hospitalization services must be furnished under an individualized written plan of care, established by the physician, which includes the active treatment provided through the combination of structured, intensive services identified in Section 1861 of the Social Security Act, that are reasonable and necessary to treat the presentation of serious psychiatric symptoms and to prevent relapse or hospitalization.

**PHYSICIAN RECERTIFICATION**

- The first recertification is required by the 18th calendar day following admission to the PHP.
- Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days.
- Recertification should be based on a thorough re-evaluation of the treatment plan in relation to the reason for admission and the progress of the patient.

Certifications and recertifications may use any format desired and may be part of the treatment plan. **However, the following statement must be used.**

*"I certify that the beneficiary would require inpatient psychiatric care in the absence of partial hospitalization services, and services will be furnished under the care of a physician, and under a written plan of treatment."*
*Physician signature:* ___________________________ *Date:* ___________________

Certifications are prospective; the physician (M.D./D.O.) certifies that future services are required. A physician certification must cover all periods of service. A physician certification is required to be made and maintained in the patient's file, but does not guarantee approval of services. A psychologist is not considered a physician for the purpose of establishing a certification or recertification.

### References

- Medicare Benefit Policy Manual, Chapter 6 – Hospital Services Covered Under Part B *70.3 – Partial Hospitalization Services*
- First Coast Service Options, Florida Medicare Part A, local coverage determination (LCD) name **APHPPROG**/ LCD Database ID Number **L1212**/ LCD Title **Psychiatric Partial Hospitalization Program**

See the Medicare Claim Processing Manual, Chapter 4, "Hospital Outpatient Services," Section 100, for billing instructions for partial hospitalization services.

Eligibility criteria and documentation requirements can be found in the Coverage Determination Manual

## Use of Modifiers to Establish Liability on Noncovered Charges

Use of modifiers has been increasing in institutional billing over the time. Medicare uses modifiers to provide more specific instructions to certain aspects of billing such as in association with advance beneficiaries notices (ABNs) to determine financial liability for services not covered or payable by Medicare. Providers are liable for these services unless a specific modifier or indicator on the claim (i.e., occurrence code 32) specifically attaches liability to the beneficiary.

Modifier **GA** (waiver of liability statement on file) must be reported on a line item when a beneficiary is notified in advance that a service or item may be denied as not medically necessary. Occurrence code 32 must still be used on claims using modifier GA on the line items related to the ABN.

Modifier **GY** (item or service statutorily excluded or does not meet the definition of any Medicare benefit) must be reported on all types of line items submitted as noncovered.

Reason code 31947 has been revised to indicate noncovered charges billed without one of the these modifiers:

> "This claim line was submitted by the provider as noncovered. Providers are liable for this denial unless a specific modifier or indicator (example: occurrence code 32) on the claim attaches liability to the beneficiary. For billing instructions see the Internet Only Manual (IOM) publication 100-04 Chapter 1, Section 60.4.2."

# AMBULANCE SERVICES

## Ambulance Inflation Factor

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

### Provider Types Affected

Providers and suppliers of ambulance services billing Medicare carriers and fiscal intermediaries (FIs) for those services

### Provider Action Needed

None. This article is for your information only. It provides the ambulance inflation factor (AIF) for calendar (CY) 2005.

### Background

Section 1834(l)(3)(B) of the Social Security Act (SSA) provides the basis for updating the payment limits that your contractors use to determine how much to pay you for claims that you submit for ambulance services. This update, the AIF, is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U), for the 12-month period ending with June of the previous year. The Centers for Medicare & Medicaid Services (CMS) is required to issue this AIF so that your contractors can pay your Medicare ambulance claims accurately and in accordance with statutory requirements. **The AIF for calendar year 2005 is 3.3 percent.**

Remember that during the five-year transition period to the ambulance fee schedule, payments are based on a blended methodology. In the blend, the AIF is applied, separately, to both the fee schedule portion (incorporated in the ambulance fee schedule file) and the reasonable charge/cost portions of the blended payment amount. Then, these two amounts are added together to determine your total payment.

For CY 2005, the blending percentages used to combine these two components of the payment amounts for ambulance services are 80 percent of the ambulance fee schedule and 20 percent of the reasonable charge/cost. Remember also that Part B coinsurance and deductible requirements apply to these claims.

### Additional Information

You can find more information about the AIF by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R411CP.pdf*.

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

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

Related Change Request (CR) Number: 3599
Related CR Release Date: December 23, 2004
Related CR Transmittal Number: 411
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 411, CR 3599

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## Billing Modifier HJ by Florida Ambulance Suppliers

**Effective August 18, 2004,** FCSO considers reimbursement for medically necessary ambulance transportation services billed with origin and destination modifier combination HJ (hospital to free standing non-hospital based ESRD facility).

An example of this type transport is when a Medicare patient is treated at the hospital emergency department (ED) for an episode that may or may not be related to his/her dialysis, and upon discharge is instructed to attend his/her scheduled dialysis session that day before returning to the nursing home. The patient is transported from the hospital ED to the dialysis facility.

# Reminder Notice of the Ambulance Transition Schedule Implementation

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

## Provider Types Affected

Ambulance providers and suppliers

## Provider Action Needed

## STOP – Impact to You

During the current calendar year (CY) 2004, year three of a five-year transition to the ambulance fee schedule implementation, payment for ambulance services is based on a blend of 60 percent of the fee schedule amount plus 40 percent of the provider's reasonable cost or the supplier's reasonable charge for the service. As of January 1, 2005, the amounts payable under the ambulance fee schedule for CY2005 will consist of 80 percent of the fee schedule amount and 20 percent of providers' reasonable cost or suppliers' reasonable charge amount for the service.

## CAUTION – What You Need to Know

The fee schedule applies to **ALL** ambulance services furnished as a benefit under Medicare Part B. Ambulance providers and suppliers are required to accept assignment, and therefore must accept Medicare allowed charges as payment in full.

They may not bill or collect from the beneficiary any amount other than an unmet Part B deductible and the Part B coinsurance amounts.

## GO – What You Need to Do

Be aware that the next phase of the fee schedule payment process goes into effect on January 1, 2005 and adjust accounts receivable processes as necessary.

## Background

Section 4531(b)(2) of the Balanced Budget Act (BBA) of 1997 added a new section 1834(l) to the Social Security Act, which mandates implementation of a national fee schedule for ambulance services furnished as a benefit under Medicare Part B. On April 1, 2002, CMS implemented a new fee schedule that applies to all ambulance services. The schedule applies to all ambulance services: volunteer, municipal, private, independent, as well as institutional providers, i.e., hospitals and skilled nursing facilities. The fee schedule will be phased in over a five-year transition period, during which time the amounts payable for services provided will be a blend of fee schedule amount and the provider's reasonable cost or supplier's reasonable charge amount. (Ambulance services covered under Medicare will be paid based on the lower of the actual billed amount or the ambulance fee schedule amount.)

Ambulance providers and suppliers are currently paid a blended rate, consisting of 60 percent of the fee schedule amount and 40 percent of the provider's reasonable cost amount or the supplier's reasonable charge amount.

Providers and suppliers are reminded that the ambulance fee schedule is being implemented on a five-year transition period as follows:

| Year | Fee Schedule Percentage | Cost/Charge Percentage |
|---|---|---|
| Year 1(4/1/02 – 12/31/02)* | 20% | 80% |
| Year 2 (CY 2003)* | 40% | 60% |
| Year 3 (CY 2004)* | 60% | 40% |
| Year 4 (CY 2005)* | 80% | 20% |
| Year 5 (CY 2006 and thereafter) | 100% | 0% |

*Previous and current year percentages

Section 1834 (l) also requires mandatory assignment for all ambulance services. Ambulance providers and suppliers must accept the Medicare allowed charge as payment in full and not bill or collect from the beneficiary any amount other than any unmet Part B deductible and the Part B coinsurance amounts.

## Implementation

Implementation of the next phase of the fee schedule will begin on January 3, 2005, for services provided on or after January 1, 2005.

## Related Instructions

Providers should note when billing ambulance services to intermediaries that all ancillary services and supplies provided are considered part of the base rate and are not separately billable under the ambulance fee schedule. For Part B suppliers billing Medicare carriers for ambulance services, separately billable supplies may be billed, depending on the supplier's billing method.

Suppliers should also note that Medicare carriers will deny claims for separately billed supplies and ancillary services furnished during an ambulance transport on or after January 1, 2006.

The payment increases for ambulance transports available under Section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) effective July 1, 2004 have been implemented. No additional changes are required to implement this MMA provision. Please refer to Change Request 3099, Transmittals 88 and 220 for details.

## Additional Information

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

From that Web page, look for CR 3473 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 intermediary/carrier. To find that toll free phone number, 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: 3473
Related CR Release Date: October 22, 2004
Related CR Transmittal Number: 320
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 320, CR 3473

## Ambulance Medical Conditions List

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

### Provider Types Affected

Providers and suppliers of ambulance services as well as Medicare contractors (carriers and fiscal intermediaries)

### Provider Action Needed

This article is for educational guideline only. It explains use of the ambulance fee schedule – medical conditions list to help you document your patient's signs and symptoms on scene and during ambulance transportation. It will also tell you how to find the ambulance medical conditions code list.

### Background

Under Medicare, the Healthcare Common Procedure Coding System (HCPCS) codes provide a uniform method for providers and suppliers to report professional services, while the International Classification of Diseases Nineth Edition Clinical Modification (ICD-9-CM) codes document the patient's diagnosis or clinical signs or symptoms. The ambulance fee schedule – medical conditions list, which this article and related CR 3619 discuss, gives you a crosswalk from the ICD-9-CM code (which your dispatch centers and/ or ambulance crews may use to describe a patient's medical condition or signs and symptoms on scene and during the transport) to the HCPCS code.

Please note the following details:

- Using the ICD-9-CM diagnosis/ambulance medical condition code(s) (and their crosswalk to HCPCS codes) will not guarantee payment of the claim or payment for a certain level of service.
- Remember that you must retain adequate documentation of dispatch instructions, patient's condition, other on-scene information, and details of the transport (e.g., medications administered, changes in the patient's condition, and miles traveled), all of which may be subject to medical review by your Medicare contractor or other oversight authority.
  Additionally, your contractor will rely on medical record documentation (and not simply the HCPCS code or the condition code by themselves) to justify coverage.
- Also be aware that all current Medicare ambulance policies remain in place.

**Note:** Providers/suppliers should use the ICD-9-CM code (not the ambulance condition code) on the ambulance claim form.

### Additional Information

You can find more information about the Ambulance Fee Schedule – Medical Conditions List by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3619 in the CR NUM column on the right, and click on the file for that CR.

The Ambulance Fee Schedule – Medical Conditions List can be found as an attachment to that CR.

If you have any questions, please contact your intermediary/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: 3619
Related CR Release Date: December 15, 2004
Related CR Transmittal Number: 395
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 395, CR 3619

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# GENERAL COVERAGE

## Initial Preventive Physical Examination

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

### Provider Types Affected

Physicians, providers, and suppliers

### Provider Action Needed

### STOP – Impact to You

Effective for dates of service on or after January 1, 2005, Section 611 of the Medicare Modernization Act provides for coverage under Part B of an initial preventive physical examination (IPPE) for new Medicare beneficiaries, but only if the beneficiary's eligibility also begins on or after January 1, 2005

### CAUTION – What You Need to Know

This new benefit is subject to certain eligibility and other limitations as described in this article.

### GO – What You Need to Do

Understand the new rules for providing this important new benefit to ensure prompt and accurate payment for services.

### Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA Section 611) provides for coverage under Medicare Part B of an initial preventive physical examination (IPPE), including a screening electrocardiogram (EKG) for new beneficiaries (subject to certain eligibility and other limitations) effective for services furnished on or after January 1, 2005.

In addition, pursuant to final regulations published on November 15, 2004 (42 CFR 410.16, added by 69 FR 66236, 66420) CMS amended 42 CFR sections 411.15 (a)(1) and 411.15 (k)(11) to allow payment for an IPPE not later than 6 months after the date the beneficiary's first coverage period begins under Medicare Part B.

> *This physical examination is a once-a-lifetime benefit for a beneficiary and it must be performed within six months after the effective date of the beneficiary's first Part B coverage, but only if such Part B coverage begins on or after January 1, 2005. A physical examination given on January 10, 2005, for example, to a beneficiary whose Medicare Part B was effective initially on December 1, 2004 would not be covered under this benefit. If a beneficiary is first covered by Part B on January 1, 2005, then a physical provided on January 10, 2005 would be covered by this new benefit.*

This provision provides for payment for an IPPE examination to be performed in various provider settings by:

- Physicians, or
- Qualified nonphysician practitioners (NPPs).

**Services Included in the Initial Examination**

The initial examination means all of the following services:

- Review of an individual's medical and social history, with attention to modifiable risk factors for disease detection, including past medical and surgical history, such as experiences with illnesses, hospital stays, operations, allergies, injuries and treatments, current medication and supplements, family history (including diseases that may be hereditary or place the individual at risk), history of alcohol, tobacco, and illicit drug use, diet, and physical activities.
- Review of an individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the physician or other qualified NPP may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations.
- Review of the individual's functional ability and level of safety based on the use of appropriate screening questions or a screening questionnaire, which the physician or other qualified NPP may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations, including, at a minimum, a review of hearing impairment, activities of daily living, falls risk, and home safety.
- An examination to include measurement of the individual's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the physician or qualified NPP, based on the individual's medical and social history (refer to service element 1) and current clinical standards.
- Performance and interpretation of an EKG.
- Education, counseling, and referral as deemed appropriate by the physician or qualified NPP, based on the results of the review and evaluation services described in the previous five elements.
- Education, counseling, and referral, including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining the appropriate screening and other preventive services, which are covered separately under Medicare Part B. These include: (1) pneumococcal, influenza, and hepatitis B vaccines and their administration; (2) screening mammography; (3) screening pap smear and screening pelvic examinations; (4) prostate cancer screening tests; (5) colorectal cancer screening tests; (6) diabetes outpatient self-management training services; (7) bone mass measurements; (8) screening for glaucoma; (9) medical nutrition therapy

***Initial Preventive Physical Examination (continued)***

for individuals with diabetes or renal disease; (10) cardiovascular screening blood tests; and (11) diabetes screening tests.

A new Healthcare Common Procedure Coding System (HCPCS) code, G0344 (IPPE; face-to-face visit, services limited to new beneficiary during the first six months of Medicare enrollment), will be used for billing the IPPE. As required by statute, this benefit always includes a screening EKG, which should be billed appropriately using new HCPCS codes G0366 (Electrocardiogram, routine ECG with 12 leads; performed as a component of the initial preventive examination with interpretation and report) for the full EKG service; G0367 (tracing only, without interpretation and report; performed as a component of the initial preventive examination) when only the tracing is performed; and G0368 (interpretation and report only, performed as a component of the initial preventive examination) when only the interpretation and report are performed. These three codes reflect the global, technical, and professional components of the screening EKG, respectively.

If the primary physician or qualified NPP does not perform the EKG during the IPPE visit, another physician or entity may perform and/or interpret the EKG. But, the referring provider must ensure that the performing provider bills the appropriate G code for the screening EKG and **not a CPT code** in the 93000 series.

Physicians and qualified NPPs should bill G0366 for the full EKG service (tracing, interpretation, and report), or G0367 when only the tracing is performed, or G0368 when only the interpretation or reporting is performed. Hospitals can only perform the EKG tracing, so they should bill G0367 when they perform the tracing component of the EKG.

While some components for a medically necessary evaluation and management (E/M) service will be reflected in the new HCPCS code of G0344, Medicare will, when it is clinically appropriate, allow payment for a medically necessary E/M service (CPT codes 99201-99215) at the same visit as the IPPE. That portion of the visit must be medically necessary to treat the patient's illness or injury or to improve the function of a malformed body member and will be reported with modifier 25.

A physician or qualified NPP, in various provider settings, may bill for the screening and other preventive services currently covered and paid by Medicare Part B under separate provisions of section 1861 of the Act, if provided during this IPPE.

*The MMA did not make any provision for the waiver of Medicare coinsurance and Part B deductible for the IPPE. Payment for this service would be applied to the required deductible, which is $110 for calendar year 2005, if the deductible has not been met, with the exception of federally qualified health centers (FQHCs), and the usual coinsurance provisions would apply.*

**Special Instructions for Rural Health Clinics (RHCs)/ FQHCs**

- RHCs/FQHCs should follow normal procedures for billing for RHC/FQHC services. Payment for the professional services will be made under the all-inclusive rate and the payment should be requested on a type of bill 71x (RHC) or 73x (FQHC) with revenue code 052x. Encounters with more than one health professional and multiple encounters with the same health professionals that take place on the same day and at a single location constitute a single visit.
- Medicare will pay for the technical component of the IPPE EKG performed in provider-based RHCs/FQHCs when billed under the base provider's number using the above requirements for that particular base provider type. Medicare will pay for the technical component of the IPPE EKG performed in independent RHCs/FQHCs when billed by the practitioner to its carrier, when billed in accordance with the information provided in this article for practitioners.

**Maryland Hospitals**

Maryland hospitals will be paid for an IPPE, on both an inpatient and an outpatient basis, in accordance with the state of Maryland cost containment plan.

**Critical Access Hospitals (CAHs)**

CAHs billing on type of bill 85x will be paid on a reasonable cost basis for the IPPEs and the EKGs.

**Indian Health Service (IHS) Hospitals**

IHS hospitals will be paid on the all-inclusive rate for the IPPE and/or EKG and should bill using type of bill 13x with revenue code 051x.

## Implementation

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

## Additional Information

Chapter 18, Section 80 (Initial Preventive Physical Examination), and Chapter 12, Section 30.6.1.1 (Initial Preventive Physical Examination) of the Medicare Claims Processing Manual (Pub 100-04) are new and included in the official instruction issued to your carrier/intermediary. That official instruction can be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3638 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3638
Related CR Release Date: December 22, 2004
Related CR Transmittal Number: 417
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 417, CR 3638

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## Electrocardiographic Services

*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 electrocardiographic (ECG or EKG) services

### Provider Action Needed

### STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) nationally covers the use of electrocardiographic (ECG or EKG) services under specific criteria described in section 20.15, Pub. 100-03, National Coverage Determinations (NCD) Manual.

EKG technologies are now organized into an updated framework to aid in making reasonable and necessary coverage determinations as they pertain to EKG technology. Effective August 26, 2004, electrocardiographic (EKG) services performed with a marketed, Food and Drug Administration (FDA)-approved device, are eligible for coverage if they can be categorized according to the EKG services framework described in the NCD Manual.

### CAUTION – What You Need to Know

Ambulatory cardiac monitoring performed with a marketed, FDA-approved device is eligible for coverage if it can be categorized according to the EKG framework. Unless there is a specific NCD for that device or service, determination as to whether a device or service that fits into the framework is reasonable and necessary is at the discretion of your local FI or carrier.

### GO – What You Need to Do

To ensure accurate claims processing for EKG services, review the information included here and stay current with instructions for electrocardiograhic services.

### Background

EKG technologies are now organized into an updated framework to aid in making reasonable and necessary coverage determinations as they pertain to EKG technology. Ambulatory cardiac monitoring performed with a marketed, FDA-approved device is eligible for coverage if it can be categorized according to that framework.

The framework is detailed and described in a revised portion of the NCD manual and that revised portion is attached to CR 3590. The following table summarizes the nationally covered indications and nationally non-covered indications for EKG technologies:

| Nationally Covered Indications | Nationally Non-Covered Indications |
|---|---|
| 1. Computer analysis of EKGs when furnished in a setting and under the circumstances required for coverage of other EKG services. | 1. The time-sampling mode of operation of ambulatory EKG cardiac event monitoring/recording. |
| 2. EKG services rendered by an independent diagnostic testing facility (IDTF), including physician review and interpretation. Separate physician services are not covered unless he/she is the patient's attending or consulting physician. | 2. Separate physician services other than those rendered by an IDTF unless rendered by the patient's attending or consulting physician. |
| 3. Emergency EKGs performed as a laboratory or diagnostic service by a portable X-ray supplier only when a physician is in attendance at the time the service is performed or immediately thereafter. | 3. Emergency EKG services by a portable X-ray supplier without a physician in attendance at the time of service or immediately thereafter. |
| 4. Home EKG services with documentation of medical necessity. | 4. Home EKG services without documentation of medical necessity. |
| 5. Ambulatory cardiac monitoring performed with a marketed, FDA-approved device is eligible for coverage if it can be categorized according to the electrocardiographic services framework of Chapter 1, Section 20.15 of the NCD Manual. Unless there is a specific NCD for that device or service, determination as to whether a device or service that fits into the framework is reasonable and necessary is according to local contractor discretion. | 5. Any marketed Food and Drug Administration (FDA)-approved ambulatory cardiac monitoring device or service that cannot be categorized according to the electrocardiographic services framework discussed in Chapter 1, Section 20.15 of the NCD manual. |
| 6. Trans-telephonic EKG transmissions used for the specific indications, when performed with specific equipment and subject to the specific limitations and conditions detailed in Chapter 1, Section 20.15 of the NCD manual. | 6. Twenty-four-hour attended coverage used as early post-hospital monitoring of patients discharged after myocardial infarction unless provided according to specific criteria as mentioned in Chapter 1, Section 20.15 of the NCD manual. |

*Electrocardiographic Services (continued)*

### Additional Information

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

On the above page, scroll down the CR NUM column on the right to find the link for CR 3590. Click on the link to open and view the file for the CR.

The revised section 20.15, Pub. 100-03, National Coverage Determinations Manual, is attached to CR 3590. If you have questions regarding this issue, you may also contact your carrier or 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: 3590
Related CR Release Date: December 10, 2004
Related CR Transmittal Number: 26
Effective Date: August 26, 2004
Implementation Date: December 10, 2004

Source: CMS Pub. 100-3, Transmittal 26, CR 3590

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

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

### Provider Types Affected

Clinical diagnostic laboratories

### Provider Action Needed

CR 3429 announces changes to the list of codes associated with the 23 negotiated laboratory national coverage determinations (NCDs). These changes are:

- A result of coding analysis completed by the Centers for Medicare & Medicaid Services (CMS).
- Necessary revisions to implement the cardiovascular and diabetes screening benefits added to Medicare under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003.

### Background

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

In addition, the laboratory edit module for the NCDs is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. (See the Medicare Claims Processing Manual, Pub. 100-4, Chapter 16, Section 120.2.) CR 3429 announces changes that will be included in the January 2005 release of the edit module for clinical diagnostic laboratory services.

In accordance with the coding analysis published on the coverage Internet site on July 26, 2004, CMS is implementing the following:

- For the urine culture and serum iron studies NCD, CMS is deleting the ICD-9-CM code V72.84 (Pre-operative examination, unspecified) from the list of ICD-9-CM codes covered by Medicare. Coverage for this code will terminate for services furnished **on or after January 1, 2005.** See: *http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=127*.

In accordance with the coding analysis published on the coverage Internet site on July 27, 2004, CMS is implementing the following changes:

- For the tumor antigen by immunoassay CA 125 NCD, CMS is adding the following ICD-9-CM diagnosis codes to the list of ICD-9-CM codes covered by Medicare:
  - V10.41 Personal history of malignant neoplasm, cervix uteri
  - V10.42 Personal history of malignant neoplasm, other parts of uterus

  Coverage for these codes will begin for services furnished **on or after January 1, 2005.** See: *http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=132*.

In accordance with the coding analysis published on the coverage Internet site on July 28, 2004, CMS is implementing the following change:

- For the prothrombin time (PT) test NCD, CMS is removing ICD-9-CM diagnosis code V43.60 (Unspecified joint replaced by other means) from the list of ICD-9-CM codes covered by Medicare. Coverage for this code will terminate for services furnished on or after January 1. See: *http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=131*.

To accommodate the new cardiovascular and diabetes screening benefits that were added to Medicare by the MMA, CMS is removing the following ICD-9-CM codes from the list of ICD-9-CM codes not covered by Medicare:

- V77.1 Screening for diabetes mellitus
- V81.0 Screening for ischemic heart disease
- V81.1 Screening for hypertension
- V81.2 Screening for other unspecified cardiovascular conditions

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

In order to implement the new cardiovascular and diabetes screening benefits that were added to Medicare by the MMA, CMS is making the following changes.

- The lipid NCD edit is being subdivided into two parts:
  1. For *Current Procedural Terminology* (CPT) codes *80061 (lipid panel), 82465 (cholesterol, serum total), 83718 (lipoprotein, direct, HDL), and 84478 (triglycerides),* CMS is adding the following ICD-9-CM diagnosis codes to the list of ICD-9-CM codes covered by Medicare:
     - V81.0 Screening for ischemic heart disease
     - V81.1 Screening for hypertension)
     - V81.2 Screening for other unspecified cardiovascular conditions)
  2. The covered codes for the remaining CPT codes in the lipid NCD listed below remain unchanged:
     - *83715 Lipoprotein, blood; electrophoretic separation and quantitation*
     - *83716 high resolution fractionation and quantitation of lipoprotein including lipoprotein subclasses when performed (eg, electrophoresis, nuclear magnetic resonance, ultracentrifugation)*
     - *83721 direct measurement, LDL cholesterol*

For the diabetes benefit, the blood glucose NCD edit is being subdivided into two parts.

1. For *CPT* code *82947*, CMS is adding ICD-9-CM diagnosis code V77.1 (screening for diabetes mellitus) to the list of ICD-9-CM diagnosis codes covered by Medicare.
2. The covered codes for the remaining CPT codes in the blood glucose NCD listed below remain unchanged:
   - *82948 Glucose, quantitative, blood, reagent strip*
   - *82962 Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use*

**Note:** Effective October 1, 2003, all claims for clinical diagnostic laboratory services submitted to Medicare must include ICD-9-CM diagnosis codes. Coding guideline #1 of the laboratory NCDs has been amended to reflect this requirement and the guideline now states: "Any claim for a clinical diagnostic laboratory service must be submitted with an ICD-9-CM diagnosis code. Codes that describe symptoms and signs, as opposed to diagnosis, should be provided for reporting purposes when a diagnosis has not been established by the physician."

### Implementation

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

### Additional Information

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

From that Web page, look for CR 3429 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/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: 3429
Related CR Release Date: November 26, 2004
Related CR Transmittal Number: 380
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub 100-4 Transmittal 380, CR 3429

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## Diabetes Screening Tests

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

### Provider Types Affected

All Medicare providers

### Provider Action Needed

### STOP – Impact to You

This article notifies providers that Medicare will permit coverage for the following diabetes screening tests for services performed on or after January 1, 2005 for individuals who satisfy the eligibility requirements of being at risk for diabetes:

- Fasting plasma glucose test; and
- Post-glucose challenge test (an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults or a two-hour post glucose challenge test alone).

### CAUTION – What You Need to Know

Coverage will be provided for two screening tests per calendar year for individuals diagnosed with pre-diabetes, and one screening test per year for individuals previously tested who were not diagnosed with pre-diabetes, or who have never been tested. This coverage does not apply to individuals previously diagnosed as diabetic.

*Diabetes Screening Tests (continued)*

## GO – What You Need to Do

Please refer to the *Background* and *Additional Information* sections of this instruction for further details.

## Background

This coverage is mandated by Section 613 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA).

Initially, coverage was limited to a fasting plasma glucose test. However, coverage is now provided for the following two screening blood tests:

- Fasting plasma glucose test
- Post-glucose challenge test (an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults, or a two-hour post-glucose challenge test alone).

Any individual with **one of the following individual risk factors for diabetes is eligible** for this new benefit:

- Hypertension
- Dyslipidemia
- Obesity (with a body mass index greater than or equal to 30 kg/m2)
- Previous identification of elevated impaired fasting glucose or glucose intolerance.

Or, an individual with any two of the following risk factors for diabetes is also eligible for this new benefit:

- Overweight (a body mass index >25, but<30kg/m2)
- A family history of diabetes
- Age 65 years or older
- A history of gestational diabetes mellitus or giving birth to a baby weighing > 9 lb.

Effective for services performed **on or after January 1, 2005,** Medicare will pay for diabetes screening tests under the Medicare clinical laboratory fee schedule. To indicate that the purpose of the test(s) is for diabetes screening, a screening diagnosis code is required in the diagnosis section of the claim:

- Two screening tests per calendar year are covered for individuals diagnosed with pre-diabetes.
- One screening test per year is covered for individuals previously tested who were not diagnosed with pre-diabetes, or who have never been tested.

Those providers billing fiscal intermediaries should note the following:

- The diabetes screening tests will be paid only when submitted on type of bills (TOBs) 12x, 13x, 14x, 22x, 23x, and 85x.
- Claims submitted on TOBs 13x, 14x, 22x, and 23x will be paid in accordance with the clinical laboratory fee schedule.
- Critical access hospitals (TOB 85x) will be paid based on reasonable cost.
- Maryland hospitals submitting Part B claims to fiscal intermediaries on TOBs 12x, 13x, or 85x will be paid according to the Maryland cost containment plan.

**Nationally Non-Covered Indications**

- No coverage is permitted under the MMA benefit for individuals previously diagnosed as diabetic.
- Other diabetes screening blood tests for which Medicare has not specifically indicated national coverage continue to be non-covered.

## Implementation

The implementation date is January 3, 2005 and applies to services furnished on or after January 1, 2005.

## Related Instructions

Updated manual instructions are included in the official instruction issued to your carrier or intermediary and can be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3637 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3637
Related CR Release Date: December 21, 2004
Related CR Transmittal Number: 409
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 409, CR 3637

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# Ocular Photodynamic Therapy with Verteporfin for Age-Related Macular Degeneration

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

**Note:** This article was revised on December 14, 2004 to show that HCPCS code J3396, instead of J3395, should be used for services rendered on or after January 1, 2005. The original article was published in the Third Quarter 2004 *Medicare A Bulletin* (pages 28-29).

## Provider Types Affected

All Medicare providers.

## Provider Action Needed

## STOP – Impact to You

This national coverage determination (NCD) provides for a change in the Medicare coverage policy for the use of ocular photodynamic therapy (OPT) with verteporfin for age-related macular degeneration (AMD). Under certain conditions (described below), OPT with verteporfin for AMD is now covered for additional clinical indications.

## CAUTION – What You Need to Know

CMS has determined that, provided certain criteria are met, OPT with verteporfin (*CPT* code *67221 and 67225,* as well as HCPCS code J3395) will now be covered for AMD in two additional clinical instances:

1) subfovial occult lesions with no classic choroidal neovascularization (CNV); and
2) subfoveal minimally classic CNV associated with AMD.

**Note:** HCPCS code J3396 should be used instead of J3395 for services furnished on or after January 1, 2005.

## GO – What You Need to Do

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

## Background

This NCD is documented in revisions to Chapters 80.2 and 80.3 of Pub. 100-03. Remember that NCDs are binding on all Medicare carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans. An NCD is also binding on Medicare [+ Choice] Advantage organizations. Administrative law judges may not review NCDs.

This NCD addresses coverage for the use of OPT with verteporfin in additional clinical instances. OPT with verteporfin continues to be approved for patients with a diagnosis of neovascular AMD with predominately classic subfoveal CNV lesions (where the area of classic CNV occupies = 50 percent of the area of the entire lesion).

**Note:** Remember that this diagnosis must be determined by a fluorescein angiogram at the initial visit. Also, there are no requirements regarding visual acuity, lesion size, and number of retreatments when treating predominantly classic lesion patients; however, they do require a fluorescein angiogram in subsequent, follow-up visits prior to treatment.

In addition to this diagnosis, after thorough review and reconsideration of the August 20, 2002, noncoverage policy, CMS has determined that there is enough evidence to conclude that OPT with verteporfin, in certain instances, may be reasonable and necessary for treating subfoveal occult lesions with no classic CNV and subfoveal minimally-classic CNV lesions (where the area of classic CNV occupies <50 percent of the area of the entire lesion).

These two new covered indications are considered reasonable and necessary only when:

- The lesions are small (four disk areas or less in size) at the time of initial treatment or within the three months prior to initial treatment; and
- They have shown evidence of progression within the three months prior to initial treatment. You must confirm this evidence of progression by documenting the deterioration of visual acuity (at least five letters on a standard eye examination chart); lesion growth (an increase in at least one disk area); or the appearance of blood associated with the lesion.

Be aware that the other AMD-related uses of OPT with verteporfin, not already addressed by CMS, will continue to be noncovered. These include, but are not limited to: juxtafoveal or extrafoveal CNV lesions (lesions outside the fovea); inability to obtain a fluorescein angiogram; or atrophic or "dry" AMD.

On the other hand, the use of OPT with verteporfin for other ocular indications, such as pathologic myopia or presumed ocular histoplasmosis syndrome, continue to be eligible for local coverage determinations through individual Medicare contractor discretion.

The following is a short history leading up to the current NCD.

1. Effective July 1, 2001, CMS approved the use of OPT with verteporfin in neovascular AMD patients having predominately classic subfoveal CNV lesions.
2. On October 17, 2001, CMS announced its "intent to cover" OPT with verteporfin for AMD patients with occult subfoveal CNV lesions; however, this decision was never implemented.
3. On March 28, 2002, CMS reviewed the October 17, 2001, intent to cover policy, and determined that the (then) current noncoverage policy for OPT for verteporfin for AMD patients with occult subfoveal CNV should remain in effect.
4. Effective August 20, 2002, CMS issued a noncovered instruction for OPT with verteporfin for AMD patients with occult subfoveal CNV lesions.
5. Now CMS, after through review and reconsideration of the August 2002 decision, has determined that there is enough evidence to conclude that OPT with verteporfin is also reasonable and necessary in these additional clinical instances. Therefore, this NCD, effective April 1, 2004, provides for covering the use of OPT with verteporfin in patients with subfoveal occult lesions

*Ocular Photodynamic Therapy with Verteporfin for Age-Related Macular Degeneration (continued)*

with no classic CNV, and subfoveal minimally classic CNV lesions as described above.

### Additional Information

You can find additional background information in Pub. 100-03, Chapters 80.2 and 80.3, which are included in the actual instruction issued to Medicare carriers and fiscal intermediaries on this NCD. This instruction can be found in CR3191 at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

Once at that site, scroll down to find 3191 in the CR NUM column on the right and then click on the file for that number.

Related Change Request (CR) Number: 3191
Related CR Release Date: April 1, 2004
Related CR Transmittal Number: 9
Effective Date: April 1, 2004
Implementation Date: April 1, 2004

Source: CMS Pub 100-3 Transmittal 9, CR 3191

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## Cardiovascular Screening Blood Tests

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

### Provider Types Affected

Physicians, providers, and suppliers

### Provider Action Needed

The information in this article provides guidance for the new national coverage policy related to cardiovascular screening tests covered, effective for services performed on or after January 1, 2005.

### Background

In accordance with Section 612 of the Medicare Modernization Act (MMA), Medicare coverage is provided for cardiovascular screening blood tests (tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk for that disease) effective for services performed on or after January 1, 2005.

The MMA permits coverage of tests for cholesterol and other lipid or triglycerides levels for this purpose. Therefore, effective January 1, 2005, coverage is provided for the following:

- Total cholesterol test
- Cholesterol test for high density lipoproteins
- Triglycerides test

Effective, January 1, 2005, Medicare provides coverage for the cardiovascular screening blood test for beneficiaries every five years (i.e., 59 months after the last covered screening tests.) Medicare has determined that it is not necessary to test more frequently since lipid and cholesterol levels for people often stay fairly consistent beyond age 65.

Medicare Part B covers cardiovascular screening blood tests when ordered by the physician who is treating the beneficiary for the purpose of early detection of cardiovascular disease in individuals without apparent signs or symptoms.

The implementation of this new benefit permits Medicare beneficiaries who have not been previously diagnosed with cardiovascular disease to receive cardiovascular screening blood tests for risk factors associated with cardiovascular disease. This includes individuals who have no prior knowledge of heart problems but recognize that their behavior or lifestyle may be at risk because of diet or lack of exercise.

Payment is provided under the Medicare clinical laboratory fee schedule. There is no deductible or copayment for this benefit.

**HCPCS/CPT Codes/Diagnosis Codes**

The following HCPCS/*CPT* Codes are to be billed for the cardiovascular screening blood tests:

*80061* *Lipid panel*
*82465* *Cholesterol, serum, or whole blood, total*
*83718* *Lipoprotein, direct measurement; high-density cholesterol*
*84478* *Triglycerides*

(The tests should be performed as a panel; however, they are also available as individual tests.) The following diagnosis codes must be submitted on the claim for when billing for cardiovascular screening blood test:

V 81.0 Special screening for ischemic heart disease
V81.1 Special screening for hypertension
V81.2 Special screening for other and unspecified cardiovascular conditions

Medicare will pay for cardiovascular disease screening under the Medicare clinical laboratory fee schedule. Providers and suppliers that bill for the cardiovascular disease screening benefit must point the screening diagnosis (V81.0, V81.1, V81.2) to the line item service.

Other cardiovascular screening blood tests (for which CMS has not specifically indicated approval for national coverage) continue to be non-covered.

**How Intermediaries and Carriers Will Treat Claims**

Medicare intermediaries and carriers will treat claims as follows:

- Intermediaries/carriers will accept claims with *CPT* codes *80061* (lipid panel), *82465* (cholesterol, serum or whole blood, total), *83718* (lipoprotein, direct measurement; high density cholesterol, HDL cholesterol), or *84478* (triglycerides) when there is a reported diagnosis of V81.0 (special screening for ischemic heart disease), V81.1 (special screening for hypertension), or V81.2 (special screening for other and unspecified cardiovascular conditions).

*Cardiovascular Screening Blood Tests (continued)*

- Intermediaries/carriers will deny claims with code *80061* when there is already evidence of a paid claim within the prior 60 months that was billed with a diagnosis code of V81.0, V81.1, or V81.2, and with a procedure code of *80061, 82465, 83718*, or *84478.*
- Intermediaries/carriers will deny claims with procedure codes of *82465, 83718,* or *84478* when billed within 60 months of a previous paid claim with a diagnosis code of V81.0, V81.1, 0r V81.2 and a procedure code of *80061*.

### Additional Information

The Medicare Claims Processing Manual, Chapter 18, Section 100 is new. The new manual instructions are attached to the official instruction (CR 3411) released to your carrier/intermediary. You may view that instruction by going to:
*http://www.cms.hhs.gov/manuals/pm_trans/R408CP.pdf*.

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

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

Related Change Request (CR) Number: 3411
Related CR Release Date: December 17, 2004
Related CR Transmittal Number: 408
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 408, CR 3411

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## Coverage of Routine Costs of Clinical Trials Involving Investigational Device Exemption Category A Devices

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

### Provider Types Affected

Physicians and providers

### Provider Action Needed

### STOP – Impact to You

Effective for routine costs incurred on or after January 1, 2005, Medicare will cover the routine costs of clinical trials involving Investigational Device Exemption (IDE) Category A devices (used in the diagnosis, monitoring, or treatment of an immediately life-threatening disease or condition).

### CAUTION – What You Need to Know

This extension of coverage refers to the routine services performed for such clinical trials. **The Category A device itself remains noncovered.**

### GO – What You Need to Do

This extension of coverage refers to the routine services performed for such clinical trials. **The Category A device itself remains noncovered.**

### Background

Prior to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the Centers for Medicare & Medicaid Services (CMS) limited coverage of clinical trials to:

- IDE Category B trials (21 CFR 405.201); and
- Routine costs for qualifying clinical trials (National Coverage Determinations Manual 310.1).

The MMA (Section 731(b)) expands the ability of CMS to cover costs in clinical trials by authorizing coverage of routine costs in certain clinical trials involving IDE Category A devices effective for routine costs incurred on or after January 1, 2005.

**This extension of coverage refers to the routine services performed for such a trial, and the Category A device itself remains noncovered.**

Category A (experimental/investigational) devices are innovative medical devices about which the Food and Drug Administration (FDA) has major questions regarding safety and effectiveness. For a trial to qualify for payment of routine costs, it must meet certain criteria established by the Secretary of the Department of Health and Human Services to ensure that the trial conforms to appropriate scientific and ethical standards.

In addition, the MMA established additional criteria for trials initiated before January 1, 2010, to ensure that the devices involved in these trials be intended for use in the:

1) **Diagnosis;**
2) **Monitoring; or**
3) **Treatment of an immediately life-threatening disease or condition** ("a stage of a disease in which there is a reasonable likelihood that death will occur within a matter of months or in which premature death is likely without early treatment).

*Coverage of Routine Costs of Clinical Trials Involving Investigational Device Exemption Category A Devices (continued)*

Providers participating in the clinical trial are responsible for furnishing all information the Medicare contractor (fiscal intermediary or carrier) deems necessary for coverage determination and claims processing regarding:

- The device;
- The clinical trial; and
- The participating Medicare beneficiaries.

Also, the provider must contact their local Medicare intermediary or carrier before billing for this service.

### Billing Instructions

For routine services performed in a clinical trial where a category A device is used for a patient with a life threatening condition:

- **Physicians billing with Form CMS-1500** must place the IDE number of the category A device in Item 23.
- **Physicians billing electronically** must place the IDE number on the 2300 Investigational Device Exemption Number REF segment, data element REF02 (REF01=LX) of the 837p.
- **Hospitals** must place the category A IDE number on the 837I electronic claim format in 2300 Investigational Device Exemption Number REF Segment, data element REF02 (REF01=LX). If billing on the UB-92 CMS-1450 paper form, the IDE number must be in form locator 43.
- **All providers** should place modifier QV on the claim to reflect routine costs in a clinical trial associated with an IDE category A device. Note, however, that CMS is working to obtain another modifier that will be required in addition to modifier QV. Further news will be provided on that modifier once CMS receives it.
- **All providers** should also note that Medicare will continue to deny claims submitted for the IDE category A device itself.

### Implementation

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

### Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R131OTN.pdf*.

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

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

Related Change Request (CR) Number: CR 3548
Related CR Release Date: December 17, 2004
Related CR Transmittal Number: 131
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-20, Transmittal 131, CR 3548

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# HOSPITAL SERVICES

## Inpatient Psychiatric Facility Prospective Payment System Implementation

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

### Provider Types Affected

Inpatient psychiatric facilities (IPFs), including distinct part psychiatric units of acute care hospitals

### Provider Action Needed

### STOP – Impact to You

Medicare is changing the way it will pay for services provided to Medicare beneficiaries in IPFs, including distinct part psychiatric units, **effective with discharges on or after January 1, 2005.**

### CAUTION – What You Need to Know

This article provides information needed to implement Medicare standard systems for IPF PPS. Be aware of the full impact of this change on your facility's billing processes.

### GO – What You Need to Do

Familiarize your billing staffs with this information and the details in related CR 3541.

Staff should avail themselves of additional training and materials, to be available from your Medicare fiscal intermediary (FI), to ensure accurate and timely payments from Medicare under this new payment system.

### Background

IPFs are certified under Medicare as inpatient psychiatric hospitals and distinct psychiatric units of acute care hospitals that:

1) have been excluded from the hospital inpatient PPS under the Social Security Act (SSA, Section 1886(d)((1)(B)(i)); and
2) are included for purposes of Medicare payment.

The IPF PPS will replace the existing reasonable cost-based payment system under which the IPFs are currently paid.

**Statutory Requirements**

- The Balanced Budget Refinement Act (BBRA) of 1999 requires that a budget neutral, per diem PPS for IPFs include an adequate patient classification system, reflecting the differences in patient resource use and costs among psychiatric hospitals and psychiatric units of acute care hospitals, be implemented for cost reporting periods beginning on or after October 1, 2002. This will replace the reasonable cost-based Tax Equity and Fiscal Responsibility Act (TEFRA) payment system.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Section 902 amended section 1871 (a) of the Act stating that the timeliness for regulations will not exceed three years after publication of the preceding proposed or interim final regulation except under exceptional circumstances. This final rule finalizes the provisions set forth in the November 28, 2003, proposed rule. Payments for IPF services delivered for cost reporting periods starting on or after January 1, 2005, will be based on the policies set forth in the November 15, 2004, final rule (69 CFR 66922).

**Affected Medicare Providers**

IPFs are certified under Medicare as inpatient psychiatric hospitals—institutions that are primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of the mentally ill person. An IPF maintains clinical records necessary to determine the degree and intensity of the treatment provided to the mentally ill person and meets staffing requirements sufficient to carry out active programs of treatment for individuals who are furnished care in the institution.

Distinct psychiatric units must meet the clinical record and staffing requirements to be considered a "psychiatric hospital." Both psychiatric hospitals and distinct psychiatric units of acute care hospitals are referred to in the IPF PPS rule as "inpatient psychiatric facilities." IPFs are identified by the last four digits of the Medicare provider number, which range between "4000" and "4499" for psychiatric hospitals and "Sxxx" and "Mxxx."

Hospitals excluded from the IPF PPS include the following:

- Veterans Administration hospitals
- Hospitals that are reimbursed under state cost control systems approved under 42 CFR Part 403.
- Hospitals that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90-248 (42 U. S. C. 1395b-1) or section 222(a) of Public Law 92-603 (42 U. S. C. 1395b-1).
- Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries. Payment to foreign hospitals will be made in accordance with the provisions set forth in section 413.74 of the regulation. See section 412.22(c).
- IPFs in acute care hospitals that are currently paid in accordance with demonstration projects.
- Freestanding IPFs (provider number xx-4000 through xx-4499) in Maryland will be paid under the IPF PPS, though distinct part psychiatric units located in Maryland (fourth position of provider number is 'S') will be waived from the IPF PPS. There are currently no critical access hospitals in Maryland.

As mentioned previously, this article provides some basic information about this new PPS, but it is very important that affected providers become familiar with the full details of the official instruction issued by the Centers for Medicare & Medicaid Services (CMS) regarding this new

*Inpatient Psychiatric Facility Prospective Payment System Implementation (continued)*

system The CR related to this article, CR 3541, has been issued to your FI and provides the CMS policy, business requirements, and information on the data elements of the provider-specific file that is relevant to the IPF. CR 3541 may be viewed at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3541 in the CR NUM column on the right, and click on the file for that CR.

## Key Provisions

While affected providers need to be familiar with the full details of CR 3541, some of the key provisions are as follows:

## Implementation Date

This change will not be implemented in Medicare systems until April 4, 2005. However, the changes are effective with claims for discharges on or after January 1, 2005. Since you may submit claims for affected services prior to April 4, 2005, CMS has instructed your FI to mass adjust claims submitted prior to April 4, once Medicare systems have implemented this PPS. **Your FI should complete such mass adjustments by July 1, 2005.**

**Remember:** IPFs must follow the PPS billing requirements for claims for discharges on or after January 1, 2005 as if Medicare systems were paying under the PPS. This is required so the mass adjustments can be made in an accurate and timely manner.

**What are those billing requirements?**

Effective with cost reporting periods that begin on or after January 1, 2005, IPFs must bill or be aware of the following so FIs can accurately price and pay a claim under the IPF PPS:

- Submit the claim on type of bill (TOB) 11x.
- Code the claim using ICD-9-CM codes based on principal diagnosis, up to eight additional diagnoses, and one principle procedure and up to five additional procedures performed during the stay, as well as age, sex, and discharge status of the patient on the claim.
- Submit one admit-through-discharge claim for the stay upon discharge. (Should the stay be exceptionally long, interim bills based on 60-day intervals may be submitted. But the final PPS payment will be based on the discharge bill.).
- Adjustment bills will be accepted, but late charge bills will not be allowed.
- While all patient status (i.e., discharge disposition codes) for TOB 11x are valid, there are no special policies related to transfers. (The same patient status codes applicable under inpatient PPS for same day transfers [with condition code 40] are applicable under IPF PPS.)
- Indicate on the claim, under revenue code 0901, the total number of ECT treatments provided to the patient during their IPF stay listed under "Service Units." Use code ICD-9-CM procedure code 94.27 in the procedure code field and use the date of the last ECT treatment provided the patient during their stay.
- IPFs continue to be subject to the one-day payment window for outpatient bundling rules.
- The payer at the patient's admission to the IPF is responsible for the patient's entire stay, e.g., when a patient moves from traditional Medicare to a Medicare Advantage plan, or vice versa, during the stay.
- There are no grace days allowed under IPF PPS. Thus, the date the beneficiary is notified of your intent to bill (occurrence code 31) is the last covered day for that patient.

**Transition (Phase-in Implementation)**

The IPF PPS will be phased in over three years from the current cost-based reimbursement and all IPFs must go through the transition, except for new IPF providers. (See CR 3541 for definitions of "new providers," who will be paid immediately at 100 percent of the IPF PPS rate.) The transition period is as follows:

- Year 1 (effective for cost reporting periods on or after January 1, 2005): 75 percent of payment will be at the current TEFRA rate and 25 percent at the IPF federal rate.
- Year 2 (effective for cost reporting periods on or after January 1, 2006): 50 percent of payment will be at the TEFRA rate and 50 percent at the IPF PPS federal rate.
- Year 3 (effective for cost reporting periods on or after January 1, 2007): 25 percent of payment will be at the TEFRA rate and 75 percent at the IPF PPS federal rate.
- Commencing with cost reporting periods on or after January 1, 2008: payments will be based 100 percent on the IPF PPS rate.

**Payment Information**

Key points of interest regarding the payment rates are as follows:

- The IPF PPS must be budget neutral, i.e., total payments under the IPF PPS must equal the total amount that would have been paid if the PPS had not been implemented.
- The standardized federal per diem base rate, adjusted for budget neutrality, behavioral offset, outlier payments, stop-loss payments is $575.95.
- The federal per diem base rate is adjusted by all applicable patient and facility characteristics.
- The first annual update to the IPF PPS will occur on July 1, 2006, and annual updates will occur yearly thereafter on July 1. Please note that the annual update cycle is separate from the transition period.
- The first annual update notice will be published in the *Federal Register* in the spring of 2006.

**Patient-Level Adjustments**

Payments will be adjusted at the patient level and those adjustments include the following:

- A DRG specific adjustment for 15 specific DRGs as noted in the CR 3541. Although an IPF will not receive a DRG specific adjustment for a principal diagnosis not found in one of the identified 15 psychiatric DRGs

***Inpatient Psychiatric Facility Prospective Payment System Implementation (continued)***

listed in CR 3541, the IPF will receive the federal per diem base rate and all other applicable adjustments. Please note the information regarding the "Code First" rules that immediately follow the list of these 15 DRGs in CR 3541.

- The IPF PPS also has comorbidity adjustments for 17 comorbidity groupings, each containing ICD-9-CM codes of comorbid conditions and these are also listed in CR 3541. An IPF can receive only one comorbidity adjustment per comorbidity category, but can receive an adjustment for more than one comorbidity category.
- The IPF PPS has an age adjustment that the facility will receive for each day of the stay as noted in CR 3541. This age adjustment has nine age categories; under age 45, over age 80, and categories in five year groupings in between the ages of 45 and 80.
- There is a "variable per diem" adjustment that accounts for the ancillary and certain administrative costs that occur disproportionately in the first days after admission to an IPF. This variable adjustment, as shown in CR 3541 declines each day of the patient's stay through day 21. After day 21, the variable per diem adjustment flattens out and remains the same for the remainder of the patient's stay.

**Facility-Level Adjustments**

There are also the following adjustments related to the facility:

- A wage index adjustment accounts for geographic differences in labor costs.
- A 17 percent adjustment is allotted to facilities located in rural areas.
- Teaching facilities will receive an adjustment that is measured as one plus the ratio of interns and residents to the average daily census raised to the power of 0.5150. Further, the number of interns and residents is capped at the level indicated on the latest cost report submitted by the IPF prior to January 1, 2005.
- An adjustment will be provided for the first day of a psychiatric stay for IPFs with emergency departments as defined by CR 3541.

**Other Adjustments**

In addition to the patient-level and facility-level adjustments, there will be adjustments provided for electro-convulsive therapy, cost-of-living adjustments for IPFs located in Alaska and Hawaii, and payments for interrupted stays, outliers, and stop-loss. These payment factors are all further described in CR 3541.

### Further Action for Affected Providers

Affected providers must be familiar with the official instruction on this new system. That instruction can be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3541 in the CR NUM column on the right, and click on the file for that CR.

Please look for further educational opportunities and information from your FI regarding this new PPS.

If you have any questions or need additional information, 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: 3541
Related CR Release Date: December 1, 2004
Related CR Transmittal Number: 384
Effective Date: January 1, 2005
Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 384, CR 3541

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## Inpatient Rehabilitation Facility Classification Requirements

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

### Provider Types Affected

Inpatient rehabilitation facilities (IRF)

### Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) recently issued guidance to Medicare fiscal intermediaries (FI) on coding corrections and further clarification of existing policies within the IRF prospective payment system (PPS). This article summarizes that guidance.

To ensure accurate claims processing, please stay current on:

- The criteria used for IRF classification and verification; and
- The appropriate use of ICD-9-CM and impairment group codes from the IRF-patient assessment instrument (PAI) database.

### Background

CMS regional offices generally determine that a facility is classified as an IRF on an annual basis at the start of a facility's cost reporting period. The RO's determination applies to the entire cost-reporting period for which the determination is made.

If a determination is made by the RO to change the classification of a facility, the IRF status classification remains in effect for the duration of that cost reporting period. How a hospital or unit is classified takes effect only at the start of the facility's cost reporting period.

*Medicare IRF Classification Requirements*

An IRF that has already been excluded from the acute care hospital PPS is always subject to verification that it continues to meet the criteria necessary to allow the facility to be excluded from the acute care hospital PPS. The results

***Inpatient Rehabilitation Facility Classification Requirements (continued)***

of the verification procedure are used in determining each facility's classification status for the next cost reporting period.

If a facility fails to meet the criteria necessary to be classified as an IRF, but meets the criteria to be classified as an acute care hospital or acute care hospital unit, it may be paid under the acute care hospital PPS.

For the services furnished to a patient who was admitted when the facility was classified as an IRF, but who is discharged after the facility is no longer classified as an IRF, payment to the facility will be from the applicable payment system the facility is paid under when the facility is no longer classified as an IRF.

IRFs that have already been excluded from the acute care hospital PPS need not reapply to be classified as an IRF. However, on an annual basis an IRF must self-attest, except for the criteria specified in section 140.1.1B of the Medicare Claims Processing Manual, that it still meets the criteria for being classified as an IRF. The Medicare FI is always required to verify that an IRF has met the criteria specified in section 140.1.1B.

The facility must have approval from the RO and the state agency prior to making changes in operations.

All IRFs are notified by letter by the appropriate CMS RO of the self-attestation procedures, and other procedures and requirements that apply to them. Your Medicare FI is not responsible for monitoring or enforcing IRF self-attestation procedures.

*Update on FI Documentation Review for Certain Medical Conditions*

The FI has the discretion to review documentation (to ensure that an inpatient has completed an appropriate, aggressive, and sustained course of therapy or services in less intensive rehabilitation settings and to ensure that the conditions result in significant functional impairment of ambulation and other activities of daily living that have not improved following such therapy) for the following medical conditions:

- Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies
- Systemic vasculidities with joint inflammation
- Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion and atrophy of muscles surrounding the joint.

CMS expects that the IRF will obtain copies of the therapy notes from the outpatient therapy or therapy in another less intensive setting and place it in the patient's inpatient chart (in a section for prior records).

These prior records will primarily be used by therapists and others caring for the inpatient in the IRF; however, prior records will also be available to FI staff who review the medical records for compliance with the requirements specified in section 140.1.1B.

*Clarification on Verification Process (section 140.1.4 of the Medicare Claims Processing Manual)*

In section 140.1.4. of the Medicare Claims Processing Manual, the following guidelines have been included:

**1. General Guideline to Determine the Compliance Review Period**

In general, the RO and FI will use data from a most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI) that starts on or after July 1, 2004, to determine if a facility is in compliance with all of the criteria used to classify a facility as an IRF. The RO and FI will notify the facility regarding which most recent, consecutive, and appropriate 12-month period will be used as the review time period when they determine if the criteria used to classify a facility as an IRF was met.

The RO and FI will begin four months prior to the start of the facility's next cost reporting time period the process necessary to verify all the criteria used to classify a facility as an IRF. If for any reason the RO or FI requires additional time to complete their compliance review, the RO and FI must consult with the facility prior to changing the compliance time period subject to review, and before using patient data that may overlap patient data from the previous 12-month review period.

**2. Guideline for Compliance Review Period Transition Cases**

If an IRF has a cost reporting period beginning on or after July 1, 2004, and before November 1, 2004, the RO and FI cannot collect 12 months of the most recent, consecutive, and appropriate data from a period falling completely after, as opposed to before, July 1, 2004, and have the four months of time necessary to make the compliance determination.

To determine whether a hospital with a cost reporting period beginning on July 1, 2004, should continue to be classified as an IRF for the cost reporting period beginning on July 1, 2005, the RO and FI would have to start their compliance review four months prior to July 1, 2005, which means that the compliance review will start on March 1, 2005.

As stated above, in general the RO and FI will use 12 months of data from the most recent, consecutive, and appropriate time period that is after July 1, 2004. Starting the compliance review on March 1, 2005, means that the RO and FI must use data from the previous 12 months, which is March 1, 2004, to February 28, 2005. However, using data from March 1, 2004, to February 28, 2005, would result in the RO and FI using four months of data, that is, March 1, 2004, to June 30, 2004, from a time period that is before July 1, 2004.

**3. Table of Compliance Review Periods**

For a facility that has been classified as an IRF but is not a "new" IRF as defined below in section 140.1.7, the following table illustrates how both the *General Guideline To Determine the Compliance Review Period*, and the *Guideline for Compliance Review Period Transition Cases* are used to calculate the applicable compliance review time period.

For cost reporting periods that start on or after July 1, 2004, and on or before October 1, 2005, the following are the compliance review periods. For this table of compliance review periods, the patient cases used will be any admission that occurred during the compliance review period and that was also discharged during the compliance review period, and any other discharges that occur during the compliance review period.

*Inpatient Rehabilitation Facility Classification Requirements (continued)*

| For Cost Reporting Periods Beginning On | Review Period: (Admissions During) | Number of Months in Review Period | Compliance Determination Applies to Cost Reporting Period Beginning On |
|---|---|---|---|
| July 1, 2004 | July 1, 2004 – 02/28/2005 | 8 | July 1, 2005 |
| August 1, 2004 | July 1, 2004 – 03/31/2005 | 9 | August 1, 2005 |
| September 1, 2004 | July 1, 2004 – 04/30/2005 | 10 | September 1, 2005 |
| October 1, 2004 | July 1, 2004 – 05/31/2005 | 11 | October 1, 2005 |
| November 1, 2004 | July 1, 2004 – 06/30/2005 | 12 | November 1, 2005 |
| December 1, 2004 | August 1, 2004 – July 31, 2005 | 12 | December 1, 2005 |
| January 1, 2005 | September 1, 2004 – August 31, 2005 | 12 | January 1, 2006 |
| February 1, 2005 | October 1, 2004 – September 30, 2005 | 12 | February 1, 2006 |
| March 1, 2005 | November 1, 2004 – October 31, 2005 | 12 | March 1, 2006 |
| April 1, 2005 | December 1, 2004 – November 30, 2005 | 12 | April 1, 2006 |
| May 1, 2005 | January 1, 2005 – December 31, 2005 | 12 | May 1, 2006 |
| June 1, 2005 | February 1, 2005 – January 31, 2006 | 12 | June 1, 2006 |
| July 1, 2005 | March 1, 2005 – February 28, 2006 | 12 | July 1, 2006 |
| August 1, 2005 | April 1, 2005 – March 31, 2006 | 12 | August 1, 2006 |
| September 1, 2005 | May 1, 2005 – April 30, 2006 | 12 | September 1, 2006 |
| October 1, 2005 | June 1, 2005 – May 31, 2006 | 12 | October 1, 2006 |

As illustrated in the table above, if a cost reporting period starts on or after July 1, 2004, and before November 1, 2004, data from a compliance review period that is less than 12 months in length will be used to determine if the facility met all of the criteria necessary to be classified as an IRF for the next cost reporting period. For cost reporting periods beginning on or after November 1, 2004, data from the most recent, consecutive, and appropriate 12-month period of time would be used, giving the ROs and FIs a four-month time period to make and administer a compliance determination.

**4. Guideline for Determining the Compliance Review Period of a Facility Classified as a New IRF, and for an IRF Expanding its Size**

For an IRF to be classified as a new IRF, or to add new bed capacity, it must meet the criteria specified in the regulations and below in section 140.1.7. A facility classified as a new IRF, or adding new bed capacity, will have a compliance review period that is similar to an IRF whose cost reporting period begins on July 1, 2004. In other words, a facility classified as a new IRF, or adding new bed capacity, will have a compliance review period that starts immediately when its cost reporting period starts, and ends four months before the start of its next cost reporting period.

For example, if a facility has a cost reporting period that starts on July 1, 2004, and is undergoing the conversion process to be classified as an IRF, its compliance review period would start on July 1, 2004, and end on February 28, 2005. Thus, a facility classified as a new IRF, or adding new bed capacity, will have a compliance review period that is eight months in length, to allow the RO and FI a four-month time period to make and administer a compliance determination.

The compliance threshold for a facility classified as a new IRF, or adding new bed capacity, which had a cost reporting period that started on or after June 30, 2003, and before July 1, 2004, will be as specified above in section 140.1.1B1.

**5. Guideline for Determining the Compliance Review Period of a Facility Undergoing Conversion to an IRF**

A facility undergoing the conversion process to be classified as an IRF will have a compliance review period that is similar to an IRF whose cost reporting periods begins on July 1, 2004. In other words, a facility undergoing the conversion process to be classified as an IRF will have a compliance review period that starts immediately when the cost reporting period starts and ends four months before the start of its next cost reporting period.

For example, if a facility has a cost reporting period that starts on July 1, 2004, and is undergoing the conversion process to be classified as an IRF, its compliance review period would start on July 1, 2004, and end on February 28, 2005. Thus, a facility that is undergoing the conversion process to be classified as an IRF will have a compliance review period that is eight months in length, to allow the RO and FI a four-month time period to make and administer a compliance determination.

The compliance threshold for a facility undergoing the conversion process to be classified as an IRF that had a cost reporting period that started on or after June 30, 2003, and before July 1, 2004, will be as specified above in section 140.1.1B1.

**6. Guideline for Determining the Compliance Review Period of a Facility that Changes Its Cost Reporting Period**

A facility that changes its cost reporting period will have a compliance review period that, in accordance with the above table, is based on its new cost reporting period.

*Verification of Compliance Using ICD-9-CM and Impairment Group Codes*

Appendix A of Chapter 140 includes ICD-9-CM and impairment group codes from the IRF-PAI database that will be used to presumptively verify compliance with the requirements specified in section 140.1.1B. The instructions specified in section 140.1.4B(1), section 140.1.4B(2), and in

*Inpatient Rehabilitation Facility Classification Requirements (continued)*

Appendix A are to be used by your FI when verifying compliance with the requirements specified in section 140.1.1B.

The instructions in section 140.1.4B(1) and section 140.1.4B(2) and this Appendix are not intended to be used to complete the IRF-PAI. To complete the IRF-PAI, an IRF must use the instructions in the IRF-PAI manual and any other CMS approved instructions that specifically state how to complete the IRF-PAI.

### Additional Information

Appendix A, as well as other revised portions of the Medicare Claims Processing Manual, are attached to the official instruction issued to your FI regarding this change, which can be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR 3503. Click on the link to open and view the file for the CR.

You may also refer to CR 3334 and MM3334 on Medicare Inpatient Rehabilitation Facility Classification Requirements for additional background information. CR 3334 may be found at the same site as mentioned above for CR 3503, but click on the file for CR 3334. MM3334 may be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3334.pdf*.

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

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

Related Change Request (CR) Number: 3503
Related CR Release Date: October 29, 2004
Related CR Transmittal Number: 347
Effective Date: N/A
Implementation Date: November 29, 2004

Source: CMS Pub. 100-4, Transmittal 347, CR 3503

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## Extension of Interrupted Stay Policy Under Long Term Care Hospital PPS

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

**Note:** This article was revised on December 28, 2004 to reflect a new transmittal number and release date for CR 3279. The CR 3279 was amended to add the surgical DRG (diagnosis related group) table for federal fiscal year 2005 and that table can be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R399CP.pdf*. The article was published in the First Quarter 2005 Medicare A Bulletin (pages 38-39).

### Provider Types Affected

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

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

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

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

### CAUTION – What You Need to Know

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

### GO – What You Need to Do

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

### Background

Medicare considers an "interrupted stay" to be part of the first LTCH admission (or, a single discharge from the LTCH). Further, Medicare will only make a **single** LTCH PPS payment for an interrupted patient stay. For example, if the LTCH discharges the patient on July 1, 2004 and the patient is readmitted to the same LTCH on July 3, 2004, this is an interrupted stay and should be billed as one claim with an occurrence span code 74 from July 1, 2004 through July 2, 2004. The occurrence span code 74 cannot be used for days where other services were performed in another facility, because these should be performed under arrangements. Please keep in mind that Medicare will reject as an interrupted stay LTCH bills where the patient returns to the same LTCH within three days of being discharged.

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

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

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

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

**So, the original interrupted stay policy is as follows:**

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

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

## Implementation

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

To summarize, effective July 1, 2004, in addition to the original policies regarding interrupted stays, there is a special three-day interrupted stay policy that applies regardless of the patient's discharge venue. This policy requires that if a patient is readmitted to the LTCH within three days of the discharge, Medicare will pay only one LTC DRG. Medicare will not pay separately for claims submitted by other providers (acute hospital, SNF/swing bed, IRF, or any outpatient bill) for the patient's care during this three-day interruption.

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

"Under arrangements" means that the LTCH will bill and be paid for those services performed in another setting and no separate payment will be made to another facility during the three days. The LTCH is responsible for paying the other providers.

There is an exception for surgical DRGs in an acute care hospital. Medicare will issue a separate payment to the acute hospital if the patient stay is grouped to a surgical DRG. A list of surgical DRGs, effective through September 30, 2004, is attached to the instruction issued to your Medicare contractor. That instruction, which is CR 3279, can be found at:
*http://www.cms.hhs.gov/manual/pm_trans/R399CP.pdf*.

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

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

## Additional Information

You can find more information about the extension of the LTCH interrupted stay policy by reviewing the official instruction issued to your intermediary, which can be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R399CP.pdf*.

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

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

Related Change Request (CR) Number: 3279
Related CR Release Date: December 16, 2004 (Re-issued)
Related CR Transmittal Number: 399
Effective Date: July 1, 2004
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 399, CR 3279

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## Hospital Billing for Repetitive Services

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

### Provider Types Affected

Hospitals billing Medicare fiscal intermediaries (FIs)

### Provider Action Needed

This article provides information contained in Change Request (CR) 3633 that is related to hospital billing for repetitive services. The Centers for Medicare & Medicaid Services (CMS) has decided to reevaluate the policy of repetitive billing to reduce the burden on hospitals and maintain the ability to achieve accurate data for ambulatory patient classification (APC) recalibration.

CMS is also clarifying that the list of repetitive services is a complete list in the Medicare Claims Processing Manual (Pub. 100-04), Chapter 1 (General Billing Requirements), Section 50.2.2 (Frequency of Billing for Outpatient Services to FIs). (See the Additional Information section below.) Finally, CMS is also modifying billing for chemotherapy services.

### Background

CMS issued CR 3382 on August 3, 2004 (Transmittal 270 – Update to Frequency of Billing), to become effective January 1, 2005. CR 3382 updated instructions for hospitals billing repetitive services to allow CMS to accept more singleton claims (claims with only one significant procedure) for APC rate-setting.

However, in November 2004, CMS was notified by concerned hospitals of possible difficulties that might arise from such changes. To be responsive to these hospital concerns, CMS has reevaluated the repetitive services billing policy to reduce the burden on hospitals and maintain the ability to achieve accurate data for APC recalibration:

- Beginning January 1, 2005, repetitive service bills may include services paid under the clinical laboratory fee schedule. However, to allow for APC recalibration, repetitive bills may no longer include other nonrepetitive services, even if both the nonrepetitive service and the repetitive service are paid under the outpatient prospective payment system (OPPS).
- If an individual OPPS service is provided on the same day as an OPPS repetitive service, the individual OPPS service is to be billed on a separate OPPS claim containing the individual service and all packaged and/or related services.

**Note:** Providers are strongly encouraged to separate repetitive services from nonrepetitive services effective January 1, 2005. However, to allow sufficient time for providers to adjust their operations, CMS has delayed editing that would enforce providers to separate repetitive services from nonrepetitive services. Providers will be given advance notice of the effective date for such editing in a future Medlearn Matters article.

**EXAMPLE**

A patient receives a radiation therapy treatment (a repetitive service [revenue code 0333] on the repetitive service list) and on the same day the patient receives the following services:

- An outpatient consultation
- A CT scan
- Clinical laboratory services.

The hospital will report:

- The radiation therapy on the monthly claim (with the other radiation therapy services)
- The visit for the outpatient consultation and CT scan on a separate claim (from that submitted for the radiation therapy)
- The clinical laboratory services on either claim.

Similarly, if a chemotherapy drug is administered on the same day a repetitive service is rendered, then the chemotherapy drug, its administration, and its related supplies are reported on a separate claim from the monthly repetitive services claim.

**Note:** Chemotherapy administration is no longer a repetitive service as defined in the Medicare Claims Processing Manual (Pub. 100-04, Chapter 1, Section 50.2.2). However, chemotherapy is commonly administered during multiple encounters in a month. Where there are multiple encounters for chemotherapy or other non-repetitive services in a month, they may all be reported on the same claim, or they may be billed separately.

CMS does not believe brachytherapy meets the criteria for repetitive billing. Consequently, CMS prefers that hospitals bill brachytherapy in revenue code 0342, rather than revenue code 0333 (which is specific to repetitive services).

### Implementation

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

### Additional Information

To recap briefly:

- FIs will allow claims not paid under the OPPS (laboratory services) to be included on an OPPS claim.
- FIs will not allow claims with repetitive services to be billed on the same claim with nonrepetitive services furnished on the same date of service, even if the repetitive and non-repetitive services are both paid under the OPPS.

  **Note:** Providers are strongly encouraged to separate repetitive services from non-repetitive services effective January 1, 2005. However, to allow sufficient time for providers to adjust their operations, CMS has delayed editing that would enforce providers to separate repetitive services from non-repetitive services. Providers will be given advance notice of the effective date for such editing in a future Medlearn Matters article.

*Hospital Billing for Repetitive Services (continued)*

- FIs will accept claims with multiple encounters of non-repetitive services, throughout multiple days in a month, to be included on a single claim or separate claims.
- The list of repetitive claims is all-inclusive as shown in the following paragraph and table.

**Definition of Repetitive Part B Services**

The following was taken from the Medicare Claims Processing Manual (Pub. 100-04), Chapter 1 (General Billing Requirements), Section 50.2.2 (Frequency of Billing for Outpatient Services to FIs):

Repetitive Part B services are defined as services billed under the following (**and only the following**) revenue codes:

| Type of Service | Revenue Code(s) |
|---|---|
| DME Rental | 0290 – 0299 |
| Radiation Therapy | 0333 |
| Respiratory Therapy | 0410 – 0419 |
| Physical Therapy | 0420 – 0429 |
| Occupational Therapy | 0430 – 0439 |
| Speech Pathology | 0440 – 0449 |
| Home Health Visits | 0550 – 0559 |
| Kidney Dialysis Treatments | 0820 – 0859 |
| Cardiac Rehabilitation Services | 0482, 0943 |
| Psychological Services | 0900, 0901, 0911 – 0919 (in a psychiatric facility) |

**Note:** This does not apply to home health agency (HHA) services. See the Medicare Claims Processing Manual (Pub. 100-04, Chapter 10) for HHA requirements.

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

That instruction includes the revised sections 50.2.1 and 50.2.2 of Chapter 1 of the Medicare Claims Processing Manual. The instruction, CR 3633, may be viewed by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3633 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: 3633
Related CR Release Date: December 17, 2004
Related CR Transmittal Number: 407
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 407, CR 3633

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## Additional Information on Payment for Emergency Medical Treatment and Labor Act–Mandated Screening and Stabilization Services

An article addressing payments for Emergency Medical Treatment and Labor Act (EMTALA) mandated screens and stabilization services published First Quarter 2005 *Medicare A Bulletin* (page 42).

The Medicare Modernization Act of 2003 (MMA) Section 944(a) requires that determinations of whether items and services provided in emergency departments (EDs) are reasonable and necessary 1) be made on the basis of information available to the treating physician or practitioner at the time the item or service was ordered or furnished by the physician or practitioner, and 2) take into consideration the patient's presenting symptoms or complaint, and not only on the patient's principal diagnosis. The frequency with which a patient receives a service may not be considered.

This instruction is effective for services provided **on or after January 1, 2004.**

### Action Required by Providers

Providers (acute and critical care hospitals) that believe their EMTALA claims should be adjusted due to the admitting diagnosis not being appropriately reviewed by the FI, need to resubmit the claim as an adjustment indicating in the "Remarks" field "Adjustment due to CR 3437."

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

# Critical Access Hospital Services

## Corrected ZIP Code Files for the Health Professional Shortage Areas

The Center for Medicare & Medicaid Services (CMS) has released information that some ZIP codes were left off the files provided for the automated payment of the health professional shortage areas (HPSA) bonus. Corrected files are now available on CMS website at *http://www.cms.hhs.gov/providers/bonuspayment*.

These corrected files will be used for processing HPSA bonus payments for 2005.

A special edition Medlearn Matters article addressing the implementation of the physician scarcity bonus an the HPSA bonus was published in the First Quarter 2005 *Medicare A Bulletin* (page 44-45). This article is also available at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0453.pdf*.

Source: CMS Joint Signature Memorandum 05099, December 1, 2004

## Low Osmolar Contrast Material/Laboratory Tests/Payment for Inpatient Services Furnished by a Critical Access Hospital

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

### Provider Types Affected

Critical access hospitals (CAHs)

### Provider Action Needed

CR 3439 includes the following:

- Revisions to the Medicare Claims Processing Manual to state that payment will be made to CAHs for low osmolar contrast material (LOCM) furnished as part of medically necessary imaging procedures (and without the previous requirement for one or more of five medical conditions listed in other instructions).
- Clarification that if a CAH sets up "draw stations" in non-CAH providers or facilities, payment for clinical diagnostic laboratory tests performed on those specimens will not be made on a reasonable cost basis but will be paid under the laboratory fee schedule.

**Note:** CAHs should note that, while these changes are effective on January 1, 2005, Medicare systems changes will not be made until April 4, 2005. Therefore, Medicare advises CAHs to hold LOCM line items on claims for services provided on or after January 1 through April 10, 2005 and to bill Medicare for those services beginning April 10, 2005. Further, Medicare requests that CAHs not bill Medicare beneficiaries for LOCM services provided on or after January 1, 2005 through April 10, 2005 and, instead, wait until April 10 to begin billing Medicare.

### Background

**Payment for LOCM Furnished by a CAH**

Payment for LOCM (furnished in connection with medically necessary imaging procedures for intrathecal procedures and in intra-venous and intra-arterial injections) was made under previous policy only if the beneficiary had one or more of the following five medical conditions:

- A history of previous adverse reactions to contrast media
- A history of asthma or allergy
- Significant cardiac dysfunction
- Generalized dehabilitation

LOCM was previously not paid for intra-venous and intra-arterial injections unless at least one of these conditions was present.

Based on a review of current medical practices regarding the use of contrast material, the Centers for Medicare & Medicaid Services (CMS) has concluded that the presence of one of these five medical conditions should no longer be a requirement for the payment for LOCM. Therefore, payment will be made for LOCM furnished as part of medically necessary imaging procedures, regardless of whether any of the medical conditions listed above or in previous instructions are present.

**Clinical Diagnostic Laboratory Tests Furnished by CAHs**

The regulations (as revised) provide that **payment** for outpatient clinical diagnostic laboratory tests will be made on a reasonable cost basis only if the individuals satisfy the following:

- They are outpatients of the CAH; and
- They are physically present in the CAH at the time the specimens are collected.

(See Federal Register document published on August 1, 2003 (48 FR 45471) and 42 CFR 413.70 (b)(3)(iii)).)

Clinical diagnostic laboratory tests for individuals who are not physically present in the CAH at the time the specimens are collected will be made in accordance with the Medicare laboratory fee schedule.

Since publication of the above-cited regulations, some CAHs have asked whether reasonable cost payment will be made for clinical diagnostic laboratory tests performed on specimens from patients not physically present in the CAH when the specimens are collected, if:

- Collection occurs in "draw stations" or other similar locations within non-CAH providers (such as rural health clinics or in other non-CAH settings); and
- They represent those providers or locations as parts of the CAH.

*LOCM/Laboratory Tests/Payment for Inpatient Services Furnished by a Critical Access Hospital (continued)*

To prevent this practice and ensure that the requirements of the regulations are implemented, payment for clinical diagnostic laboratory tests on such specimens will not be made on a reasonable cost basis. Individuals who have specimens collected in "draw stations" or other similar locations set up within non-CAH providers or facilities for collecting laboratory specimens are not considered to be physically present for specimen collection. Payment for the clinical diagnostic tests performed on these specimens is paid under the laboratory fee schedule.

**In summary:**

Medicare fiscal intermediaries (FIs) will pay (on a reasonable cost basis) for LOCM furnished as part of medically necessary imaging procedures. Such services should be billed on type of bill (TOB) 11x for LOCM furnished during an inpatient stay covered under Medicare Part A, on TOB 12x for LOCM furnished to an inpatient where payment is under Part B because the stay is not covered under Part A, or TOPB 85x for LOCM furnished to an outpatient. Bills should include revenue code 636 along with one of the following HCPCS codes, as appropriate:

A4644 supply of LOCM of 100-199 mgs of iodine
A4645 supply of LOCM of 200-299 mgs of iodine
A4646 supply of LOCM of 300-399 mgs of iodine.

FIs will also pay under the laboratory fee schedule for clinical diagnostic laboratory tests performed on specimens from individuals that are collected in "draw stations" or other similar facilities for collecting laboratory specimens that are set up in non-CAH facilities or locations.

## Implementation

The implementation date for this instruction is April 4, 2005.

## Related Instructions

The Medicare Claims Processing Manual (Pub 100-04), Chapter 3 (Inpatient Hospital Billing) and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)) are being revised to reflect these revised policies, which only impact CAHs. The updated manual instructions are included in the official instruction issued to your intermediary. These instructions can be found at the following CMS website: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3439 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: 3439
Related CR Release Date: November 26, 2004
Related CR Transmittal Number: 379
Effective Date: January 1, 2005
Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 379, CR 3439

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# January 2005 Update to the Medicare Non-OPPS Outpatient Code Editor

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

## Provider Types Affected

Hospitals and other providers that provide outpatient services billed to Medicare fiscal intermediaries (FIs) and are not paid under the OPPS

## Provider Action Needed

This article includes information contained in change request (CR) 3621, which informs FIs that the outpatient code editor (OCE), used to process bills from hospitals not paid under the OPPS (non-OPPS), has been updated with new additions, changes, and deletions to Healthcare Common Procedure Coding System (HCPCS) codes, diagnosis codes, and procedure codes to ensure correct billing.

## Background

The non-OPPS OCE has been updated with additions, changes, and deletions to HCPCS/Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4) codes. This OCE is used to process bills from hospitals not paid under the OPPS, and the Centers for Medicare & Medicaid Services (CMS) has provided detailed information about these changes in separate communications.

The following are changes made for version 20.1 of the non-OPPS OCE:

The following ambulatory surgical center (ASC) procedure codes will be **deleted** from ASC procedures and payments groups, effective **January 1, 2005**:

| Code | Description of Code |
|---|---|
| *50559* | Renal endoscopy/radiotracer |
| *50959* | Ureter endoscopy & tracer |
| *50978* | Ureter endoscopy & tracer |

The following new procedures have been **added** to the list of procedures for females only, **effective January 1, 2005**:

| Code | Description of Code |
|---|---|
| *57267* | Insert mes/pelvic flr addon |
| *57283* | Colpopexy, intraperitoneal |
| *58356* | Endometrial cryoblation |
| *58565* | Hysteroscopy, sterilization |
| *58956* | Bso, omentectomy w/tah |
| *84163* | Pappa, serum |
| *0500F* | Initial prenatal care visit |
| *0501F* | Prenatal flow sheet |
| *0502F* | Subsequent prenatal care |
| *0503F* | Postpartum care visit |
| *0071T* | U/s leiomyomata ablate <200 |
| *0072T* | U/s leiomyomata ablate >200 |

*January 2005 Update to the Medicare Non-OPPS Outpatient Code Editor (continued)*

The following new procedure codes have been **added** to the list of procedures for males only **effective January 1, 2005**:

| Code | Description of Code |
|---|---|
| *52402* | Cystourethro cut ejacul duct |
| *0084T* | Temp prostate urethral stent |

The following codes have been **removed** from the list of non-reportable procedures, **effective January 1, 2002**:

| Code | Description of Code |
|---|---|
| *90379* | Rsv ig, iv |
| *90389* | Tetanus ig, im |

The following codes have been **removed** from the list of non-reportable procedures **effective January 1, 2005**:

| Code | Description of Code |
|---|---|
| *36415* | Routine venipuncture |
| *96400* | Chemotherapy, sc/im |
| *96405* | Intralesional chemo admin |
| *96406* | Intralesional chemo admin |
| *96408* | Chemotherapy, push technique |
| *96410* | Chemotherapy, infusion method |
| *96412* | Chemo, infuse method add-on |
| *96414* | Chemo, infuse method add-on |
| *96420* | Chemotherapy, push technique |
| *96422* | Chemotherapy, infuse method |
| *96423* | Chemotherapy, infusion method add-on |
| *96425* | Chemotherapy, infusion |
| *96440* | Chemotherapy, intracavitary |
| *96445* | Chemotherapy, intracavitary |
| *96450* | Chemotherapy into CNS |
| *96542* | Chemotherapy injection |
| *96545* | Provide chemotherapy agent |
| *96549* | Chemotherapy, unspecified |

- The new HCPCS/CPT codes, as described in **Appendix A of CR 3621,** have been **added** to the list of valid codes for the non-OPPS OCE.
- The HCPCS/CPT codes listed in **Appendix B and C of CR 3621** have been **deleted** from the non- OPPS OCE.
- The HCPCS/CPT codes listed in **Appendix D of CR 3621** have been **added** to the list of non-reportable procedures.

## Implementation

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

## Additional Information

For complete details, see CR 3621, which is the official instruction issued to your intermediary regarding this change and includes the following:

- **Appendix A** - HCPCS/CPT codes **added** to the list of valid codes for the non-OPPS OCE
- **Appendix B and C** - HCPCS/CPT codes **deleted** from the non-OPPS OCE
- **Appendix D** - HCPCS/CPT codes **added** to the list of non-reportable procedures

That instruction may be viewed by going to the following CMS website: *http://www.cms.hhs.gov/manuals/pm_trans/R402CP.pdf*.

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

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

Related Change Request (CR) Number: 3621
Related CR Release Date: December 17, 2004
Related CR Transmittal Number: 402
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 402, CR 3621

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# SKILLED NURSING FACILITY SERVICES

## Medicare Rural Health Clinics and Federally Qualified Health Centers Payment Rate Increase—Skilled Nursing Facility Consolidated Billing As It Applies to Services Provided by RHCs and FQHCs

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

### Provider Types Affected

Rural health clinics (RHCs) and federally qualified health centers (FQHCs)

### Provider Action Needed

RHCs and FQHCs should be aware of the calendar year (CY) 2005 payment rate increase, an amendment to SNF CB that enables RHCs and FQHCs to bill for certain services furnished in the SNF setting.

### Background

This article and related CR 3575 provide details regarding the CY 2005 payment rate increase for RHC and FQHC services, as well as for the coverage and payment of RHC/FQHC visits furnished within the SNF setting.

**RHCs and FQHCs Upper Payment Limits for 2005**

Effective for services provided **on or after January 1, 2005,** for CY 2005, the following upper payment limits (UPLs) per visit apply:

- RHC UPL is increased from $68.65 to $70.78
- Urban FQHC UPL is increased from $106.58 to $109.88
- Rural FQHC UPL is increased from $91.64 to $94.48

These RHC and FQHC rates reflect a 3.1 percent increase over the 2004 payment limit in accordance with the rate of increase in the Medicare Economic Index (MEI) as authorized by the Social Security Act (SSA) (Section 1833(f)).

**RHC/FQHC Visits Within the SNF Setting:**

The Balanced Budget Act (BBA) of 1997 (Section 4432) amended the statute to add consolidated billing for SNFs in the SSA (Section 1862 (a) (18)). Similar to the hospital bundling provision in the SSA (Section 1862(a)(14)), this provision bundled all Part B services furnished to SNF patients into the SNF prospective payment system, except those services specifically excluded by law.

RHC services were not among the excepted services. Consequently, when an SNF resident received RHC or FQHC services during a covered Part A stay, the services were bundled into the SNF's comprehensive per diem payment for the covered stay itself, and were not separately billable as RHC or FQHC services to the fiscal intermediary (FI). This meant that, rather than submitting a separate bill to the FI for these services, the RHC or FQHC looked to the SNF for its payment.

However, the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), Public Law 108-173, (Section 410) amended the BBA (Section 4432) to specify that when an SNF Part A patient receives the services of a physician from an RHC or FQHC, those services are not subject to SNF CB just because the services were furnished under the auspices of the RHC or FQHC. Note that this also applies to services provided by other types of practitioners that the law identifies as being excluded from SNF CB. In accordance with the MMA (Section 410), services that are included within the scope of RHC and FQHC services and are also described in the SSA (Clause (ii) of Section 1888(e)(2)(A)) are excluded from the SNF CB provision. These services are limited to physician, physician's assistant, and nurse practitioner services. Only this subset of RHC/FQHC services may be covered and paid through the RHC/FQHC benefit when furnished to RHC/FQHC patients in a covered Part A, SNF stay.

The MMA amendment enables such RHC and FQHC services to retain their separate identity as excluded "practitioner" services. As such, these RHC and FQHC services are separately billable to the FI when furnished to an SNF resident during a covered Part A stay, effective with services furnished on or after January 1, 2005.

### Implementation

The implementation date for this instruction is January 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*.

From that Web page, look for CR 3575 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: 3575
Related CR Release Date: December 10, 2004
Related CR Transmittal Number: 390
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 390, CR 3575

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# Annual Update of Healthcare Common Procedure Coding System Codes Used for Skilled Nursing Facility Consolidated Billing

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

## Provider Types Affected

Skilled nursing facilities, physicians, providers, and suppliers

## Provider Action Needed

Affected providers should note that this article and the related CR 3542 contain the annual update of HCPCS codes used for SNF CB. It provides an updated list of exclusions and some inclusions to SNF CB, and only applies to codes affected by Medicare fiscal intermediary (FI) claim processing.

## Background

The Social Security Act (Section 1888) codifies SNF prospective payment system (PPS) and consolidated billing (CB). New coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services will be added by these routine updates. The new updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

This notification provides a list of the exclusions, and some inclusions, to SNF CB, and applies only to codes affected by Medicare FI claim processing.

A separate notification is published for codes affected by Medicare carrier claim processing.

**2005 Annual Update**

CR 3542 is the 2005 annual update in the routine and comprehensive process that the Centers for Medicare & Medicaid Services (CMS) has established for updating SNF CB edits affected by HCPCS coding changes in each quarter.

It is the first quarterly SNF CB update for fiscal year (FY) 2005, and it incorporates a list of new temporary codes (such as K codes, if applicable), as well as the annual update of all HCPCS codes.

Since this is the only quarter in which new permanent HCPCS codes are produced, the instruction is referred to as an annual update. Other updates for the remaining quarters of the FY will occur **as needed** due to the creation of new temporary codes prior to the next annual update. In lieu of any other update, editing based on these codes remains in effect.

In several past instructions, CMS established the process of periodically updating the lists of HCPCS codes that are subject to the CB provision of the SNF PPS. Services that appear on this list of HCPCS codes submitted on claims to both Medicare fiscal intermediaries 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; however, SNF CB applies to physical and occupational therapies and speech language pathology services 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. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

**Note:** A revised SNF help file, separate from the code list, is not included in CR 3542. The help file provides billing guidance only to FIs, SNFs, and suppliers on HCPCS codes. It includes codes affected by SNF CB and many other codes, and it will be updated from the current version separately after release of this notification with the new code list.

## Implementation

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

## Additional Information

The official instruction issued to your intermediary contains a comprehensive list of HCPCS codes involved in editing claims submitted to FIs for services subject to SNF CB.

In that list, new codes listed subsequent to prior publications appear in bold in HCPCS code charts, and boldface is also used outside of the code charts in cases as noted when type of bill or revenue codes, rather than HCPCS codes, are used to perform editing. Bolding is also used to highlight titles, captions, and other billing information for SNFs. Codes from previous lists not appearing have been deleted. For complete details and to see the comprehensive list, 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*.

From that Web page, look for CR 3542 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: 3542
Related CR Release Date: November 5, 2004
Related CR Transmittal Number: 360
Effective Date: January 1, 2005 (for services provided on or after that date)
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 360, CR 3542

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# Editing of Hospital and Skilled Nursing Facility Part B Inpatient Services (Full Replacement of Change Request 3366)

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

## Provider Types Affected

Hospitals and skilled nursing facilities (SNFs)

## Provider Action Needed

## STOP – Impact to You

Change Request (CR) 3531 replaces CR 3366, changing the payable/non-payable status of some revenue codes billed as Part B services. These updates to these revenue codes are reflected in the discussion below. An article related to CR 3366 was published in the First Quarter 2005 *Medicare A Bulletin* (pages 67-68).

## CAUTION – What You Need to Know

Medicare is requiring your fiscal intermediaries (FI) to install an edit to assure that payment is made on type of bills (TOBs) 12x and 22x for claims with revenue codes listed in the nonpayable table for SNFs and hospitals. CR 3531 also updates some edits regarding the following revenue codes:

024x all inclusive ancillary

0634 EPO under 10,000 units

0635 EPO over 10,000 units

0379 other anesthesia

096x professional fees

0948 not a valid code

This article explains the changes. It also adds 22x as an applicable TOB for diabetes self management training services (DSMT).

## GO – What You Need to Do

Make sure that your billing staffs are aware these to assure prompt and accurate claims processing.

## Background

As communicated in CR 3366 (released on July 23, 2004), Medicare will pay, under Part B, for certain physician and for certain nonphysician medical and other health services that a participating hospital or SNF furnishes to their inpatients. This is done when these patients are not eligible or entitled to, or have exhausted, their Part A benefits.

However, CMS identified that some FIs are paying for services under TOBs 12x and 22x that do not meet the definition of these inpatient Part B services. Therefore, CR 3366 required the standard Medicare systems to include an edit to assure payment is made on TOBs 12x and 22x only for those services defined in section 10, Chapter 6, of the Medicare Benefit Policy Manual, as an inpatient Part B service.

This manual may be found at: *http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp*.

This CR updates edits as follows:

- Removes revenue code 024x from the nonpayable table for hospital Part B inpatient services (TOB 12x).
- Removes revenue code 0379 from the nonpayable table for SNFs (TOB 22x) and hospitals (TOB 012x) inpatient Part B services.
- Removes revenue code 096x from the nonpayable table and replaces it with revenue codes 0960, 0961, 0962, and 0969 for SNFs and hospitals inpatient Part B services.
- Removes revenue code 0948 from the nonpayable table for SNFs (TOB 22x) and hospitals (TOB 12x).
- Updates Section 300.5.1, Chapter 15 of the Medicare Benefit Policy Manual to include TOB 22x as an applicable TOB for diabetes self-management training.

## Additional Information

Specific revenue codes that will never be paid are listed in the related CR 3531, which may be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3531 in the CR NUM column on the right, and click on the file for that CR.

You might also want to look at the revised pages of the Medicare Claims Processing Manual, Chapter 4, Section 240.1 (Editing Hospital Part B Inpatient Services) and Chapter 7, Section 10.1.1 (Editing of Skilled Nursing Facilities Part B Inpatient Services). These revised sections are attached to CR 3531.

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: 3531
Related CR Release Date: October 29, 2004
Related CR Transmittal Number: 351
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 351, CR 3531

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## Allow for Provider Liability Days on Skilled Nursing Facility and Swing Bed Facility Inpatient Bills

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

### Provider Types Affected

Skilled nursing facilities (SNFs) and swing bed facilities

### Provider Action Needed

Affected providers should note that this article clarifies the procedures to allow for provider liability days on the SNF and swing bed facility inpatient bills.

### Background

Currently, the Fiscal Intermediary Shared System (FISS) used by Medicare requires the sum of all the covered units reported on all revenue code 0022 lines to match the covered days field reported on the claim.

CR 3568 will result in modifications to this Medicare system to allow the sum of all covered units reported on all revenue code 0022 lines **to equal** the covered days reported on the claim **minus** the number of days reported in the OSC 77.

However, for proper reimbursement, the provider liability days billed under an OSC 77 **must not be counted** in the covered units field for the health insurance prospective payment system (HIPPS) code reported on revenue code 0022 lines.

For types of bill **21x** (SNF inpatient) and **18x** (swing bed inpatient), the **sum** of all covered units reported on all revenue code 0022 lines should be **equal to** the covered days field **minus** the number of days reported in an OSC 77.

Because of this problem, some fiscal intermediaries have been holding types of bill **18x** or **21x** with days reported under an OSC 77. Upon this correction, these intermediaries will release and process these claims.

If you have claims that were incorrectly processed by your intermediary because of this problem, please notify the intermediary within the timely filing period and the intermediary will adjust those claims.

### Additional Information

The official instruction issued to your intermediary regarding this change can be found online, referenced via CR 3568, at: *http://www.cms.hhs.gov/manuals/pm_trans/R378CP.pdf*.

This document contains the actual revisions to Medicare's Claims Processing Manual resulting from this change.

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

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

Related Change Request (CR) Number: 3568
Related CR Release Date: November 26, 2004
Related CR Transmittal Number: 378
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 378, CR 3568

## 2005 Annual Update for Skilled Nursing Facility Consolidated Billing for the Common Working File and Medicare Carriers

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

### Provider Types Affected

Skilled nursing facilities (SNFs)

### Provider Action Needed

### STOP – Impact to You

The 2005 update for SNF consolidated billing (CB) is available. These codes are used in applying the SNF CB edits that only allow services that are excluded from CB to be separately paid by Medicare carriers.

### CAUTION – What You Need to Know

These new code files are posted to the Centers for Medicare & Medicaid Services (CMS) website at: *www.cms.hhs.gov/medlearn/snfcode.asp*.

### GO – What You Need to Do

The edits for claims received for beneficiaries in both Part A SNF stays and covered and non-covered Part A SNF stays allow services that are excluded from consolidated billing to be separately paid by the carrier.

### Additional Information

The official instruction issued to your contractor regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/pm_trans/R328CP.pdf*.

For additional information relating to this issue, please contact your contractor at their toll free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

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

Related Change Request (CR) Number: 3535
Related CR Release Date: October 22, 2005
Related CR Transmittal Number: 328
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 328, CR 3535

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## Correction to January 2005 Annual Update of HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement

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

### Provider Types Affected

Skilled nursing facility (SNF) and ambulance suppliers billing Medicare carriers or intermediaries for patients in an SNF stay

### Provider Action Needed

### STOP – Impact to You

Transmittal 360, change request (CR) 3542 of the Medicare Claims Processing Manual (published on November 5, 2004) was the 2005 skilled nursing facility annual update. CR 3613 provides a correction to the annual SNF CB update for calendar year 2005 by adding one HCPCS code under Major Category I.H. (ambulance services) that was inadvertently omitted, namely A0999 – unlisted ambulance service.

### CAUTION – What You Need to Know

*CPT* codes *53660*, *95974*, and HCPCS code G0168 had been reported twice in Major Category I.F. – this duplication of codes has also been corrected.

### GO – What You Need to Do

To ensure accurate claims processing, please review the information included here and stay current with instructions for SNF CB.

### Additional Information

The official instruction issued regarding this change can be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R421CP.pdf*.

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

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

Related Change Request (CR) Number: 3613
Related CR Release Date: December 30, 2004
Related CR Transmittal Number: 421
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 421, CR 3613

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## Nursing Facility Visits (Codes 99301 – 99313)—CR 3096 Rescinded

The Centers for Medicare & Medicaid Services (CMS) has rescinded Change Request 3096, Transmittal 302.

The Medlearn Matters article related to Change Request 3096 was published in the First Quarter 2005 *Medicare A Bulletin* (pages 66-67).

Source: CMS JSM-05109, December 13, 2004

# ESRD SERVICES

## End Stage Renal Disease Reimbursement for AMCC Tests

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

**Note:** This article was revised on November 26, 2004, to delete an incorrect reference to organ and disease-oriented panels referred in the last paragraphs from Section 40.6.1 extract. The original article was published in the Fourth Quarter 2004 *Medicare A Bulletin* (pages 63-64).

### Provider Types Affected

Physicians, suppliers, and providers

### Provider Action Needed

Physicians, suppliers, and providers should note that this instruction expands the implementation of certain processing rules to all bill types for automated multi-channel chemistry tests for end stage renal disease (ESRD) beneficiaries.

### Background

The Office of Inspector General (OIG) conducted several studies that identified Medicare payments for end stage renal disease (ESRD) laboratory related services that were not being paid in compliance with Medicare payment policy.

In response to the payment vulnerabilities identified by the OIG, the claim processing instructions contained in the *Medicare Claims Processing Manual* (Pub 100-04, Transmittal 79, Chapter 16, Section 40.6.1) directed all contractors to implement changes to ensure that all ESRD laboratory claims are paid in accordance with Medicare payment policy.

This instruction expands the implementation of procedures for reimbursement of AMCC tests to all bill types for ESRD beneficiaries.

### Implementation

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

### Related Instructions

Medicare will apply the rules identified in the Medicare Claims Processing Manual, Pub 100-04, Chapter 16 (Laboratory Services from Independent Labs, Physicians, and Providers), Section 40.6.1 (Automated Multi-Channel Chemistry (AMCC) Tests for ESRD Beneficiaries – FIs) to all bill types for AMCC tests for ESRD beneficiaries. This chapter can be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

An extract of Section 40.6.1 is included as follows:

**40.6.1 – Automated Multi-Channel Chemistry (AMCC) Tests for ESRD Beneficiaries – FIs**

This section will be updated July 2004 – Visit *http://www.cms.hhs.gov/manuals/pm_trans/R79CP.pdf* to view updated section.
(Rev. 1, 10-01-03) A-03-033

Medicare will apply the following rules to AMCC tests for ESRD beneficiaries:

- Payment is at the lowest rate for services performed by the same provider, for the same beneficiary, for the same date of service.
- The facility must identify, for a particular date of service, the AMCC tests ordered that are included in the composite rate and those that are not included. See Chapter 8 for the composite rate tests for hemodialysis, intermittent peritoneal dialysis (IPD), continuous cycling peritoneal dialysis (CCPD), hemofiltration, and continuous ambulatory peritoneal dialysis (CAPD).
- If 50 percent or more of the covered tests are included under the composite rate payment, then all submitted tests are included within the composite payment. In this case, no separate payment in addition to the composite rate is made for any of the separately billable tests.
- If less than 50 percent of the covered tests are composite rate tests, all AMCC tests submitted for that date of service (DOS) for that beneficiary are separately payable.
- A noncomposite rate test is defined as any test separately payable outside of the composite rate or beyond the normal frequency covered under the composite rate that is reasonable and necessary. (See section 100.6 for details regarding pricing modifiers.)

The FI shared system must calculate the number of AMCC tests provided for any given date of service. The FI sums all AMCC tests with a CD modifier and divides the sum of all tests with a CD, CE, and CF modifier for the same beneficiary and provider for any given date of service. If the result of the calculation for a date of service is 50 percent or greater, the FI does not pay for the tests.

If the result of the calculation for a date of service is less than 50 percent, the FI pays for all of the tests.

All tests for a date of service must be billed on the monthly ESRD bill. Providers must send in an adjustment if they identify additional tests that have not been billed.

### Additional Information

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

From that Web page, look for CR 3239 in the CR NUM column on the right, and click on the file for that CR.

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

Related Change Request (CR) Number: 3239
Related CR Release Date: May 28, 2004
Related CR Transmittal Number: 190
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Source: CMS Pub. 100-4, Transmittal 190, CR 3239

## New ESRD Composite Payment Rates Effective January 1, 2005

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

### Provider Types Affected

Renal dialysis facilities

### Provider Action Needed

### STOP – Impact to You

Section 623 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates that the current end stage renal disease (ESRD) composite payment rates be increased by 1.6 percent for dialysis treatments furnished on or after January 1, 2005. The statute further mandates that the composite payment rates must also include a drug add-on adjustment of 8.7 percent for the difference between the payment amounts for separately billable drugs and biologicals and their acquisition costs, as determined by the Office of the Inspector General (OIG) reports.

### CAUTION – What You Need to Know

Section 623(d) of the MMA requires a basic case-mix adjusted composite rate for ESRD facility services and also requires a budget neutrality adjustment. (See Medlearn Matters article MM3572 for details on the case-mix and prospective payment rates.)

### GO – What You Need to Do

To ensure accurate claims processing, please review the information included here and stay current with updated instructions for ESRD composite payment rates.

### Background

Section 623 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), includes major provisions which affect the development of revised ESRD composite payment rates effective for services furnished on or after January 1, 2005.

The statute mandates that the current composite payment rates be increased by 1.6 percent for dialysis treatments furnished on or after January 1, 2005. The statute further mandates that the composite payment rates must also include a drug add-on adjustment for the difference between the payment amounts for separately billable drugs and biologicals and their acquisition costs, as determined by the OIG reports.

The fiscal intermediaries will utilize the rates in Tables 1 and 2 in the Attachments to CR 3554 to determine the new composite payment rates for each renal facility located in an urban or rural area. Table 1 lists the new composite rates for each renal facility located in an urban area. Table 2 lists the new composite rates for renal facilities in rural areas.

(To view CR3554 and these tables, go to http://www.cms.hhs.gov/manuals/pm_trans/R373CP.pdf.)

In accordance with the appropriate provisions of section 623 of the MMA, the rates in the attachments were calculated as follows:

- The wage-adjusted composite payment rates in effect on December 31, 2004 were increased by 1.6 percent as required by section 623(a)(3)
- These new rates were further increased by a drug add-on adjustment (or multiplier) in the amount of 8.7 percent.

  (This drug add-on adjustment represents the difference between the current payment of 95 percent of the average wholesale price (AWP) for separately billed drugs and biologicals, and $10.00 per 1,000 units for EPO, and the acquisition costs of such drugs and biologicals, as determined by the OIG reports to the Secretary as required by section 623(c) and section 623(d)(1)(B) of the MMA.)

Note that, **effective January 1, 2005,** the cost for supplies to administer EPO/Aranesp® may also be billed to your fiscal intermediary. Previously, Medicare made no additional payment for such supplies.

In accordance with additional requirements in CR 3554, renal facilities should:

- Use condition code 59 when ESRD beneficiaries receive dialysis services at a facility that is not the beneficiary's home facility (the non-home facility providing dialysis services will utilize condition code 59 on the type of bill 72x.
- Populate value code A8 with the patient's weight (from the last dialysis session of the month) in kilograms up to two decimal places on all ESRD claims.
- Populate value code A9 with the height (from the last dialysis session of the month) in centimeters on type of bill 72x.
- Use HCPCS code A4657 with revenue code 270 for injection supplies used in the administration of EPO/Aranesp® in all renal dialysis facilities (RDF).

### Additional Information

To view the official instructions issued to your fiscal intermediary regarding this change, go to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

On that page, scroll down the CR NUM column on the right to find the link for CR 3554. Click on the link to open and view the files associated with that CR.

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

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

Related Change Request (CR) Number: 3554
Related CR Release Date: November 19, 2004
Related CR Transmittal Number: 27 and 373
Effective Date: January 1, 2005
Implementation Date: January 1, 2005

Source: CMS Pub. 100-4, Transmittal 373, CR 3554

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# Hospital Outpatient Prospective Payment System

## Hospital Outpatient Prospective Payment System Misclassified Drugs and Biologicals

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

### Provider Types Affected

Hospitals paid under the outpatient prospective payment system (OPPS).

### Provider Action Needed

The intent of this article is to provide hospitals background information on the misclassification of ganciclovir long act implant (Ganciclovir), BCG live intravesical vac (BCG), and gallium Ga 67 (Gallium), and to alert hospitals of the process by which the Centers for Medicare & Medicaid Services (CMS) intends to correct erroneous hospital payments that were made due to the misclassification of these drugs.

In the April 2004 OPPS update (Change Request 3144), CMS misclassified ganciclovir long act implant, BCG live intravesical vac, and gallium Ga 67 (Gallium) as multiple-source products and, as a result, implemented codes, effective January 1, 2004, for both a generic and a brand name form of each drug, as follows:

| Generic Codes | Brand Name Codes |
|---|---|
| J7310 Ganciclovir 4.5 mg. long act implant | C9412 Ganciclovir implant, brand |
| J9031 BCG live (intravesical) per instillation | C9416 BCG live intravesical, brand |
| Q3002 Gallium Ga 67 | C9434 Gallium Ga 67, brand |

CMS corrected the error in the October 2004 OPPS update by deleting from the OPPS outpatient code editor (OCE) the brand name codes for BCG and Gallium, C9416 and C9434, effective January 1, 2004, and correcting the payment rates for all three drugs in the OPPS PRICER (see table below).

**Note:** CMS inadvertently neglected to delete the brand name code for Ganciclovir, C9412, in the October 2004 OPPS update, but will delete C9412, effective January 1, 2004, in the January 1, 2005 OPPS update.

In Table B4 of the October 2004 OPPS update change request, CR 3420, CMS issued the correct HCPCS code assignments and payment rates for ganciclovir, BCG, and gallium effective January 1, 2004 through December 31, 2004,as follows:

**Reclassified Drugs and Biologicals**

| HCPCS | SI | APC | Long Descriptor | Payment Rate | Minimum Unadjusted Copayment |
|---|---|---|---|---|---|
| J7310 | K | 0913 | Ganciclovir, 4.5 mg, long-acting implant | $4,400.00 | $880.00 |
| J9031 | K | 0809 | BCG live (intravesical) per instillation | $148.33 | $29.67 |
| Q3002 | K | 1619 | Supply of radiopharmaceutical diagnostic imaging agent, Gallium Ga 67, per millicurie | $28.73 | $5.75 |

After implementation of the October 2004 OPPS update (CR 3420), hospitals that wish to do so may submit adjustment requests for any claims containing HCPCS codes J7310, C9412, J9031, C9416, Q3002, or C9434, with dates of service on or after January 1, 2004 that were processed and paid between January 1, 2004 and implementation of the October update (October 4, 2004).

Because the brand name codes for BCG and gallium, C9416 and C9434, were deleted in the October 2004 OPPS update, adjustment requests that are submitted after implementation of the October 2004 OPPS update that contain C9416 and C9434 will be returned to the provider.

Additionally, because the brand name code for ganciclovir, C9412, will be deleted effective January 1, 2004, in the January 2005 OPPS update, adjustment requests submitted after implementation of the January 2005 OPPS update that contain C9412 will also be returned to the provider.

**Note:** Consequently, hospitals will need to change the HCPCS on adjustment requests submitted after implementation of the October 2004 update from C9416 to J9031 for BCG and from C9434 to Q3002 for gallium. Further, hospitals will need to change the HCPCS on adjustment requests submitted after installation of the January 2005 OPPS update from C9412 to J7310 for ganciclovir.

***Hospital Outpatient Prospective Payment System Misclassified Drugs and Biologicals (continued)***

### Additional Information

To view CR 3540, go to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

Once at that site, scroll down the CR NUM column on the right and click on the file for CR 3540. 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 Requests (CR) Number: 3540
Related CR Release Date: November 26, 2004
Related CR Transmittal Number: 377
Effective Date: January 1, 2004
Implementation Date: December 28, 2004

Source: CMS Pub. 100-4, Transmittal 377, CR 3540

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## January 2005 Update to the Hospital Outpatient Prospective Payment System PRICER

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

### Provider Types Affected

Hospitals and other providers paid by Medicare under the OPPS

### Provider Action Needed

Affected providers should note that this article and related CR 3586 provide information changes to the outpatient prospective payment system (OPPS) outpatient code editor (OCE) data files and OPPS PRICER logic being implemented in the January 2005 update. The article also describes payment policy changes for diagnostic mammography.

### Background

The policies implemented in this CR 3586 were provided in the 2005 OPPS final rule (*Federal Register*, November 15, 2004), and the attachment to the official instruction (issued to your intermediary) contains a detailed summary of data changes to the OPPS OCE, effective January 1, 2005, including the following:

- Ambulatory Payment Classification (APC) Changes
- Diagnosis Code Changes
- Healthcare Common Procedure Coding System (HCPCS)/Common Procedure Terminology (CPT ) Code Changes
- HCPCS Description Changes
- APC Assignment Changes
- Status Indicator or Edit Changes
- Modifier Changes
- Revenue Code Changes

**PRICER Changes**

The OPPS PRICER logic as described in CR 3586 will be effective beginning January 1, 2005, unless otherwise noted in CR 3586. These are summarized as follows:

- The Centers for Medicare & Medicaid Services (CMS) is in the process of reviewing the wage indexes for the inpatient prospective payment system (IPPS). This review may impact the wage index values. CMS emphasizes that the methodology for adjusting OPPS payment and co-payment rates for geographic wage differences using the IPPS wage index has not changed. The policy of CMS has consistently been to adopt the IPPS wage index for purposes of payment under the OPPS, and finalized tables will be published in a future *Federal Register* document. The final wage index values will be in the January 2005 OPPS PRICER.
- New OPPS payment rates and coinsurance amounts will be effective January 1, 2005. APCs have coinsurance amounts limited to 45 percent of the payment rate, effective January 1, 2005. Some APCs have coinsurance limits equal to the inpatient deductible of $912, which is also effective as of January 1, 2005.
- For outliers for hospitals, CMS will change the factor multiplied by the total line item payments from 2.6 to 1.75. In addition, the cost for the line item must exceed the APC payment plus a fixed dollar threshold of $1,175. The factor used to multiply the difference between line item payments and costs remains at 50 percent.
- For outliers for community mental health centers (CMHCs); type of bill 76x, CMS will change the factor multiplied by the total line item payments from 3.65 to 3.5. The factor used to multiply the difference between line item payments and costs remains at 50 percent.
- There are no device offsets for 2005.

**Payment for Diagnostic Mammography**

In addition, affected providers should note that section 614 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 provides for a change in payments for diagnostic mammography (HCPCS 76090,

*January 2005 Update to the Hospital Outpatient Prospective Payment System PRICER (continued)*

76091, G0204, and G0206), including diagnostic computer-aided detection (CAD) services (code 76082), furnished by hospitals subject to the OPPS. Effective for services provided on or after January 1, 2005, Medicare will pay for diagnostic mammography, including the CAD services, based on the Medicare physician fee schedule, and such payments will not be based on the OPPS.

### Implementation

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

### Additional Information

The list of diagnosis, HCPCS/CPT, APC, and other code changes, additions, and deletions is extensive. The changes and the respective effective dates of each change are detailed in an extensive attachment to the official instruction, CR 3586, which has been issued to your intermediary. That instruction may be viewed at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3586 in the CR NUM column on the right, and click on the file for that CR.

If you wish to view the November 15, 2004, final rule, you may find it at: *http://www.cms.hhs.gov/providers/hopps/2005fc/1427fc.asp*.

If you have any questions, please contact your intermediary at their toll-free number 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: 3586
Related CR Release Date: December 3, 2004
Related CR Transmittal Number: 385
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 385, CR 3586

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## Billing Non-Transitional Pass-Through Devices Not Classified as New Technology

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

### Provider Types Affected

Hospitals and other providers subject to the OPPS

### Provider Action Needed

Affected providers should note that this article and the related CR 3606 describe changes to billing for devices that do not have transitional pass-through status and are not classified as new technology ambulatory payment classification APC groups.

### Background

Under the OPPS, the Centers for Medicare & Medicaid Services (CMS) packages payment for an implantable device into the APC for the procedure performed for that implantation. Because the pass-through status of so many devices expired at the end of calendar year (CY) 2002, CMS discontinued the codes that were established to report pass-through devices in CY 2003.

However, CMS found that, in order to improve the specificity of data used for developing payment bases for device-dependent APCs, the device codes and related charges were needed. Therefore, in CY 2004, CMS reestablished the device codes and encouraged hospitals to report the data on a voluntary basis.

In CY 2005, such reporting will be required in order to process the claims.

The goal is to base payment for device-dependent APCs under the OPPS on single bill claims data, without adjustment for erratic data, and unless otherwise noted, all changes addressed in this article and CR 3606 are effective for services furnished on or after January 1, 2005.

**Effective January 1, 2005**, hospitals paid under the OPPS submitting claims on types of bill 12x and 13x that report procedure codes requiring the use of devices must also report the applicable Healthcare Common Procedure Coding System (HCPCS) codes and charges for all devices that are used to perform the procedures where such codes exist. This is necessary so that the OPPS payment for these procedures will be correct in future years in which the claims are used to create the APC amounts.

**Effective for services furnished on or after April 1, 2005,** Medicare will return to the provider any claim that reports an applicable "device-required" procedure code that does not report at least one device HCPCS code required for that procedure. Chapter 4 of the *Medicare Claims Processing Manual* has been amended to include tables that show the specific codes and edits that Medicare will use to implement these requirements, specifically:

- Table 1 in Section 61.1 of Chapter 4 lists the HCPCS codes for devices to be reported, as applicable, on the same claim as procedures in which devices are used.
- Table 2 of Section 61.2 of Chapter 4 shows the list of procedure-to-device code edits.

To assist providers, these tables are available in Excel® format on the CMS' OPPS Web page at: *http://www.cms.hhs.gov/providers/hopps/2005fc/1427fc.asp*.

The January 2005 OPPS OCE and OPPS PRICER will reflect the changes identified in this notification, and their installation instructions were provided in the following change requests (CRs):

***Billing Non-Transitional Pass-Through Devices Not Classified as New Technology (continued)***

- January 2005 OPPS PRICER installation instructions were provided in CR 3586: January 2005 Update of the Hospital Outpatient Prospective Payment System: Summary of OPPS Outpatient Code Editor Data Changes and OPPS PRICER Logic. A Medlearn Matters article, MM3586, is available on this CR at: *http://www.cms.hhs.gov/medlearn/matters*.
- January 2005 OPPS OCE installation instructions were provided in CR 3583: January 2005 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 6.0. A Medlearn Matters article, MM3583, is also available on CR 3583.

### Implementation

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

### Additional Information

The *Medicare Claims Processing Manual (Pub. 100-04), Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)* has been revised to include the new Section 61 and that section contains the two tables mentioned earlier in this article.

The new manual section is attached to the official instruction released to your intermediary. You may view that instruction by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR3606 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: 3606
Related CR Release Date: December 17, 2004
Related CR Transmittal Number: 403
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 403, CR 3606

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## January 2005 Update of the Hospital Outpatient Prospective Payment System—Coding and Payment for Drug Administration

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

### Provider Types Affected

Hospitals and providers paid under the OPPS

### Provider Action Needed

Affected providers should note that this article and related CR 3610 describe **changes to coding and payment for drug administration** to be implemented by Medicare for services on and after January 1, 2005 as part of the January 2005 OPPS update.

The key change for hospitals paid under the OPPS (types of bills 12x and 13x) is that CPT codes must be used in place of HCPCS codes for infusion of drugs other than chemotherapy, infusion of anti-neoplastic (chemotherapy) drugs, and administration of anti-neoplastic drugs by route other than infusion.

### Background

**For services furnished prior to January 1, 2004:**

Hospitals paid under the OPPS used the following Healthcare Common Procedure Coding System (HCPCS) code to report administration of anti-neoplastic drugs by both 1) infusion; and 2) a route other than infusion: **Q0085**, *Administration of chemotherapy by both infusion and another route, per visit.*

**For services furnished prior to January 1, 2005:**

Drug administration services are reported using the following HCPCS alphanumeric codes:

Q0081 Infusion therapy other than chemotherapy, per visit

Q0083 Administration of chemotherapy by any route other than infusion, per visit

Q0084 Administration of chemotherapy by infusion only, per visit

**Effective for services furnished on or after January 1, 2005:**

Hospitals paid under the OPPS should use the appropriate CPT code to report the following:

- *Infusion of drugs other than chemotherapy*
- *Infusion of anti-neoplastic (chemotherapy) drugs*
- *Administration of anti-neoplastic drugs by routes other than infusion*

Once again, this change only affects hospitals paid under the OPPS and such hospitals must abide by the 2005 *CPT* definitions of the codes when reporting them.

**Also, effective for services furnished on or after January 1, 2005**, hospitals paid under the OPPS (types of bill 12xand 13x) should report covered services associated with the administration of drugs as part of a clinical trial using the appropriate CPT code (See Table 1 below).

**For services prior to January 1, 2005**, covered services associated with the administration of drugs as part of a clinical trial were reported with code **G0292**. However, **G0292** is deleted from the OPPS OCE and discontinued from the HCPCS file effective January 1, 2005.

The following table identifies the applicable *CPT* codes that should be reported for services furnished on or after January 1, 2005, the corresponding HCPCS alphanumeric codes that should no longer be reported, and the APCs to which the current CPT codes are assigned.

*January 2005 Update of the Hospital OPPSystem—Coding and Payment for Drug Administration (continued)*

**Table 1. Crosswalk from CPT Codes for Drug Administration to Drug Administration APCs**

| HCPCS Codes used before January 1, 2005 | Use CPT Code on or after January 1, 2005 | Description | SI | APC | Maximum number of units of the APC OCE will assign without modifier 59 | Maximum number of units of the APC OCE will assign with modifier 59 |
|---|---|---|---|---|---|---|
| – | *96412* | Chemo, infuse method add-on | N | – | 0 | 0 |
| – | *96423* | Chemo, infuse method add-on | N | – | 0 | 0 |
| – | *96545* | Provide chemotherapy agent | N | – | 0 | 0 |
| – | *90781* | IV infusion, additional hour | N | – | 0 | 0 |
| Q0081 | *90780* | IV infusion therapy, 1 hour | T | 120 | 1 | 4 |
| Q0083 | *96400* | Chemotherapy, sc/im | S | 116 | 1 | 2 |
| Q0083 | *96405* | Intralesional chemo admin | S | 116 | 1 | 2 |
| Q0083 | *96406* | Intralesional chemo admin | S | 116 | 1 | 2 |
| Q0083 | *96408* | Chemotherapy, push technique | S | 116 | 1 | 2 |
| Q0083 | *96420* | Chemotherapy, push technique | S | 116 | 1 | 2 |
| Q0083 | *96440* | Chemotherapy, intracavitary | S | 116 | 1 | 2 |
| Q0083 | *96445* | Chemotherapy, intracavitary | S | 116 | 1 | 2 |
| Q0083 | *96450* | Chemotherapy, into CNS | S | 116 | 1 | 2 |
| Q0083 | *96542* | Chemotherapy injection | S | 116 | 1 | 2 |
| Q0083 | *96549* | Chemotherapy, unspecified | S | 116 | 1 | 2 |
| Q0084 | *96410* | Chemotherapy, infusion method | S | 117 | 1 | 2 |
| Q0084 | *96414* | Chemo, infuse method add-on | S | 117 | 1 | 2 |
| Q0084 | *96422* | Chemotherapy, infusion method | S | 117 | 1 | 2 |
| Q0084 | *96425* | Chemotherapy, infusion method | S | 117 | 1 | 2 |

The following drug administration services have been reported using CPT codes and paid under the OPPS since the implementation of the OPPS. They continue to be reported under the CPT codes and payment for them continues to be made under the APC indicated below.

**Table 2. Drug Administration Services Reported Using CPT Codes and Corresponding APCs**

| *CPT* | SI | APC | Description |
|---|---|---|---|
| *90782* | X | 353 | Injection SC/IM |
| *90783* | X | 359 | Injection IA |
| *90784* | X | 359 | Injection IV |
| *90788* | X | 359 | Injection of antibiotic |
| *90799* | X | 352 | Ther/prophylactic/dx inject |

All changes identified in this instruction are effective for services furnished on or after January 1, 2005 (unless otherwise noted) and will be reflected in the January 2005 OPPS OCE and OPPS PRICER.

## Implementation

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

## Additional Information

To see the official instruction issued to your intermediary, including regional home health intermediaries, regarding this change go to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3610 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.

**Description of CPT and HCPCS Codes**

**Current Procedural Terminology (CPT codes) –** *The American Medical Association's (AMA) Physicians' Current Procedural Terminology (CPT)* is contained in the *CPT* user guide. AMA is responsible for maintaining these codes, with consultation from the AMA *CPT* Editorial Panel, Advisory Committee, and the AMA *CPT* Health Care Professionals Advisory Committee. Procedure codes in the *CPT* user guide are reviewed and revised annually. *CPT* codes are **five-character** with **all numeric** configurations (e.g., *99215*).

***January 2005 Update of the Hospital OPPSystem—Coding and Payment for Drug Administration (continued)***

**Healthcare Common Procedure Coding System (HCPCS) –** The HCPCS Level II National codes are contained in the HCPCS user's guide and are published in the *Federal Register*. The Center for Medicare & Medicaid Services is responsible for maintaining these codes. Procedure codes in the HCPCS user guide are reviewed and revised annually. HCPCS codes are five characters with one alpha and four numeric configurations (e.g., A0042).

Related Change Request (CR) Number: 3610
Related CR Release Date: December 17, 2004
Related CR Transmittal Number: 404
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 404, CR 3610

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## January 2005 Outpatient Prospective Payment System Code Editor Specifications Version 6.0

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

### Provider Types Affected

All outpatient providers with the exception of hospitals **not** subject to the outpatient prospective payment system (OPPS).

### Provider Action Needed

Affected hospitals and providers should note that the related CR provides intermediaries with the January 2005 updates of the outpatient prospective payment system (OPPS) outpatient code editor (OCE).

### Background

This article reflects specifications that were issued for the October 2004 revision of the OCE (Version 5.3), and all shaded material in the attachment to CR 2583 reflects changes incorporated into the January version of the revised OPPS OCE (Version 6.0) specifications. It contains detailed OCE instructions and specifications to be utilized under the OPPS for those providers paid under the OPPS.

**Note:** Discontinued HCPCS codes were retained in prior year's January OCE updates in order to facilitate the 90-day grace period that was allowed for such HCPCS codes. As mentioned in Medlearn Matters article MM3093, this 90-day grace period is being eliminated effective January 1, 2005. The MM3093 article may be viewed at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3093.pdf.

### Summary of Modifications

The modifications of the OPPS OCE for the January 2005 release (V6.0) are summarized in the table below. Readers should also read through the specifications attached to CR 3583 and note the highlighted sections, which also indicate changes from the prior release of the OPPS OCE software.

Instructions for accessing the complete specifications are provided in the *Additional Information* section of this article. Note also that some of these modifications have an effective date earlier than January 1, 2005 and such dates are reflected in the "Effective Date" column.

Some OCE/APC modifications in the release may also be retroactively added to prior releases. If so, the retroactive date will appear in the 'Effective Date' column.

*January 2005 Outpatient Prospective Payment System Code Editor Specifications Version 6.0 (continued)*

**OPPS OCE Modifications**

| Mod. Type | Effective Date | Edit | Description |
|---|---|---|---|
| Logic | 8/1/2000 | 27 | Change disposition for edit 27 from claim rejection to **Claim Denial** |
| Logic | 1/1/05 | | New packaging flag 4: "Packaged as part of drug administration APC payment." For all bill types where APCs are assigned, apply to excess drug administration APC units or occurrences when multiple occurrences are submitted without modifier – 59; or when more than the maximum allowed number of occurrences are submitted with modifier – 59. |
| Logic | 7/1/04 | 68 | New edit 68 "Service submitted prior to date of National Coverage Determination (NCD) approval." |
| Logic | 1/1/05 | 52 | Replace procedure code Q0081 with 90780 in T procedure exemption for payable observation. |
| Logic | 1/1/05 | 56 & 57 | Remove requirement for ancillary testing from payable observation logic. |
| Logic | 10/1/03 | 23 | For all bill types where edit 23 is applied, extend edit 23 to require line item date on all line items, not just on lines with HCPCS codes (HIPAA requirement). |
| Logic | 10/1/04 | 69 | New edit 69 "Service provided outside approval period" - Line item rejection. Make HCPCS/APC/SI and modifier changes, as specified by CMS. |
| Content | | 19, 20, 39, 40 | Implement version 10.3 of the NCCI file, removing all code pairs, which include anesthesia (00100-01999), E&M (92002-92014, 99201-99499), MH (90804-90911), CAD (76082, 76083) or drug admin (96400-96450; 96542-96549; 90780,90781). |
| Content | 1/1/05 | nada | Remove all HCPCS codes deleted 12/31/04 from the valid code list effective 1/1/05 (No grace period). |
| Content | 8/1/00 | 16, 17 | Remove all 'Add-on' codes from the exclusive bilateral list that is used for the bilateral edits (16, 17). |
| Content | | 22 | Add new modifiers to the valid modifiers list as indicated by CMS. |
| Doc | | 67 | Change description for edit 67 to read "Service provided prior to FDA approval." |
| Doc | | 56, 57 | Revise description for edits 56 and 57 to delete reference to ancillary procedures; descriptions to read "E/M condition not met and line item date..." |

## Implementation

The implementation date for this instruction is January 3, 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.

From that Web page, look for CR3583 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: 3583
Related CR Release Date: December 3, 2004
Related CR Transmittal Number: 387
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 387, CR 3583

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# PROVIDER AUDIT ISSUES

## Skilled Nursing Facility Prospective Payment System PRICER Update FY 2005 for Nine Metropolitan Statistical Areas with New Wage Index Values

Section 1888(e) of the Social Security Act, as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, requires annual updates to the prospective payment system (PPS) rates relating to Medicare payments and (consolidated billing) for skilled nursing facilities (SNFs).

CMS published the SNF payment rates for fiscal year (FY) 2005 (October 1, 2004 through September 30, 2005), in the *Federal Register* on July 30, 2004 (69 FR 45775). CMS published a correction notice to the SNF payment rates for FY 2005 on October 7, 2004 (69 FR 60158). CMS published the changes to nine metropolitan statistical areas (MSAs) in a correction notice on December 23, 2004.

This instruction provides information on updates to the wage index for the nine (MSAs) listed below:

| MSA | Old Value | New Value |
|---|---|---|
| 3960 – Lake Charles, LA | 0.7959 | 0.7972 |
| 4280 – Lexington, KY | 0.8053 | 0.9219 |
| 5000 – Miami, FL | 1.0225 | 0.9870 |
| 5380 – Nassau-Suffolk, NY | 1.2921 | 1.2907 |
| 5600 – New York, NY | 1.3587 | 1.3586 |
| 6780 – Riverside-San Bernardino, CA | 1.0975 | 1.0970 |
| 8780 – Visalia-Tulare-Porterville, CA | 0.9964 | 0.9975 |
| 8960 – West Palm Beach-Boca Raton, FL | 1.0059 | 1.0362 |
| 9040 – Wichita, KS | 0.9472 | 0.9486 |

The wage index update affects the payment rates used under the PPS for SNF for FY 2005. The new wage index values will be available in an updated PRICER software. Fiscal intermediaries with providers in the nine affected MSAs will apply the new wage index effective January 1, 2005.

### Action Required by Providers

Providers located in one of the above MSAs need to split the billing so that the new wage index is used starting January 1, 2005. All other providers shall continue their usual billing process.

Source: CMS Pub. 100-4, Transmittal 413, CR 3651

## Supplemental Security Income Medicare Beneficiary Data for Fiscal Year 2003

The Supplemental Security Income (SSI) data file below shows the latest available inpatient rehabilitation facility (IRF)-specific data to compute an IRF's SSI ratio for the specified fiscal year (FY). An IRF may use this ratio as part of the formula to estimate the adjustment for low-income patients (LIP) for a cost-reporting period that begins subsequent to that specified FY. The file will be updated annually (usually each October/November).

More specifically, this instruction provides updated data for determining additional payment amounts for IRF with a disproportionate share of low-income patients. The SSI/Medicare beneficiary data for IRF prospective payment system (PPS) is available to fiscal intermediaries (FIs) electronically and contains the name of the facility, provider number, SSI days, covered Medicare days, and the ratio of Medicare Part A patient days attributable to SSI recipients. FIs will use this information to update their provider specific file. The file is located at the following Centers for Medicare & Medicaid Services (CMS) website address: *http//www.cms.hhs.gov/providers/irfppsdata_ratio.asp*.

The table below contains the files for calculating the SSI ratio for each fiscal year. Please make note that the last three years share the same data files until the cost-reporting period is settled for the most recent fiscal year.

Cost report periods beginning in FY 2002 (1/1/02-9/30/02) – Settled
Filename: *http://www.cms.hhs.gov/providers/irfppp/ssirstio02.zip*.

Cost report periods beginning in FY 2003 (10/1/02-9/30/03) – Settled
Filename: *http://www.cms.hhs.gov/providers/irfppp/ssirstio03.zip*.

Cost report periods beginning in FY 2004 (10/1/03- 9/30/04) – Interim
Filename: *http://www.cms.hhs.gov/providers/irfppp/ssirstio03.zip*.

Cost report periods beginning in FY 2005 (10/1/04- 9/30/05) – Interim
Filename: *http://www.cms.hhs.gov/providers/irfppp/ssirstio03.zip*.

FIs use this data to determine an initial PPS payment amount, and if applicable, to determine a final outlier payment amount for IRFs with cost-reporting periods beginning on or after the first day of the cost-reporting period, and before the first day of the next cost-reporting period. Since the disproportionate share percentage is based on a facility's cost-reporting period, FIs make a final determination of the amount of this percentage to compute the final LIP adjustment at the year-end settlement of the facility's cost report. The final LIP adjustment is used to retrospectively adjust the initial PPS payment amount.

## Clarification of Allowable Medicaid Days in Calculating the Disproportionate Share Variable

Program Memorandum A-99-62 (Excerpts referenced in PM A-01-131)

## Background

Under section 1886(d)(5)(F) of the Act, the Medicare disproportionate share patient percentage is made up of two computations. The first computation includes patient days that were furnished to patients who, during a given month, were entitled to both Medicare Part A and supplemental security income (SSI) (excluding state supplementation). This number is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. The second computation includes patient days associated with beneficiaries who were eligible for medical assistance (Medicaid) under a state plan approved under Title XIX but who were not entitled to Medicare Part A. (See 42 CFR 412.106(b)(4).) This number is divided by the total number of patient days for that same period.

**Included Days:**

In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a state plan approved under Title XIX on the day of service. If the patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. The statutory formula for "Medicaid days" reflects several key concepts. First, the focus is on the patient's eligibility for Medicaid benefits as determined by the state, not the hospital's "eligibility" for some form of Medicaid payment. Second, the focus is on the patient's eligibility for medical assistance under an approved Title XIX state plan, not the patient's eligibility for general assistance under a state-only program. Third, the focus is on eligibility for medical assistance under an approved Title XIX state plan, not medical assistance under a state-only program or other program. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under the federal-state cooperative program known as Medicaid (under an approved Title XIX state plan). In other words, for purposes of the Medicare disproportionate share adjustment calculation, the term "Medicaid days" refers to days on which the patient is eligible for medical assistance benefits under an approved Title XIX state plan. The term "Medicaid days" does not refer to all days that have some relation to the Medicaid program, through a matching payment or otherwise; if a patient is not eligible for medical assistance benefits under an approved Title XIX state plan, the patient day cannot become a "Medicaid day" simply by virtue of some other association with the Medicaid program.

Medicaid days, for purposes of the Medicare disproportionate share adjustment calculation, include all days during which a patient is eligible, under a state plan approved under Title XIX, for Medicaid benefits, even if Medicaid did not make payment for any services. Thus, Medicaid days include, but are not limited to, days that are determined to be medically necessary but for which payment is denied by Medicaid because the provider did not bill timely, days that are beyond the number of days for which a state will pay, days that are utilized by a Medicaid beneficiary prior to an admission approval but for which a valid enrollment is determined within the prescribed period, and days for which payment is made by a third party. In addition, we recognize in the calculation days that are utilized by a Medicaid beneficiary who is eligible for Medicaid under a state plan approved under Title XIX through a managed care organization (MCO) or health maintenance organization (HMO). However, in accordance with 42 CFR 412.106(b)(4), a day does not count in the Medicare disproportionate share adjustment calculation if the patient was entitled to both Medicare Part A and Medicaid on that day. Therefore, once the eligibility of the patient for Medicaid under a state plan approved under Title XIX has been verified, the FI must determine whether any of the days are dual entitlement days and, to the extent that they are, subtract them from the other days in the calculation.

**Excluded Days:**

Many states operate programs that include both state-only and federal-state eligibility groups in an integrated program. For example, some states provide medical assistance to beneficiaries of state-funded income support programs. These beneficiaries, however, are not eligible for Medicaid under a state plan approved under Title XIX, and, therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the state for assistance in doing so.

In addition, if a given patient day affects the level of Medicaid DSH payments to the hospital but the patient is not eligible for Medicaid under a state plan approved under Title XIX on that day, the day is not included in the Medicare DSH calculation.

It should be noted that the types of days discussed above are not necessarily the only types of excluded days. See the chart below, which summarizes some, but not necessarily all, of the types of days to be excluded from (or included in) the Medicare DSH adjustment calculation.

To provide consistency in both components of the calculation, any days that are added to the Medicaid day count must also be added to the total day count, to the extent that they have not been previously so added.

Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the state that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. Days for patients that cannot be verified by state records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.

### Types of Days Included/Excluded in the Medicare DSH Adjustment Calculation

**Type of Day:** General assistance patient days
Description: Days for patients covered under a state-only (or county-only) general assistance program (whether or not any payment is available for health care services under the program). These patients are not Medicaid-eligible under the state plan.
Eligible Title XIX day: No

**Type of Day:** Other state-only health program patient days
Description: Days for patients covered under a state-only health program. These patients are not Medicaid-eligible under the state plan.
Eligible Title XIX day: No

**Type of Day:** Charity care patient days
Description: Days for patients not eligible for Medicaid or any other third-party payer, and claimed as uncompensated care by a hospital. These patients are not Medicaid eligible under the state plan.
Eligible Title XIX day: No

**Type of Day:** Actual 1902(r)(2) and 1931(b) days
Description: Days for patients eligible under a state plan based on a 1902(r)(2) or 1931(b) election. These patients are Medicaid-eligible under the Title XIX state plan under the authority of these provisions, which is exercised by the state in the context of the approved state plan.
Eligible Title XIX day: Yes

**Type of Day:** Medicaid optional targeted low-income children (CHIP-related) days
Description: Days for patients who are Title XIX-eligible and who meet the definition of "optional targeted low-income children" under section 1905(u)(2). The difference between these children and other Title XIX children is the enhanced FMAP rate available to the state. These children are fully Medicaid-eligible under the state plan.
Eligible Title XIX day: Yes

**Type of Day:** Separate CHIP Days
Description: Days for patients who are eligible for benefits under a non-Medicaid state program furnishing child health assistance to targeted low-income children. These children are, by definition, not Medicaid-eligible under a state plan.
Eligible Title XIX day: No

**Type of Day:** 1915(c) Eligible patient (the "217" group) days
Description: Days for patients in the eligibility group under the state plan for individuals under a home and community based services waiver. This group includes individuals who would be Medicaid-eligible if they were in a medical institution. Under this special eligibility group, they are Medicaid-eligible under the state plan.
Eligible Title XIX day: Yes

**Type of Day:** Retroactive eligible days
Description: Days for patients not enrolled in the Medicaid program at the time of service, but found retroactively eligible for Medicaid benefits for the days at issue. These patients are Medicaid-eligible under the state plan.
Eligible Title XIX day: Yes

**Type of Day:** Medicaid managed care organization days
Description: Days for patients who are eligible for Medicaid under a state plan when the payment to the hospital is made by an MCO for the service. An MCO is the financing mechanism for Medicaid benefits, and payment for the service through the MCO does not affect eligibility.
Eligible Title XIX day: Yes

**Type of Day:** Medicaid DSH days
Description: Days for patients who are not eligible for Medicaid benefits, but are considered in the calculation of Medicaid DSH payments by the state. These patients are not Medicaid-eligible. Sometimes Medicaid state plans specify that Medicaid DSH payments be based upon a hospital's amount of charity care or general assistance days. This, however, is not "payment" for those days, and does not mean that the patient is eligible for Medicaid benefits or can be counted as such in the Medicare formula.
Eligible Title XIX day: No

Source: CMS Pub 100-4 Transmittal 392, CR 3567

# AMBULANCE SERVICES

## 2005 Ambulance Fee Schedule and Inflation Factor

Section 1834(l)(3)(A) of the Act provides the basis for updating payment limits for ambulance services. Specifically, this section provides for an update in payments for 2005 that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the ambulance inflation factor (AIF). The AIF for calendar year (CY) 2005 is 3.3 percent.

### 2005 Ambulance Fee Schedule Transition/Reasonable Cost Blend

During the transition period, the AIF is applied to both the fee schedule portion of the blended payment amount (incorporated in the ambulance fee schedule file), and to the reasonable cost portion of the blended payment amount separately for each ambulance provider. Then, these two amounts are added together to determine the total payment amount for each provider. The blending percentages used to combine these two components of the payment amounts for ambulance services for CY 2005 are **20 percent** of the reasonable cost and **80 percent** of the ambulance fee schedule (AFS).

The AFS rates for 2005 for Florida based on localities are provided below. Providers may calculate their payment by combining 80 percent of the appropriate fee schedule with 20 percent of their 2005 reasonable cost for the same service. Part B coinsurance and deductible requirements apply to these services.

### 2005 Ambulance Fee Schedule Rates

| Procedure | Loc 01/02 | | Loc 03 | | Loc 04 | |
|---|---|---|---|---|---|---|
| | Urban | Rural | Urban | Rural | Urban | Rural |
| A0425 | $5.90 | $5.96 | $5.90 | $5.96 | $5.90 | $5.96 |
| A0426 | $211.15 | $213.24 | $220.87 | $223.05 | $227.96 | $230.22 |
| A0427 | $334.31 | $337.62 | $349.70 | $353.17 | $360.94 | $364.51 |
| A0428 | $175.95 | $177.70 | $184.05 | $185.88 | $189.97 | $191.85 |
| A0429 | $281.53 | $284.31 | $294.49 | $297.40 | $303.95 | $306.96 |
| A0430 | $2,393.91 | $3,590.87 | $2,471.65 | $3,707.48 | $2,528.41 | $3,792.62 |
| A0431 | $2,783.27 | $4,174.90 | $2,873.65 | $4,310.48 | $2,939.65 | $4,409.47 |
| A0432 | $307.92 | $310.97 | $322.09 | $325.28 | $332.44 | $335.74 |
| A0433 | $483.87 | $488.67 | $506.15 | $511.16 | $522.41 | $527.59 |
| A0434 | $571.85 | $577.51 | $598.18 | $604.10 | $617.40 | $623.51 |
| Q3019 | $281.53 | $284.31 | $294.49 | $297.40 | $303.95 | $306.96 |
| Q3020 | $175.95 | $177.70 | $184.05 | $185.88 | $189.97 | $191.85 |

Source: CMS Pub. 100-4, Transmittal 411, CR 3599
CMS Pub. 100-4, Transmittal 320, CR 3473

# MAMMOGRAPHY SERVICES

The following fee schedules are effective for mammography services furnished **on or after January 1, 2005.** The present of a specific fee schedule does not represent a determination that the Medicare program either covers or does not cover that services.

| Code/MD | Loc 01/02 | Loc 03 | Loc 04 |
|---|---|---|---|
| G0202TC | $93.86 | $101.07 | $107.00 |
| G0204TC | $92.43 | $99.55 | $105.41 |
| G0206TC | $74.85 | $80.65 | $85.46 |
| 76082TC | $15.44 | $16.61 | $17.56 |
| 76083TC | $15.44 | $16.61 | $17.56 |
| 76090TC | $40.30 | $43.78 | $46.90 |
| 76091TC | $50.04 | $54.31 | $58.10 |
| 76092TC | $47.19 | $51.27 | $54.92 |

# Oupatient Rehabilitation Services

The following fee schedules are effective for outpatient rehabilitation services furnished **on or after January 1, 2005.** Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

| Code/MD | Loc. 01/02 | Loc. 03 | Loc. 04 |
|---|---|---|---|
| G0101 | $36.54 | $38.11 | $39.58 |
| G0102 | $20.82 | $21.91 | $22.86 |
| G0128 | $4.58 | $4.82 | $5.11 |
| G0281 | $11.22 | $11.65 | $12.11 |
| G0283 | $11.22 | $11.65 | $12.11 |
| G0329 | $7.74 | $8.24 | $8.72 |
| 64550 | $17.28 | $18.11 | $18.87 |
| 90804 | $64.76 | $66.42 | $68.28 |
| 90805 | $71.18 | $72.86 | $74.79 |
| 90806 | $97.84 | $100.32 | $103.18 |
| 90807 | $103.90 | $106.39 | $109.29 |
| 90808 | $145.80 | $149.40 | $153.55 |
| 90809 | $151.28 | $154.97 | $159.33 |
| 90810 | $70.12 | $71.99 | $74.14 |
| 90811 | $78.32 | $80.34 | $82.64 |
| 90812 | $105.21 | $107.91 | $110.96 |
| 90813 | $110.56 | $113.22 | $116.28 |
| 90814 | $152.46 | $156.23 | $160.53 |
| 90815 | $157.23 | $161.04 | $165.52 |
| 90845 | $90.43 | $92.46 | $94.88 |
| 90846 | $94.92 | $97.29 | $100.05 |
| 90847 | $115.38 | $118.15 | $121.32 |
| 90849 | $32.94 | $33.91 | $34.99 |
| 90853 | $32.23 | $33.15 | $34.20 |
| 90857 | $35.17 | $36.19 | $37.32 |
| 90901 | $39.66 | $41.54 | $43.22 |
| 92506 | $126.30 | $132.98 | $138.40 |
| 92507 | $60.21 | $63.19 | $65.71 |
| 92508 | $28.50 | $29.88 | $31.07 |
| 92526 | $80.23 | $84.47 | $87.93 |
| 92552 | $17.60 | $19.31 | $20.93 |
| 92553 | $26.40 | $28.96 | $31.40 |
| 92555 | $15.47 | $17.03 | $18.55 |
| 92556 | $23.20 | $25.54 | $27.82 |
| 92557 | $48.18 | $52.98 | $57.63 |
| 92561 | $28.54 | $31.24 | $33.78 |
| 92562 | $16.53 | $18.17 | $19.74 |
| 92563 | $15.47 | $17.03 | $18.55 |
| 92564 | $19.15 | $21.09 | $22.98 |
| 92565 | $16.18 | $17.79 | $19.34 |
| 92567 | $21.42 | $23.64 | $25.83 |
| 92568 | $15.47 | $17.03 | $18.55 |
| 92569 | $16.53 | $18.17 | $19.74 |
| 92571 | $15.82 | $17.41 | $18.94 |
| 92572 | $3.69 | $4.07 | $4.44 |
| 92573 | $14.40 | $15.89 | $17.35 |
| 92575 | $11.65 | $12.69 | $13.65 |
| 92576 | $18.08 | $19.95 | $21.79 |
| 92577 | $29.02 | $31.89 | $34.64 |
| 92579 | $28.90 | $31.62 | $34.18 |
| 92582 | $28.90 | $31.62 | $34.18 |
| 92583 | $35.56 | $38.99 | $42.26 |
| 92584 | $98.11 | $107.44 | $116.25 |
| 92587 | $59.52 | $64.75 | $69.75 |
| 92587 TC | $51.97 | $56.89 | $61.54 |
| 92587 26 | $7.55 | $7.85 | $8.21 |
| 92588 | $78.46 | $84.64 | $90.59 |
| 92588 TC | $58.63 | $64.27 | $69.62 |
| 92588 26 | $19.82 | $20.37 | $20.97 |
| 92596 | $23.91 | $26.30 | $28.61 |
| 92597 | $94.24 | $98.77 | $102.62 |
| 92601 | $128.06 | $137.56 | $145.16 |
| 92602 | $88.16 | $94.98 | $100.63 |
| 92603 | $79.61 | $85.86 | $91.09 |
| 92604 | $51.47 | $55.83 | $59.69 |
| 92607 | $112.13 | $120.30 | $126.74 |
| 92608 | $22.00 | $24.13 | $26.16 |
| 92609 | $58.57 | $63.02 | $66.65 |
| 92610 | $126.05 | $135.54 | $143.24 |
| 92611 | $126.05 | $135.54 | $143.24 |
| 92612 | $147.67 | $154.86 | $160.88 |
| 92614 | $139.12 | $145.74 | $151.34 |
| 92616 | $194.90 | $203.98 | $211.74 |
| 94664 | $12.97 | $14.37 | $15.76 |
| 94667 | $20.93 | $22.99 | $24.97 |
| 94668 | $16.99 | $18.40 | $19.61 |
| 95831 | $27.48 | $28.74 | $29.84 |
| 95832 | $23.71 | $24.82 | $25.92 |
| 95833 | $39.44 | $41.15 | $42.73 |
| 95834 | $46.63 | $48.62 | $50.55 |
| 95851 | $19.37 | $20.39 | $21.28 |
| 95852 | $13.91 | $14.70 | $15.40 |
| 96105 | $71.37 | $78.52 | $85.45 |
| 97001 | $74.61 | $77.21 | $79.96 |
| 97002 | $39.38 | $40.75 | $42.13 |
| 97003 | $79.72 | $82.80 | $85.98 |
| 97004 | $47.57 | $49.50 | $51.28 |
| 97012 | $14.59 | $15.06 | $15.58 |
| 97016 | $13.72 | $14.31 | $14.89 |
| 97018 | $6.32 | $6.72 | $7.13 |
| 97020 | $4.89 | $5.20 | $5.54 |
| 97022 | 1$4.41 | $15.07 | $15.70 |
| 97024 | $5.25 | $5.58 | $5.93 |
| 97026 | $4.89 | $5.20 | $5.54 |
| 97028 | $6.01 | $6.34 | $6.70 |
| 97032 | $15.66 | $16.20 | $16.77 |
| 97033 | $19.95 | $20.76 | $21.53 |
| 97034 | $13.78 | $14.31 | $14.85 |
| 97035 | $12.00 | $12.40 | $12.86 |
| 97036 | $22.49 | $23.42 | $24.28 |
| 97039 | $11.62 | $12.03 | $12.48 |
| 97110 | $27.64 | $28.61 | $29.64 |
| 97112 | $29.06 | $30.13 | $31.23 |
| 97113 | $31.53 | $32.79 | $34.03 |
| 97116 | $24.19 | $24.93 | $25.68 |
| 97124 | $21.94 | $22.65 | $23.37 |
| 97139 | $15.57 | $16.21 | $16.83 |
| 97140 | $26.17 | $27.09 | $28.08 |

*Outpatient Rehabilitation Services (continued)*

| Code/MD | Loc. 01/02 | Loc. 03 | Loc. 04 |
|---|---|---|---|
| 97150 | $17.13 | $17.72 | $18.33 |
| 97504 | $30.26 | $31.53 | $32.89 |
| 97520 | $27.64 | $28.61 | $29.64 |
| 97530 | $29.04 | $30.13 | $31.25 |
| 97532 | $24.28 | $24.92 | $25.62 |
| 97533 | $25.71 | $26.44 | $27.21 |
| 97535 | $29.29 | $30.24 | $31.17 |
| 97537 | $26.80 | $27.58 | $28.39 |
| 97542 | $27.51 | $28.34 | $29.18 |
| 97597 | $47.90 | $50.29 | $52.69 |
| 97598 | $60.87 | $63.57 | $66.27 |
| 97703 | $25.04 | $26.35 | $27.57 |
| 97750 | $29.42 | $30.51 | $31.63 |
| 97755 | $34.44 | $35.43 | $36.54 |

# Surgical Dressing Services

The following fee schedules are effective for surgical dressing items furnished **on or after January 1, 2005.** Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

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

# Orthotic/Prosthetic Devices

The following fee schedules are effective for orthotic and prosthetic devices furnished **on or after January 1, 2005.** The present of a specific fee schedule does not represent a determination that the Medicare program either covers or does not cover that services.

| Code/MD | Fees |
|---|---|
| A4216 | $0.43 |
| A4217AU | $3.13 |
| A4280 | $4.98 |
| A4310 | $6.56 |
| A4311 | $12.61 |
| A4312 | $18.04 |
| A4313 | $15.74 |
| A4314 | $21.50 |
| A4315 | $22.43 |
| A4316 | $24.14 |
| A4320 | $5.33 |
| A4321 | 0.00 |
| A4322 | $2.82 |
| A4326 | $10.79 |
| A4327 | $42.27 |
| A4328 | $9.86 |
| A4330 | $7.15 |
| A4331 | $3.18 |
| A4332 | $0.12 |
| A4333 | $2.20 |
| A4334 | $4.93 |
| A4338 | $12.26 |
| A4340 | $31.75 |
| A4344 | $16.02 |
| A4346 | $19.59 |
| A4348 | $27.83 |
| A4349 | 0.00 |
| A4351 | $1.81 |
| A4352 | $5.46 |
| A4353 | $6.99 |
| A4354 | $10.03 |
| A4355 | $7.57 |
| A4356 | $45.63 |
| A4357 | $9.70 |
| A4358 | $6.63 |
| A4359 | $29.01 |
| A4361 | $18.37 |
| A4362 | $3.39 |
| A4364 | $2.62 |
| A4365 | $11.32 |
| A4366 | $1.30 |
| A4367 | $7.35 |
| A4368 | $0.26 |
| A4369 | $2.42 |
| A4371 | $3.65 |
| A4372 | $4.18 |
| A4373 | $6.28 |
| A4375 | $17.18 |
| A4376 | $47.58 |
| A4377 | $4.29 |
| A4378 | $30.75 |
| A4379 | $15.02 |
| A4380 | $37.33 |
| A4381 | $4.61 |
| A4382 | $24.62 |
| A4383 | $28.19 |
| A4384 | $9.62 |
| A4385 | $5.10 |
| A4387 | 0.00 |
| A4388 | $4.36 |
| A4389 | $6.22 |
| A4390 | $9.61 |
| A4391 | $7.07 |
| A4392 | $8.18 |
| A4393 | $9.04 |

*Orthotic/Prosthetic Devices (continued)*

| Code/MD | Fee | Code/MD | Fees | Code/MD | Fees | Code/MD | Fees | Code/MD | Fees |
|---|---|---|---|---|---|---|---|---|---|
| A4394 | $2.58 | A5072 | $2.99 | L0100 | $457.97 | L1070 | $76.73 | L1870 | $863.68 |
| A4395 | $0.05 | A5073 | $2.74 | L0110 | $135.11 | L1080 | $53.17 | L1880 | $532.80 |
| A4396 | $40.48 | A5081 | $3.30 | L0112 | $1,132.88 | L1085 | $147.72 | L1900 | $227.67 |
| A4397 | $4.13 | A5082 | $10.11 | L0120 | $22.65 | L1090 | $69.00 | L1901 | $14.32 |
| A4398 | $13.81 | A5093 | $1.95 | L0130 | $163.75 | L1100 | $121.81 | L1902 | $61.83 |
| A4399 | $12.26 | A5102 | $22.58 | L0140 | $56.50 | L1110 | $206.31 | L1904 | $353.98 |
| A4400 | $41.54 | A5105 | $34.65 | L0150 | $94.23 | L1120 | $32.87 | L1906 | $103.44 |
| A4402 | $1.42 | A5112 | $34.62 | L0160 | $134.15 | L1200 | $1,308.20 | L1907 | $455.46 |
| A4404 | $1.69 | A5113 | $4.70 | L0170 | $567.71 | L1210 | $196.97 | L1910 | $201.30 |
| A4405 | $3.40 | A5114 | $8.06 | L0172 | $115.11 | L1220 | $166.77 | L1920 | $263.16 |
| A4406 | $5.74 | A5119 | $10.85 | L0174 | $206.79 | L1230 | $427.91 | L1930 | $178.08 |
| A4407 | $8.76 | A5121 | $6.34 | L0180 | $281.24 | L1240 | $73.64 | L1932 | 0.00 |
| A4408 | $9.87 | A5122 | $12.85 | L0190 | $423.35 | L1250 | $72.51 | L1940 | $402.43 |
| A4409 | $6.22 | A5126 | $1.12 | L0200 | $388.73 | L1260 | $74.51 | L1945 | $739.02 |
| A4410 | $9.04 | A5131 | $13.48 | L0210 | $40.35 | L1270 | $74.41 | L1950 | $560.69 |
| A4413 | $5.50 | A5200 | $11.29 | L0220 | $92.19 | L1280 | $66.34 | L1951 | $679.77 |
| A4414 | $4.93 | A7040 | $37.98 | L0430 | $1,125.88 | L1290 | $75.22 | L1960 | $417.24 |
| A4415 | $6.00 | A7041 | $71.35 | L0450 | $152.20 | L1300 | $1,257.43 | L1970 | $617.12 |
| A4416 | $2.75 | A7042 | $169.52 | L0452 | 0.00 | L1310 | $1,293.90 | L1971 | $379.40 |
| A4417 | $3.72 | A7043 | $23.31 | L0454 | $280.72 | L1500 | $1,429.84 | L1980 | $276.27 |
| A4418 | $1.81 | A7501 | $105.03 | L0456 | $805.03 | L1510 | $904.58 | L1990 | $354.96 |
| A4419 | $1.74 | A7502 | $49.91 | L0458 | $721.87 | L1520 | $2,148.52 | L2000 | $763.51 |
| A4420 | 0.00 | A7503 | $11.33 | L0460 | $812.52 | L1600 | $97.00 | L2005 | 0.00 |
| A4422 | $0.12 | A7504 | $0.67 | L0462 | $1,010.64 | L1610 | $33.05 | L2010 | $696.01 |
| A4423 | $1.86 | A7505 | $4.68 | L0464 | $1,203.15 | L1620 | $108.83 | L2020 | $878.96 |
| A4424 | $4.75 | A7506 | $0.33 | L0466 | $309.38 | L1630 | $129.86 | L2030 | $762.57 |
| A4425 | $3.58 | A7507 | $2.49 | L0468 | $387.88 | L1640 | $347.34 | L2035 | $140.22 |
| A4426 | $2.73 | A7508 | $2.87 | L0470 | $552.24 | L1650 | $184.19 | L2036 | $1,396.61 |
| A4427 | $2.78 | A7509 | $1.41 | L0472 | $346.63 | L1652 | $288.53 | L2037 | $1,287.06 |
| A4428 | $6.51 | A7520 | $47.48 | L0480 | $1,071.88 | L1660 | $128.82 | L2038 | $1,076.24 |
| A4429 | $8.25 | A7521 | $47.05 | L0482 | $1,228.76 | L1680 | $1,059.12 | L2039 | $1,798.84 |
| A4430 | $8.52 | A7522 | $45.16 | L0484 | $1,432.71 | L1685 | $1,117.55 | L2040 | $137.47 |
| A4431 | $6.22 | A7524 | $77.40 | L0486 | $1,419.28 | L1686 | $749.73 | L2050 | $366.11 |
| A4432 | $3.59 | A7525 | $2.07 | L0488 | $812.52 | L1690 | $1,565.22 | L2060 | $469.88 |
| A4433 | $3.34 | A7526 | $3.37 | L0490 | $228.96 | L1700 | $1,302.16 | L2070 | $134.98 |
| A4434 | $3.76 | A7527 | 0.00 | L0700 | $1,742.69 | L1710 | $1,530.61 | L2080 | $287.84 |
| A4450AU | $0.09 | E0752 | $372.52 | L0710 | $1,902.27 | L1720 | $1,130.66 | L2090 | $354.81 |
| A4450AV | $0.09 | E0754 | $916.00 | L0810 | $2,020.87 | L1730 | $853.07 | L2106 | $511.81 |
| A4450AW | $0.11 | E0756 | $6,767.01 | L0820 | $1,634.80 | L1750 | $148.10 | L2108 | $804.29 |
| A4452AU | $0.36 | E0757 | $4,834.90 | L0830 | $2,360.48 | L1755 | $1,241.64 | L2112 | $381.89 |
| A4452AV | $0.36 | E0758 | $4,255.80 | L0860 | $917.03 | L1800 | $66.77 | L2114 | $436.92 |
| A4452AW | $0.40 | E0759 | $558.88 | L0861 | $174.47 | L1810 | $98.00 | L2116 | $575.67 |
| A4455 | $1.22 | K0618 | $621.62 | L0960 | $69.33 | L1815 | $89.81 | L2126 | $1,024.24 |
| A4481 | $0.37 | K0619 | $402.87 | L0970 | $86.03 | L1820 | $97.60 | L2128 | $1,290.77 |
| A4483 | 0.00 | K0630 | $72.17 | L0972 | $87.94 | L1825 | $43.51 | L2132 | $607.23 |
| A4561 | $19.22 | K0631 | $195.70 | L0974 | $179.70 | L1830 | $81.65 | L2134 | $728.05 |
| A4562 | $47.78 | K0632 | 0.00 | L0976 | $160.48 | L1831 | $238.22 | L2136 | $890.21 |
| A4623 | $6.55 | K0634 | $44.60 | L0978 | $144.90 | L1832 | $610.20 | L2180 | $88.15 |
| A4625 | $6.93 | K0635 | $63.10 | L0980 | $13.14 | L1834 | $717.88 | L2182 | $68.99 |
| A4626 | $2.71 | K0636 | $332.72 | L0982 | $14.32 | L1836 | $108.00 | L2184 | $124.33 |
| A4629 | $4.63 | K0637 | $67.89 | L0984 | $45.70 | L1840 | $754.62 | L2186 | $137.77 |
| A5051 | $2.07 | K0639 | $131.07 | L1000 | $1,528.27 | L1843 | $726.26 | L2188 | $300.59 |
| A5052 | $1.49 | K0640 | $830.92 | L1005 | $2,590.66 | L1844 | $1,258.44 | L2190 | $78.07 |
| A5053 | $1.68 | K0642 | $232.10 | L1010 | $61.54 | L1845 | $758.15 | L2192 | $268.40 |
| A5054 | $1.79 | K0644 | $860.71 | L1020 | $84.08 | L1846 | $950.22 | L2200 | $35.79 |
| A5055 | $1.44 | K0645 | $1,270.02 | L1025 | $95.57 | L1847 | $465.56 | L2210 | $58.08 |
| A5061 | $3.52 | K0646 | $1,101.92 | L1030 | $63.85 | L1850 | $216.67 | L2220 | $66.68 |
| A5062 | $2.09 | K0647 | $1,067.55 | L1040 | $76.86 | L1855 | $927.17 | L2230 | $57.76 |
| A5063 | $2.70 | K0648 | $1,101.92 | L1050 | $66.55 | L1858 | $1,018.98 | L2232 | 0.00 |
| A5071 | $6.01 | K0649 | $846.98 | L1060 | $75.06 | L1860 | $840.39 | L2240 | $62.95 |

*Orthotic/Prosthetic Devices (continued)*

| Code/MD | Fees | Code/MD | Fees | Code/MD | Fees | Code/MD | Fees | Code/MD | Fees |
|---|---|---|---|---|---|---|---|---|---|
| L2250 | $267.48 | L2830 | $73.51 | L3944 | $90.19 | L5331 | $4,074.43 | L5661 | $488.03 |
| L2260 | $150.90 | L2840 | $41.02 | L3946 | $74.02 | L5341 | $4,241.50 | L5665 | $410.63 |
| L2265 | $88.65 | L2850 | $46.61 | L3948 | $49.56 | L5400 | $1,092.15 | L5666 | $56.14 |
| L2270 | $40.43 | L3224 | $44.26 | L3950 | $116.69 | L5410 | $335.08 | L5668 | $90.55 |
| L2275 | $98.36 | L3225 | $50.92 | L3952 | $129.33 | L5420 | $1,338.40 | L5670 | $217.61 |
| L2280 | $365.43 | L3650 | $44.09 | L3954 | $81.35 | L5430 | $403.56 | L5671 | $461.14 |
| L2300 | $206.27 | L3651 | $48.49 | L3956 | 0.00 | L5450 | $328.31 | L5672 | $239.14 |
| L2310 | $92.60 | L3652 | $146.18 | L3960 | $607.20 | L5460 | $437.40 | L5673 | $570.24 |
| L2320 | $154.88 | L3660 | $75.71 | L3962 | $632.23 | L5500 | $1,029.99 | L5676 | $290.61 |
| L2330 | $295.58 | L3670 | $105.53 | L3963 | $1,599.38 | L5505 | $1,424.51 | L5677 | $395.42 |
| L2335 | $173.88 | L3675 | $129.28 | L3980 | $227.72 | L5510 | $1,167.56 | L5678 | $31.84 |
| L2340 | $410.32 | L3700 | $51.42 | L3982 | $281.35 | L5520 | $1,153.27 | L5679 | $475.19 |
| L2350 | $670.74 | L3701 | $15.00 | L3984 | $300.32 | L5530 | $1,385.19 | L5680 | $265.80 |
| L2360 | $38.95 | L3710 | $106.80 | L3985 | $445.69 | L5535 | $1,359.98 | L5681 | $1,066.79 |
| L2370 | $193.24 | L3720 | $532.84 | L3986 | $515.46 | L5540 | $1,451.53 | L5682 | $501.55 |
| L2375 | $85.05 | L3730 | $701.43 | L3995 | $25.21 | L5560 | $1,558.69 | L5683 | $1,066.79 |
| L2380 | $92.67 | L3740 | $788.28 | L4000 | $982.00 | L5570 | $1,620.49 | L5684 | $38.60 |
| L2385 | $100.83 | L3760 | $368.39 | L4002 | 0.00 | L5580 | $1,891.80 | L5685 | 0.00 |
| L2390 | $82.40 | L3762 | $79.21 | L4010 | $552.61 | L5585 | $2,328.18 | L5686 | $40.97 |
| L2395 | $125.81 | L3800 | $147.29 | L4020 | $690.26 | L5590 | $1,927.88 | L5688 | $48.99 |
| L2397 | $88.23 | L3805 | $235.67 | L4030 | $380.05 | L5595 | $3,405.87 | L5690 | $78.47 |
| L2405 | $70.58 | L3807 | $184.19 | L4040 | $307.27 | L5600 | $3,661.14 | L5692 | $106.56 |
| L2415 | $98.32 | L3810 | $47.74 | L4045 | $246.93 | L5610 | $1,660.39 | L5694 | $145.49 |
| L2425 | $116.01 | L3815 | $44.32 | L4050 | $310.77 | L5611 | $1,292.11 | L5695 | $134.31 |
| L2430 | $116.01 | L3820 | $76.12 | L4055 | $201.23 | L5613 | $2,020.16 | L5696 | $148.38 |
| L2492 | $76.76 | L3825 | $54.05 | L4060 | $239.23 | L5614 | $1,368.52 | L5697 | $64.38 |
| L2500 | $237.47 | L3830 | $62.36 | L4070 | $228.25 | L5616 | $1,091.69 | L5698 | $105.28 |
| L2510 | $635.82 | L3835 | $67.60 | L4080 | $80.46 | L5617 | $453.76 | L5699 | $189.65 |
| L2520 | $346.78 | L3840 | $46.30 | L4090 | $71.22 | L5618 | $240.05 | L5700 | $2,297.79 |
| L2525 | $1,189.73 | L3845 | $59.80 | L4100 | $80.33 | L5620 | $222.96 | L5701 | $2,759.47 |
| L2526 | $641.27 | L3850 | $85.41 | L4110 | $63.84 | L5622 | $290.73 | L5702 | $3,491.15 |
| L2530 | $176.87 | L3855 | $92.31 | L4130 | $439.35 | L5624 | $291.56 | L5704 | $429.86 |
| L2540 | $318.25 | L3860 | $125.52 | L4350 | $79.16 | L5626 | $382.37 | L5705 | $768.08 |
| L2550 | $216.19 | L3900 | $1,150.76 | L4360 | $221.45 | L5628 | $408.85 | L5706 | $752.93 |
| L2570 | $478.06 | L3901 | $1,290.31 | L4370 | $142.11 | L5629 | $254.87 | L5707 | $992.63 |
| L2580 | $453.17 | L3904 | $2,626.71 | L4380 | $87.13 | L5630 | $359.92 | L5710 | $299.92 |
| L2600 | $154.60 | L3906 | $310.76 | L4386 | $128.34 | L5631 | $352.37 | L5711 | $419.18 |
| L2610 | $182.81 | L3907 | $418.21 | L4392 | $19.06 | L5632 | $196.66 | L5712 | $351.24 |
| L2620 | $201.27 | L3908 | $44.14 | L4394 | $13.91 | L5634 | $243.95 | L5714 | $360.78 |
| L2622 | $230.84 | L3909 | $10.42 | L4396 | $135.85 | L5636 | $204.34 | L5716 | $584.51 |
| L2624 | $313.82 | L3910 | $326.05 | L4398 | $62.51 | L5637 | $231.68 | L5718 | $730.57 |
| L2627 | $1,292.91 | L3911 | $18.27 | L5000 | $424.42 | L5638 | $403.58 | L5722 | $771.82 |
| L2628 | $1,518.77 | L3912 | $70.81 | L5010 | $1,025.05 | L5639 | $899.15 | L5724 | $1,210.50 |
| L2630 | $186.40 | L3914 | $71.31 | L5020 | $1,740.81 | L5640 | $512.81 | L5726 | $1,395.08 |
| L2640 | $252.97 | L3916 | $93.55 | L5050 | $1,925.65 | L5642 | $496.87 | L5728 | $1,908.28 |
| L2650 | $90.34 | L3917 | $77.81 | L5060 | $2,215.04 | L5643 | $1,248.22 | L5780 | $918.18 |
| L2660 | $140.30 | L3918 | $63.26 | L5100 | $1,929.89 | L5644 | $473.68 | L5781 | $3,244.95 |
| L2670 | $128.41 | L3920 | $75.43 | L5105 | $2,786.00 | L5645 | $639.88 | L5782 | $3,420.91 |
| L2680 | $117.80 | L3922 | $86.52 | L5150 | $2,816.26 | L5646 | $439.41 | L5785 | $516.13 |
| L2750 | $62.92 | L3923 | $28.67 | L5160 | $3,063.19 | L5647 | $637.93 | L5790 | $576.63 |
| L2755 | $105.78 | L3924 | $92.48 | L5200 | $2,933.44 | L5648 | $528.00 | L5795 | $1,148.09 |
| L2760 | $45.73 | L3926 | $76.04 | L5210 | $1,946.04 | L5649 | $1,913.22 | L5810 | $390.45 |
| L2768 | $105.48 | L3928 | $44.91 | L5220 | $2,212.03 | L5650 | $391.51 | L5811 | $584.89 |
| L2770 | $46.48 | L3930 | $46.37 | L5230 | $3,050.83 | L5651 | $963.10 | L5812 | $453.35 |
| L2780 | $54.10 | L3932 | $40.22 | L5250 | $4,161.05 | L5652 | $349.64 | L5814 | $3,011.95 |
| L2785 | $31.81 | L3934 | $35.49 | L5270 | $4,142.59 | L5653 | $466.74 | L5816 | $686.13 |
| L2795 | $63.96 | L3936 | $65.61 | L5280 | $4,110.86 | L5654 | $265.96 | L5818 | $770.15 |
| L2800 | $80.29 | L3938 | $69.02 | L5301 | $2,205.98 | L5655 | $225.39 | L5822 | $1,365.67 |
| L2810 | $58.79 | L3940 | $79.19 | L5311 | $3,157.72 | L5656 | $302.37 | L5824 | $1,229.87 |
| L2820 | $65.37 | L3942 | $54.77 | L5321 | $3,197.63 | L5658 | $291.59 | L5826 | $2,532.66 |

*Orthotic/Prosthetic Devices (continued)*

| Code/MD | Fees | Code/MD | Fees | Code/MD | Fees | Code/MD | Fees | Code/MD | Fees |
|---|---|---|---|---|---|---|---|---|---|
| L5828 | $2,264.70 | L6388 | $352.56 | L6710 | $276.79 | L7015 | $4,654.51 | L8330 | $52.00 |
| L5830 | $1,521.76 | L6400 | $1,860.88 | L6715 | $274.93 | L7020 | $2,729.03 | L8400 | $15.20 |
| L5840 | $2,813.74 | L6450 | $2,486.10 | L6720 | $684.17 | L7025 | $2,753.99 | L8410 | $17.29 |
| L5845 | $1,453.61 | L6500 | $2,600.97 | L6725 | $331.23 | L7030 | $4,211.28 | L8415 | $17.19 |
| L5848 | $872.06 | L6550 | $3,126.41 | L6730 | $545.67 | L7035 | $2,820.41 | L8417 | $60.98 |
| L5850 | $102.59 | L6570 | $3,510.11 | L6735 | $238.97 | L7040 | $2,260.89 | L8420 | $20.10 |
| L5855 | $275.68 | L6580 | $1,340.09 | L6740 | $339.57 | L7045 | $1,296.25 | L8430 | $22.10 |
| L5856 | 0.00 | L6582 | $1,213.76 | L6745 | $298.10 | L7170 | $5,968.39 | L8435 | $19.84 |
| L5857 | 0.00 | L6584 | $1,903.48 | L6750 | $298.99 | L7180 | $26,197.98 | L8440 | $42.05 |
| L5910 | $290.45 | L6586 | $1,781.35 | L6755 | $299.75 | L7181 | 0.00 | L8460 | $58.51 |
| L5920 | $425.51 | L6588 | $2,340.66 | L6765 | $316.72 | L7185 | $5,893.87 | L8465 | $52.16 |
| L5925 | $359.29 | L6590 | $2,223.28 | L6770 | $300.46 | L7186 | $7,093.85 | L8470 | $5.35 |
| L5930 | $2,729.72 | L6600 | $150.43 | L6775 | $335.81 | L7190 | $6,190.58 | L8480 | $7.38 |
| L5940 | $402.27 | L6605 | $148.53 | L6780 | $375.74 | L7191 | $7,412.66 | L8485 | $8.92 |
| L5950 | $628.99 | L6610 | $142.64 | L6790 | $362.38 | L7260 | $1,578.30 | L8500 | $529.27 |
| L5960 | $773.13 | L6615 | $153.70 | L6795 | $1,011.61 | L7261 | $2,873.10 | L8501 | $117.55 |
| L5962 | $508.80 | L6616 | $56.95 | L6800 | $812.57 | L7266 | $1,058.68 | L8507 | $33.97 |
| L5964 | $751.06 | L6620 | $245.91 | L6805 | $272.86 | L7272 | $1,833.33 | L8509 | $88.58 |
| L5966 | $957.03 | L6623 | $685.91 | L6806 | $1,311.64 | L7274 | $4,606.18 | L8510 | $204.94 |
| L5968 | $2,947.11 | L6625 | $487.36 | L6807 | $1,056.79 | L7360 | $191.36 | L8511 | $58.99 |
| L5970 | $162.88 | L6628 | $384.18 | L6808 | $902.39 | L7362 | $200.93 | L8512 | $1.77 |
| L5972 | $304.23 | L6629 | $117.33 | L6809 | $316.73 | L7364 | $319.57 | L8513 | $4.22 |
| L5974 | $186.88 | L6630 | $172.84 | L6810 | $154.66 | L7366 | $430.47 | L8514 | $76.49 |
| L5975 | $375.98 | L6632 | $60.03 | L6825 | $911.11 | L7367 | $315.73 | L8515 | 0.00 |
| L5976 | $449.12 | L6635 | $141.25 | L6830 | $1,086.02 | L7368 | $409.30 | L8600 | $500.79 |
| L5978 | $234.04 | L6637 | $301.29 | L6835 | $946.03 | L7900 | $438.92 | L8603 | $351.71 |
| L5979 | $1,829.90 | L6638 | $2,028.09 | L6840 | $690.23 | L8000 | $35.28 | L8606 | $184.62 |
| L5980 | $2,973.47 | L6640 | $267.65 | L6845 | $656.02 | L8001 | $101.72 | L8610 | $513.68 |
| L5981 | $2,402.15 | L6641 | $128.65 | L6850 | $595.18 | L8002 | $133.81 | L8612 | $541.78 |
| L5982 | $463.63 | L6642 | $174.38 | L6855 | $702.79 | L8015 | $48.61 | L8613 | $242.57 |
| L5984 | $456.86 | L6645 | $321.89 | L6860 | $534.93 | L8020 | $182.84 | L8614 | $15,353.47 |
| L5985 | $229.00 | L6646 | $2,557.88 | L6865 | $292.24 | L8030 | $264.47 | L8615 | 0.00 |
| L5986 | $508.19 | L6647 | $421.09 | L6867 | $781.30 | L8035 | $2,971.19 | L8616 | 0.00 |
| L5987 | $5,834.12 | L6648 | $2,638.08 | L6868 | $192.27 | L8040 | $1,960.33 | L8617 | 0.00 |
| L5988 | $1,620.12 | L6650 | $334.20 | L6870 | $190.62 | L8040KM | $1,862.31 | L8618 | 0.00 |
| L5990 | $1,471.32 | L6655 | $65.69 | L6872 | $755.30 | L8040KN | $784.13 | L8619 | $6,586.07 |
| L5995 | 0.00 | L6660 | $73.61 | L6873 | $375.16 | L8041 | $2,362.79 | L8620 | 0.00 |
| L6000 | $1,065.57 | L6665 | $36.94 | L6875 | $623.33 | L8041KM | $2,244.64 | L8621 | 0.00 |
| L6010 | $1,185.80 | L6670 | $40.83 | L6880 | $404.39 | L8041KN | $945.11 | L8622 | 0.00 |
| L6020 | $1,105.57 | L6672 | $162.06 | L6881 | $3,315.54 | L8042 | $2,654.81 | L8630 | $270.19 |
| L6025 | $6,489.90 | L6675 | $96.31 | L6882 | $2,515.01 | L8042KM | $2,522.08 | L8631 | $1,813.25 |
| L6050 | $1,523.44 | L6676 | $111.33 | L6890 | $136.40 | L8042KN | $1,061.92 | L8641 | $293.24 |
| L6055 | $2,123.28 | L6680 | $186.07 | L6895 | $501.79 | L8043 | $2,973.40 | L8642 | $240.71 |
| L6100 | $1,543.47 | L6682 | $205.72 | L6900 | $1,431.99 | L8043KM | $2,824.71 | L8658 | $251.57 |
| L6110 | $1,637.12 | L6684 | $279.54 | L6905 | $1,423.85 | L8043KN | $1,189.36 | L8659 | $1,564.96 |
| L6120 | $1,907.82 | L6686 | $631.27 | L6910 | $1,217.55 | L8044 | $3,291.97 | L8670 | $446.41 |
| L6130 | $2,076.07 | L6687 | $462.58 | L6915 | $613.86 | L8044KM | $3,127.38 | V2020 | $64.64 |
| L6200 | $2,187.84 | L6688 | $459.80 | L6920 | $5,352.12 | L8044KN | $1,316.80 | V2100 | $31.41 |
| L6205 | $2,920.42 | L6689 | $550.89 | L6925 | $7,204.87 | L8045 | $2,061.52 | V2101 | $33.10 |
| L6250 | $2,292.35 | L6690 | $600.31 | L6930 | $5,385.31 | L8045KM | $1,958.44 | V2102 | $46.95 |
| L6300 | $2,987.83 | L6691 | $277.86 | L6935 | $7,316.68 | L8045KN | $824.61 | V2103 | $27.28 |
| L6310 | $2,579.86 | L6692 | $448.49 | L6940 | $7,036.26 | L8046 | $2,123.85 | V2104 | $30.21 |
| L6320 | $1,409.33 | L6693 | $2,302.41 | L6945 | $8,597.47 | L8046KM | $2,017.66 | V2105 | $36.98 |
| L6350 | $3,141.25 | L6694 | 0.00 | L6950 | $7,997.69 | L8046KN | $849.53 | V2106 | $37.53 |
| L6360 | $2,825.06 | L6695 | 0.00 | L6955 | $9,578.33 | L8047 | $1,088.47 | V2107 | $39.45 |
| L6370 | $1,690.43 | L6696 | 0.00 | L6960 | $10,849.86 | L8047KM | $1,034.05 | V2108 | $38.26 |
| L6380 | $979.56 | L6697 | 0.00 | L6965 | $11,571.76 | L8047KN | $435.39 | V2109 | $43.98 |
| L6382 | $1,473.72 | L6698 | 0.00 | L6970 | $12,057.98 | L8300 | $78.10 | V2110 | $51.33 |
| L6384 | $2,038.72 | L6700 | $416.01 | L6975 | $13,187.55 | L8310 | $120.10 | V2111 | $45.25 |
| L6386 | $322.06 | L6705 | $244.23 | L7010 | $2,929.07 | L8320 | $52.46 | V2112 | $44.65 |

*Orthotic/Prosthetic Devices (continued)*

| Code/MD | Fees | Code/MD | Fees | Code/MD | Fees | Code/MD | Fees | Code/MD | Fees |
|---|---|---|---|---|---|---|---|---|---|
| V2113 | $61.69 | V2212 | $66.66 | V2309 | $83.24 | V2510 | $88.98 | V2710 | $51.42 |
| V2114 | $54.56 | V2213 | $68.36 | V2310 | $91.56 | V2511 | $127.85 | V2715 | $9.32 |
| V2115 | $59.33 | V2214 | $73.28 | V2311 | $87.20 | V2512 | $151.08 | V2718 | $22.90 |
| V2118 | $58.81 | V2215 | $79.29 | V2312 | $76.87 | V2513 | $126.84 | V2730 | $16.91 |
| V2121 | $60.72 | V2218 | $81.12 | V2313 | $104.92 | V2520 | $83.64 | V2744 | $17.54 |
| V2200 | $41.11 | V2219 | $35.71 | V2314 | $114.92 | V2521 | $145.61 | V2745 | $9.95 |
| V2201 | $44.81 | V2220 | $28.96 | V2315 | $127.59 | V2522 | $141.71 | V2750 | $20.41 |
| V2202 | $52.73 | V2221 | $77.37 | V2318 | $117.64 | V2523 | $120.76 | V2755 | $14.75 |
| V2203 | $41.48 | V2300 | $53.39 | V2319 | $39.82 | V2530 | $178.86 | V2760 | $12.85 |
| V2204 | $44.98 | V2301 | $61.92 | V2320 | $42.02 | V2531 | $439.11 | V2762 | $48.35 |
| V2205 | $49.35 | V2302 | $67.84 | V2321 | $125.76 | V2623 | $719.88 | V2770 | $16.59 |
| V2206 | $60.08 | V2303 | $56.19 | V2410 | $71.91 | V2624 | $48.82 | V2780 | $13.40 |
| V2207 | $50.15 | V2304 | $58.81 | V2430 | $93.62 | V2625 | $316.22 | V2782 | $52.20 |
| V2208 | $50.76 | V2305 | $72.12 | V2500 | $65.18 | V2626 | $200.62 | V2783 | $58.88 |
| V2209 | $55.84 | V2306 | $67.26 | V2501 | $99.29 | V2627 | $1,148.63 | V2784 | $38.28 |
| V2210 | $71.84 | V2307 | $66.68 | V2502 | $122.31 | V2628 | $262.62 | V2786 | 0.00 |
| V2211 | $61.26 | V2308 | $71.16 | V2503 | $117.02 | V2700 | $35.13 | | |

# Clinical Laboratory Services

The following fee schedules are effective for clinical laboratory services furnished **on or after January 1, 2005.** Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

| Code/MD | 60% | 62% | Code/MD | 60% | 62% | Code/MD | 60% | 62% |
|---|---|---|---|---|---|---|---|---|
| ATP02 | $7.28 | $7.52 | P9612 | $3.00 | $3.00 | 80172 | $22.76 | $23.52 |
| ATP03 | $9.29 | $9.60 | P9615 | $3.00 | $3.00 | 80173 | $20.34 | $21.02 |
| ATP04 | $9.80 | $10.13 | Q0111 | $5.96 | $6.16 | 80174 | $24.05 | $24.85 |
| ATP05 | $10.93 | $11.29 | Q0112 | $5.96 | $6.16 | 80176 | $16.26 | $16.80 |
| ATP06 | $10.96 | $11.33 | Q0113 | $7.56 | $7.81 | 80178 | $9.24 | $9.55 |
| ATP07 | $11.42 | $11.80 | Q0114 | $9.99 | $10.32 | 80182 | $18.93 | $19.56 |
| ATP08 | $11.83 | $12.22 | Q0115 | $13.83 | $14.29 | 80184 | $16.01 | $16.54 |
| ATP09 | $12.13 | $12.53 | 36415 | $3.00 | $3.00 | 80185 | $18.52 | $19.14 |
| ATP10 | $12.13 | $12.53 | 78267 | $10.98 | $11.35 | 80186 | $19.23 | $19.87 |
| ATP11 | $12.34 | $12.75 | 78268 | $94.11 | $97.25 | 80188 | $23.18 | $23.95 |
| ATP12 | $12.62 | $13.04 | 80048 | $11.83 | $12.22 | 80190 | $23.41 | $24.19 |
| ATP16 | $14.77 | $15.26 | 80051 | $9.80 | $10.13 | 80192 | $23.41 | $24.19 |
| ATP18 | $14.87 | $15.37 | 80053 | $14.77 | $15.26 | 80194 | $20.39 | $21.07 |
| ATP19 | $15.45 | $15.97 | 80061 | $18.72 | $19.34 | 80196 | $9.92 | $10.25 |
| ATP20 | $15.95 | $16.48 | 80061QW | $18.72 | $19.34 | 80197 | $19.17 | $19.81 |
| ATP21 | $16.45 | $17.00 | 80069 | $12.13 | $12.53 | 80198 | $19.77 | $20.43 |
| ATP22 | $16.95 | $17.52 | 80074 | $66.54 | $68.76 | 80200 | $22.52 | $23.27 |
| G0027 | $9.09 | $9.39 | 80076 | $11.42 | $11.80 | 80201 | $16.66 | $17.22 |
| G0103 | $25.70 | $26.56 | 80100 | $20.32 | $21.00 | 80202 | $18.93 | $19.56 |
| G0107 | $4.54 | $4.69 | 80101 | $19.24 | $19.88 | 80299 | $19.13 | $19.77 |
| G0123 | $28.21 | $29.15 | 80101QW | $19.24 | $19.88 | 80400 | $45.56 | $47.08 |
| G0143 | $28.21 | $29.15 | 80102 | $18.51 | $19.13 | 80402 | $121.46 | $125.51 |
| G0144 | $29.39 | $30.37 | 80150 | $21.06 | $21.76 | 80406 | $109.34 | $112.98 |
| G0145 | $34.70 | $35.86 | 80152 | $25.01 | $25.84 | 80408 | $175.34 | $181.18 |
| G0147 | $14.76 | $14.76 | 80154 | $25.84 | $26.70 | 80410 | $112.23 | $115.97 |
| G0148 | $14.76 | $14.76 | 80156 | $20.34 | $21.02 | 80412 | $460.50 | $475.85 |
| G0265 | $14.11 | $14.58 | 80157 | $18.52 | $19.14 | 80414 | $72.16 | $74.57 |
| G0266 | $14.11 | $14.58 | 80158 | $24.31 | $25.12 | 80415 | $78.08 | $80.68 |
| G0306 | $10.86 | $11.22 | 80160 | $24.05 | $24.85 | 80416 | $184.38 | $190.53 |
| G0307 | $9.04 | $9.34 | 80162 | $18.55 | $19.17 | 80417 | $61.46 | $63.51 |
| G0328 | $22.22 | $22.96 | 80164 | $18.93 | $19.56 | 80418 | $809.76 | $836.75 |
| G0328QW | $22.22 | $22.96 | 80166 | $21.66 | $22.38 | 80420 | $100.64 | $103.99 |
| P2038 | $7.02 | $7.25 | 80168 | $22.83 | $23.59 | 80422 | $64.38 | $66.53 |
| P3000 | $14.76 | $14.76 | 80170 | $22.90 | $23.66 | 80424 | $66.56 | $68.78 |

*Clinical Laboratory Services (continued)*

| Code/MD | 60% | 62% |
|---|---|---|
| 80426 | $207.40 | $214.31 |
| 80428 | $93.16 | $96.27 |
| 80430 | $109.60 | $113.25 |
| 80432 | $177.43 | $183.34 |
| 80434 | $141.30 | $146.01 |
| 80435 | $143.85 | $148.65 |
| 80436 | $127.36 | $131.61 |
| 80438 | $70.41 | $72.76 |
| 80439 | $93.88 | $97.01 |
| 80440 | $81.24 | $83.95 |
| 81000 | $4.43 | $4.58 |
| 81001 | $4.43 | $4.58 |
| 81002 | $3.57 | $3.69 |
| 81003 | $3.14 | $3.24 |
| 81003QW | $3.14 | $3.24 |
| 81005 | $3.03 | $3.13 |
| 81007 | $3.59 | $3.71 |
| 81007QW | $3.59 | $3.71 |
| 81015 | $4.02 | $4.15 |
| 81020 | $5.15 | $5.32 |
| 81025 | $8.84 | $9.13 |
| 81050 | $4.19 | $4.33 |
| 82000 | $17.31 | $17.89 |
| 82003 | $28.28 | $29.22 |
| 82009 | $6.31 | $6.52 |
| 82010 | $9.99 | $10.32 |
| 82010QW | $9.99 | $10.32 |
| 82013 | $15.61 | $16.13 |
| 82016 | $19.37 | $20.02 |
| 82017 | $23.57 | $24.36 |
| 82024 | $53.97 | $55.77 |
| 82030 | $18.08 | $18.68 |
| 82040 | $5.73 | $5.92 |
| 82042 | $2.46 | $2.54 |
| 82043 | $2.46 | $2.54 |
| 82044 | $6.39 | $6.60 |
| 82044QW | $6.39 | $6.60 |
| 82045 | $47.43 | $49.01 |
| 82055 | $15.10 | $15.60 |
| 82055QW | $15.10 | $15.60 |
| 82075 | $16.84 | $17.40 |
| 82085 | $13.56 | $14.01 |
| 82088 | $56.94 | $58.84 |
| 82101 | $41.94 | $43.34 |
| 82103 | $18.77 | $19.40 |
| 82104 | $20.20 | $20.87 |
| 82105 | $23.44 | $24.22 |
| 82106 | $23.44 | $24.22 |
| 82108 | $35.60 | $36.79 |
| 82120 | $4.02 | $4.15 |
| 82120QW | $4.02 | $4.15 |
| 82127 | $19.37 | $20.02 |
| 82128 | $19.37 | $20.02 |
| 82131 | $23.57 | $24.36 |
| 82135 | $23.00 | $23.77 |
| 82136 | $23.57 | $24.36 |
| 82139 | $23.57 | $24.36 |
| 82140 | $20.36 | $21.04 |
| 82143 | $9.61 | $9.93 |
| 82145 | $21.72 | $22.44 |
| 82150 | $9.06 | $9.36 |
| 82154 | $40.29 | $41.63 |
| 82157 | $40.90 | $42.26 |
| 82160 | $34.94 | $36.10 |
| 82163 | $28.68 | $29.64 |
| 82164 | $20.39 | $21.07 |
| 82172 | $19.80 | $20.46 |
| 82175 | $26.51 | $27.39 |
| 82180 | $13.81 | $14.27 |
| 82190 | $17.08 | $17.65 |
| 82205 | $16.01 | $16.54 |
| 82232 | $22.61 | $23.36 |
| 82239 | $23.94 | $24.74 |
| 82240 | $24.31 | $25.12 |
| 82247 | $7.02 | $7.25 |
| 82248 | $7.02 | $7.25 |
| 82252 | $2.73 | $2.82 |
| 82261 | $23.57 | $24.36 |
| 82270 | $4.54 | $4.69 |
| 82273 | $4.54 | $4.69 |
| 82273QW | $4.54 | $4.69 |
| 82274 | $22.22 | $22.96 |
| 82274QW | $22.22 | $22.96 |
| 82286 | $9.62 | $9.94 |
| 82300 | $13.25 | $13.69 |
| 82306 | $41.36 | $42.74 |
| 82307 | $45.02 | $46.52 |
| 82308 | $37.41 | $38.66 |
| 82310 | $7.20 | $7.44 |
| 82330 | $19.09 | $19.73 |
| 82331 | $7.23 | $7.47 |
| 82340 | $8.43 | $8.71 |
| 82355 | $16.17 | $16.71 |
| 82360 | $12.22 | $12.63 |
| 82365 | $17.30 | $17.88 |
| 82370 | $17.51 | $18.09 |
| 82373 | $24.35 | $25.16 |
| 82374 | $6.83 | $7.06 |
| 82375 | $17.22 | $17.79 |
| 82376 | $7.94 | $8.20 |
| 82378 | $26.51 | $27.39 |
| 82379 | $23.57 | $24.36 |
| 82380 | $12.89 | $13.32 |
| 82382 | $24.02 | $24.82 |
| 82383 | $35.01 | $36.18 |
| 82384 | $33.28 | $34.39 |
| 82387 | $29.07 | $30.04 |
| 82390 | $15.01 | $15.51 |
| 82397 | $19.74 | $20.40 |
| 82415 | $17.70 | $18.29 |
| 82435 | $6.42 | $6.63 |
| 82436 | $4.55 | $4.70 |
| 82438 | $6.83 | $7.06 |
| 82441 | $8.38 | $8.66 |
| 82465 | $6.08 | $6.28 |
| 82465QW | $6.08 | $6.28 |
| 82480 | $9.93 | $10.26 |
| 82482 | $8.31 | $8.59 |
| 82485 | $20.02 | $20.69 |
| 82486 | $24.35 | $25.16 |
| 82487 | $20.02 | $20.69 |
| 82488 | $20.02 | $20.69 |
| 82489 | $20.02 | $20.69 |
| 82491 | $24.35 | $25.16 |
| 82492 | $24.35 | $25.16 |
| 82495 | $28.34 | $29.28 |
| 82507 | $38.85 | $40.15 |
| 82520 | $21.17 | $21.88 |
| 82523 | $26.11 | $26.98 |
| 82523QW | $26.11 | $26.98 |
| 82525 | $17.34 | $17.92 |
| 82528 | $31.45 | $32.50 |
| 82530 | $23.35 | $24.13 |
| 82533 | $22.78 | $23.54 |
| 82540 | $6.48 | $6.70 |
| 82541 | $24.35 | $25.16 |
| 82542 | $24.35 | $25.16 |
| 82543 | $24.35 | $25.16 |
| 82544 | $24.35 | $25.16 |
| 82550 | $9.10 | $9.40 |
| 82552 | $18.71 | $19.33 |
| 82553 | $13.00 | $13.43 |
| 82554 | $13.00 | $13.43 |
| 82565 | $7.16 | $7.40 |
| 82570 | $7.23 | $7.47 |
| 82570QW | $7.23 | $7.47 |
| 82575 | $13.20 | $13.64 |
| 82585 | $11.98 | $12.38 |
| 82595 | $9.04 | $9.34 |
| 82600 | $27.11 | $28.01 |
| 82607 | $21.06 | $21.76 |
| 82608 | $20.01 | $20.68 |
| 82615 | $11.41 | $11.79 |
| 82626 | $35.31 | $36.49 |
| 82627 | $31.07 | $32.11 |
| 82633 | $43.28 | $44.72 |
| 82634 | $40.90 | $42.26 |
| 82638 | $17.11 | $17.68 |
| 82646 | $27.81 | $28.74 |
| 82649 | $35.91 | $37.11 |
| 82651 | $36.07 | $37.27 |
| 82652 | $53.78 | $55.57 |
| 82654 | $19.11 | $19.75 |
| 82656 | $16.12 | $16.66 |
| 82657 | $24.35 | $25.16 |
| 82658 | $24.35 | $25.16 |
| 82664 | $48.00 | $49.60 |
| 82666 | $30.01 | $31.01 |
| 82668 | $26.26 | $27.14 |
| 82670 | $39.04 | $40.34 |
| 82671 | $45.13 | $46.63 |
| 82672 | $30.30 | $31.31 |
| 82677 | $33.79 | $34.92 |
| 82679 | $34.88 | $36.04 |
| 82679QW | $34.88 | $36.04 |
| 82690 | $21.99 | $22.72 |
| 82693 | $13.75 | $14.21 |
| 82696 | $32.95 | $34.05 |
| 82705 | $7.11 | $7.35 |
| 82710 | $22.12 | $22.86 |

*Clinical Laboratory Services (continued)*

| Code/MD | 60% | 62% | Code/MD | 60% | 62% | Code/MD | 60% | 62% |
|---|---|---|---|---|---|---|---|---|
| 82715 | $24.05 | $24.85 | 83013 | $94.11 | $97.25 | 83715 | $15.73 | $16.25 |
| 82725 | $12.08 | $12.48 | 83014 | $10.98 | $11.35 | 83716 | $17.30 | $17.88 |
| 82726 | $24.35 | $25.16 | 83015 | $26.31 | $27.19 | 83718 | $11.44 | $11.82 |
| 82728 | $19.03 | $19.66 | 83018 | $30.68 | $31.70 | 83718QW | $11.44 | $11.82 |
| 82731 | $89.99 | $92.99 | 83020 | $17.99 | $18.59 | 83719 | $16.26 | $16.80 |
| 82735 | $12.62 | $13.04 | 83021 | $24.35 | $25.16 | 83721 | $13.33 | $13.77 |
| 82742 | $27.66 | $28.58 | 83026 | $3.30 | $3.41 | 83727 | $24.02 | $24.82 |
| 82746 | $20.54 | $21.22 | 83030 | $11.56 | $11.95 | 83735 | $9.36 | $9.67 |
| 82747 | $4.30 | $4.44 | 83033 | $6.50 | $6.72 | 83775 | $10.30 | $10.64 |
| 82757 | $16.89 | $17.45 | 83036 | $13.56 | $14.01 | 83785 | $34.36 | $35.51 |
| 82759 | $30.01 | $31.01 | 83036QW | $13.56 | $14.01 | 83788 | $24.35 | $25.16 |
| 82760 | $15.64 | $16.16 | 83045 | $4.88 | $5.04 | 83789 | $24.35 | $25.16 |
| 82775 | $29.43 | $30.41 | 83050 | $5.86 | $6.06 | 83805 | $24.63 | $25.45 |
| 82776 | $11.71 | $12.10 | 83051 | $10.21 | $10.55 | 83825 | $22.72 | $23.48 |
| 82784 | $12.99 | $13.42 | 83055 | $6.87 | $7.10 | 83835 | $23.67 | $24.46 |
| 82785 | $23.01 | $23.78 | 83060 | $8.12 | $8.39 | 83840 | $22.81 | $23.57 |
| 82787 | $4.36 | $4.51 | 83065 | $6.00 | $6.20 | 83857 | $15.01 | $15.51 |
| 82800 | $4.88 | $5.04 | 83068 | $11.83 | $12.22 | 83858 | $18.72 | $19.34 |
| 82803 | $27.04 | $27.94 | 83069 | $5.51 | $5.69 | 83864 | $27.82 | $28.75 |
| 82805 | $39.65 | $40.97 | 83070 | $6.64 | $6.86 | 83866 | $13.76 | $14.22 |
| 82810 | $12.20 | $12.61 | 83071 | $9.61 | $9.93 | 83872 | $8.19 | $8.46 |
| 82820 | $13.96 | $14.43 | 83080 | $23.57 | $24.36 | 83873 | $24.04 | $24.84 |
| 82926 | $7.61 | $7.86 | 83088 | $41.26 | $42.64 | 83874 | $18.04 | $18.64 |
| 82928 | $7.32 | $7.56 | 83090 | $23.57 | $24.36 | 83880 | $47.43 | $49.01 |
| 82938 | $24.72 | $25.54 | 83150 | $17.30 | $17.88 | 83883 | $19.00 | $19.63 |
| 82941 | $24.64 | $25.46 | 83491 | $24.47 | $25.29 | 83885 | $7.94 | $8.20 |
| 82943 | $19.97 | $20.64 | 83497 | $18.01 | $18.61 | 83887 | $33.09 | $34.19 |
| 82945 | $5.48 | $5.66 | 83498 | $37.95 | $39.22 | 83890 | $3.56 | $3.68 |
| 82946 | $21.06 | $21.76 | 83499 | $35.22 | $36.39 | 83891 | $3.56 | $3.68 |
| 82947 | $5.48 | $5.66 | 83500 | $31.65 | $32.71 | 83892 | $3.56 | $3.68 |
| 82947QW | $5.48 | $5.66 | 83505 | $33.96 | $35.09 | 83893 | $3.56 | $3.68 |
| 82948 | $4.43 | $4.58 | 83516 | $16.12 | $16.66 | 83894 | $3.56 | $3.68 |
| 82950 | $6.64 | $6.86 | 83518 | $11.85 | $12.25 | 83896 | $3.56 | $3.68 |
| 82950QW | $6.64 | $6.86 | 83518QW | $11.85 | $12.25 | 83897 | $3.56 | $3.68 |
| 82951 | $17.99 | $18.59 | 83519 | $18.88 | $19.51 | 83898 | $23.42 | $24.20 |
| 82951QW | $17.99 | $18.59 | 83520 | $18.09 | $18.69 | 83901 | $23.42 | $24.20 |
| 82952 | $5.48 | $5.66 | 83525 | $15.98 | $16.51 | 83902 | $15.17 | $15.68 |
| 82952QW | $5.48 | $5.66 | 83527 | $18.09 | $18.69 | 83903 | $23.42 | $24.20 |
| 82953 | $6.63 | $6.85 | 83528 | $22.22 | $22.96 | 83904 | $23.42 | $24.20 |
| 82955 | $13.55 | $14.00 | 83540 | $9.05 | $9.35 | 83905 | $23.42 | $24.20 |
| 82960 | $8.12 | $8.39 | 83550 | $12.21 | $12.62 | 83906 | $23.42 | $24.20 |
| 82962 | $3.27 | $3.38 | 83570 | $12.36 | $12.77 | 83912 | $3.56 | $3.68 |
| 82963 | $30.01 | $31.01 | 83582 | $19.80 | $20.46 | 83915 | $15.58 | $16.10 |
| 82965 | $7.28 | $7.52 | 83586 | $17.89 | $18.49 | 83916 | $27.42 | $28.33 |
| 82975 | $22.13 | $22.87 | 83593 | $36.75 | $37.98 | 83918 | $21.19 | $21.90 |
| 82977 | $10.06 | $10.40 | 83605 | $14.92 | $15.42 | 83919 | $21.19 | $21.90 |
| 82978 | $19.91 | $20.57 | 83605QW | $14.92 | $15.42 | 83921 | $21.19 | $21.90 |
| 82979 | $9.62 | $9.94 | 83615 | $8.44 | $8.72 | 83925 | $27.19 | $28.10 |
| 82980 | $24.31 | $25.12 | 83625 | $17.88 | $18.48 | 83930 | $9.24 | $9.55 |
| 82985 | $21.06 | $21.76 | 83630 | $16.12 | $16.66 | 83935 | $9.52 | $9.84 |
| 82985QW | $21.06 | $21.76 | 83632 | $28.24 | $29.18 | 83937 | $28.73 | $29.69 |
| 83001 | $25.97 | $26.84 | 83633 | $7.69 | $7.95 | 83945 | $17.99 | $18.59 |
| 83001QW | $25.97 | $26.84 | 83634 | $11.17 | $11.54 | 83950 | $89.99 | $92.99 |
| 83002 | $25.88 | $26.74 | 83655 | $16.91 | $17.47 | 83970 | $57.67 | $59.59 |
| 83002QW | $25.88 | $26.74 | 83661 | $27.56 | $28.48 | 83986 | $5.00 | $5.17 |
| 83003 | $23.29 | $24.07 | 83662 | $26.43 | $27.31 | 83986QW | $5.00 | $5.17 |
| 83008 | $23.45 | $24.23 | 83663 | $26.43 | $27.31 | 83992 | $20.54 | $21.22 |
| 83009 | $94.11 | $97.25 | 83664 | $26.43 | $27.31 | 84022 | $21.76 | $22.49 |
| 83010 | $17.58 | $18.17 | 83670 | $12.80 | $13.23 | 84030 | $7.69 | $7.95 |
| 83012 | $24.02 | $24.82 | 83690 | $9.62 | $9.94 | 84035 | $5.11 | $5.28 |

*Clinical Laboratory Services (continued)*

| Code/MD | 60% | 62% |
|---|---|---|
| 84060 | $10.32 | $10.66 |
| 84061 | $11.06 | $11.43 |
| 84066 | $13.50 | $13.95 |
| 84075 | $7.23 | $7.47 |
| 84078 | $10.20 | $10.54 |
| 84080 | $20.66 | $21.35 |
| 84081 | $23.09 | $23.86 |
| 84085 | $9.42 | $9.73 |
| 84087 | $11.31 | $11.69 |
| 84100 | $6.63 | $6.85 |
| 84105 | $6.50 | $6.72 |
| 84106 | $5.99 | $6.19 |
| 84110 | $11.80 | $12.19 |
| 84119 | $12.03 | $12.43 |
| 84120 | $20.55 | $21.24 |
| 84126 | $35.59 | $36.78 |
| 84127 | $16.28 | $16.82 |
| 84132 | $6.42 | $6.63 |
| 84133 | $6.01 | $6.21 |
| 84134 | $20.38 | $21.06 |
| 84135 | $26.73 | $27.62 |
| 84138 | $26.46 | $27.34 |
| 84140 | $23.53 | $24.31 |
| 84143 | $31.89 | $32.95 |
| 84144 | $29.15 | $30.12 |
| 84146 | $27.08 | $27.98 |
| 84150 | $34.88 | $36.04 |
| 84152 | $25.70 | $26.56 |
| 84153 | $25.70 | $26.56 |
| 84154 | $25.70 | $26.56 |
| 84155 | $5.12 | $5.29 |
| 84156 | $5.12 | $5.29 |
| 84157 | $5.12 | $5.29 |
| 84160 | $7.23 | $7.47 |
| 84163 | $21.03 | $21.73 |
| 84165 | $15.01 | $15.51 |
| 84166 | $24.92 | $25.75 |
| 84181 | $23.80 | $24.59 |
| 84182 | $25.15 | $25.99 |
| 84202 | $10.67 | $11.03 |
| 84203 | $10.67 | $11.03 |
| 84206 | $18.72 | $19.34 |
| 84207 | $26.00 | $26.87 |
| 84210 | $15.17 | $15.68 |
| 84220 | $7.28 | $7.52 |
| 84228 | $7.94 | $8.20 |
| 84233 | $89.99 | $92.99 |
| 84234 | $90.64 | $93.66 |
| 84235 | $73.12 | $75.56 |
| 84238 | $51.09 | $52.79 |
| 84244 | $30.73 | $31.75 |
| 84252 | $17.81 | $18.40 |
| 84255 | $35.67 | $36.86 |
| 84260 | $21.19 | $21.90 |
| 84270 | $11.17 | $11.54 |
| 84275 | $10.28 | $10.62 |
| 84285 | $32.90 | $34.00 |
| 84295 | $6.72 | $6.94 |
| 84300 | $6.79 | $7.02 |
| 84302 | $6.79 | $7.02 |

| Code/MD | 60% | 62% |
|---|---|---|
| 84305 | $27.55 | $28.47 |
| 84307 | $21.61 | $22.33 |
| 84311 | $9.77 | $10.10 |
| 84315 | $3.50 | $3.62 |
| 84375 | $12.22 | $12.63 |
| 84376 | $7.69 | $7.95 |
| 84377 | $7.69 | $7.95 |
| 84378 | $11.17 | $11.54 |
| 84379 | $11.17 | $11.54 |
| 84392 | $6.64 | $6.86 |
| 84402 | $35.57 | $36.76 |
| 84403 | $36.08 | $37.28 |
| 84425 | $12.22 | $12.63 |
| 84430 | $16.26 | $16.80 |
| 84432 | $22.44 | $23.19 |
| 84436 | $9.61 | $9.93 |
| 84437 | $7.94 | $8.20 |
| 84439 | $12.60 | $13.02 |
| 84442 | $20.66 | $21.35 |
| 84443 | $23.47 | $24.25 |
| 84445 | $24.31 | $25.12 |
| 84446 | $19.81 | $20.47 |
| 84449 | $21.05 | $21.75 |
| 84450 | $7.22 | $7.46 |
| 84450QW | $7.22 | $7.46 |
| 84460 | $7.40 | $7.65 |
| 84460QW | $7.40 | $7.65 |
| 84466 | $17.84 | $18.43 |
| 84478 | $8.04 | $8.31 |
| 84478QW | $8.04 | $8.31 |
| 84479 | $9.04 | $9.34 |
| 84480 | $19.81 | $20.47 |
| 84481 | $21.97 | $22.70 |
| 84482 | $21.97 | $22.70 |
| 84484 | $13.75 | $14.21 |
| 84485 | $10.01 | $10.34 |
| 84488 | $10.01 | $10.34 |
| 84490 | $10.01 | $10.34 |
| 84510 | $12.22 | $12.63 |
| 84512 | $7.58 | $7.83 |
| 84520 | $5.51 | $5.69 |
| 84525 | $4.02 | $4.15 |
| 84540 | $6.64 | $6.86 |
| 84545 | $9.23 | $9.54 |
| 84550 | $6.31 | $6.52 |
| 84560 | $6.64 | $6.86 |
| 84577 | $17.43 | $18.01 |
| 84578 | $4.54 | $4.69 |
| 84580 | $9.92 | $10.25 |
| 84583 | $7.02 | $7.25 |
| 84585 | $21.66 | $22.38 |
| 84586 | $26.81 | $27.70 |
| 84588 | $47.43 | $49.01 |
| 84590 | $16.20 | $16.74 |
| 84591 | $16.20 | $16.74 |
| 84597 | $9.77 | $10.10 |
| 84600 | $22.45 | $23.20 |
| 84620 | $16.55 | $17.10 |
| 84630 | $15.91 | $16.44 |
| 84681 | $26.81 | $27.70 |

| Code/MD | 60% | 62% |
|---|---|---|
| 84702 | $21.03 | $21.73 |
| 84703 | $10.49 | $10.84 |
| 84703QW | $10.49 | $10.84 |
| 84830 | $14.02 | $14.49 |
| 85002 | $6.29 | $6.50 |
| 85004 | $9.04 | $9.34 |
| 85007 | $4.81 | $4.97 |
| 85008 | $4.81 | $4.97 |
| 85009 | $5.19 | $5.36 |
| 85013 | $3.31 | $3.42 |
| 85014 | $3.31 | $3.42 |
| 85014QW | $3.31 | $3.42 |
| 85018 | $3.31 | $3.42 |
| 85018QW | $3.31 | $3.42 |
| 85025 | $10.86 | $11.22 |
| 85027 | $9.04 | $9.34 |
| 85032 | $6.01 | $6.21 |
| 85041 | $4.20 | $4.34 |
| 85044 | $6.01 | $6.21 |
| 85045 | $5.59 | $5.78 |
| 85046 | $7.80 | $8.06 |
| 85048 | $3.55 | $3.67 |
| 85049 | $6.25 | $6.46 |
| 85055 | $5.86 | $6.06 |
| 85130 | $16.62 | $17.17 |
| 85170 | $5.05 | $5.22 |
| 85175 | $6.35 | $6.56 |
| 85210 | $8.12 | $8.39 |
| 85220 | $24.66 | $25.48 |
| 85230 | $25.02 | $25.85 |
| 85240 | $25.02 | $25.85 |
| 85244 | $28.53 | $29.48 |
| 85245 | $32.06 | $33.13 |
| 85246 | $32.06 | $33.13 |
| 85247 | $32.06 | $33.13 |
| 85250 | $26.60 | $27.49 |
| 85260 | $25.02 | $25.85 |
| 85270 | $25.02 | $25.85 |
| 85280 | $27.04 | $27.94 |
| 85290 | $22.83 | $23.59 |
| 85291 | $12.42 | $12.83 |
| 85292 | $7.28 | $7.52 |
| 85293 | $7.28 | $7.52 |
| 85300 | $8.12 | $8.39 |
| 85301 | $15.11 | $15.61 |
| 85302 | $16.80 | $17.36 |
| 85303 | $19.32 | $19.96 |
| 85305 | $16.20 | $16.74 |
| 85306 | $21.41 | $22.12 |
| 85307 | $21.41 | $22.12 |
| 85335 | $17.99 | $18.59 |
| 85337 | $14.56 | $15.05 |
| 85345 | $6.01 | $6.21 |
| 85347 | $5.95 | $6.15 |
| 85348 | $5.20 | $5.37 |
| 85360 | $11.17 | $11.54 |
| 85362 | $9.62 | $9.94 |
| 85366 | $12.03 | $12.43 |
| 85370 | $14.83 | $15.32 |
| 85378 | $9.97 | $10.30 |

*Clinical Laboratory Services (continued)*

| Code/MD | 60% | 62% |
|---|---|---|
| 85379 | $14.22 | $14.69 |
| 85380 | $14.22 | $14.69 |
| 85384 | $11.87 | $12.27 |
| 85385 | $11.87 | $12.27 |
| 85390 | $6.63 | $6.85 |
| 85400 | $12.36 | $12.77 |
| 85410 | $10.77 | $11.13 |
| 85415 | $13.25 | $13.69 |
| 85420 | $9.13 | $9.43 |
| 85421 | $14.23 | $14.70 |
| 85441 | $5.88 | $6.08 |
| 85445 | $9.52 | $9.84 |
| 85460 | $10.81 | $11.17 |
| 85461 | $9.26 | $9.57 |
| 85475 | $12.40 | $12.81 |
| 85520 | $13.25 | $13.69 |
| 85525 | $13.25 | $13.69 |
| 85530 | $13.25 | $13.69 |
| 85536 | $9.04 | $9.34 |
| 85540 | $12.02 | $12.42 |
| 85547 | $12.02 | $12.42 |
| 85549 | $26.21 | $27.08 |
| 85555 | $9.34 | $9.65 |
| 85557 | $18.66 | $19.28 |
| 85576 | $30.01 | $31.01 |
| 85597 | $25.12 | $25.96 |
| 85610 | $5.49 | $5.67 |
| 85610QW | $5.49 | $5.67 |
| 85611 | $5.51 | $5.69 |
| 85612 | $13.37 | $13.82 |
| 85613 | $13.37 | $13.82 |
| 85635 | $13.76 | $14.22 |
| 85651 | $4.96 | $5.13 |
| 85652 | $3.77 | $3.90 |
| 85660 | $7.71 | $7.97 |
| 85670 | $8.07 | $8.34 |
| 85675 | $6.50 | $6.72 |
| 85705 | $11.17 | $11.54 |
| 85730 | $8.38 | $8.66 |
| 85732 | $9.04 | $9.34 |
| 85810 | $16.32 | $16.86 |
| 86000 | $9.75 | $10.08 |
| 86001 | $7.30 | $7.54 |
| 86003 | $7.30 | $7.54 |
| 86005 | $11.14 | $11.51 |
| 86021 | $21.03 | $21.73 |
| 86022 | $25.66 | $26.52 |
| 86023 | $17.40 | $17.98 |
| 86038 | $16.89 | $17.45 |
| 86039 | $15.60 | $16.12 |
| 86060 | $10.20 | $10.54 |
| 86063 | $8.07 | $8.34 |
| 86064 | $4.47 | $4.62 |
| 86140 | $7.23 | $7.47 |
| 86141 | $18.09 | $18.69 |
| 86146 | $23.12 | $23.89 |
| 86147 | $23.12 | $23.89 |
| 86148 | $22.44 | $23.19 |
| 86155 | $22.33 | $23.07 |
| 86156 | $9.36 | $9.67 |
| 86157 | $11.27 | $11.65 |
| 86160 | $16.78 | $17.34 |
| 86161 | $16.78 | $17.34 |
| 86162 | $28.39 | $29.34 |
| 86171 | $14.00 | $14.47 |
| 86185 | $12.50 | $12.92 |
| 86215 | $18.51 | $19.13 |
| 86225 | $19.20 | $19.84 |
| 86226 | $16.92 | $17.48 |
| 86235 | $25.06 | $25.90 |
| 86243 | $28.68 | $29.64 |
| 86255 | $16.84 | $17.40 |
| 86256 | $16.84 | $17.40 |
| 86277 | $21.99 | $22.72 |
| 86280 | $11.44 | $11.82 |
| 86294 | $27.41 | $28.32 |
| 86294QW | $27.41 | $28.32 |
| 86300 | $28.50 | $29.45 |
| 86301 | $28.50 | $29.45 |
| 86304 | $28.50 | $29.45 |
| 86308 | $7.23 | $7.47 |
| 86308QW | $7.23 | $7.47 |
| 86309 | $9.04 | $9.34 |
| 86310 | $10.30 | $10.64 |
| 86316 | $28.50 | $29.45 |
| 86317 | $20.95 | $21.65 |
| 86318 | $18.09 | $18.69 |
| 86318QW | $18.09 | $18.69 |
| 86320 | $31.32 | $32.36 |
| 86325 | $31.24 | $32.28 |
| 86327 | $31.70 | $32.76 |
| 86329 | $19.62 | $20.27 |
| 86331 | $16.75 | $17.31 |
| 86332 | $34.05 | $35.19 |
| 86334 | $31.21 | $32.25 |
| 86335 | $41.00 | $42.37 |
| 86336 | $21.77 | $22.50 |
| 86337 | $29.92 | $30.92 |
| 86340 | $21.06 | $21.76 |
| 86341 | $27.65 | $28.57 |
| 86343 | $17.41 | $17.99 |
| 86344 | $11.16 | $11.53 |
| 86353 | $68.49 | $70.77 |
| 86359 | $4.47 | $4.62 |
| 86360 | $9.77 | $10.10 |
| 86361 | $5.86 | $6.06 |
| 86376 | $20.33 | $21.01 |
| 86378 | $27.51 | $28.43 |
| 86379 | $4.47 | $4.62 |
| 86382 | $23.62 | $24.41 |
| 86384 | $15.91 | $16.44 |
| 86403 | $14.24 | $14.71 |
| 86406 | $14.87 | $15.37 |
| 86430 | $7.93 | $8.19 |
| 86431 | $7.93 | $8.19 |
| 86587 | $4.47 | $4.62 |
| 86590 | $12.22 | $12.63 |
| 86592 | $5.96 | $6.16 |
| 86593 | $6.16 | $6.37 |
| 86602 | $8.11 | $8.38 |
| 86603 | $17.98 | $18.58 |
| 86606 | $21.03 | $21.73 |
| 86609 | $18.00 | $18.60 |
| 86611 | $8.11 | $8.38 |
| 86612 | $18.03 | $18.63 |
| 86615 | $18.43 | $19.04 |
| 86617 | $21.64 | $22.36 |
| 86618 | $21.05 | $21.75 |
| 86618QW | $21.05 | $21.75 |
| 86619 | $18.69 | $19.31 |
| 86622 | $12.48 | $12.90 |
| 86625 | $18.33 | $18.94 |
| 86628 | $11.31 | $11.69 |
| 86631 | $16.52 | $17.07 |
| 86632 | $17.74 | $18.33 |
| 86635 | $16.03 | $16.56 |
| 86638 | $16.94 | $17.50 |
| 86641 | $15.86 | $16.39 |
| 86644 | $20.11 | $20.78 |
| 86645 | $23.54 | $24.32 |
| 86648 | $21.25 | $21.96 |
| 86651 | $18.43 | $19.04 |
| 86652 | $18.43 | $19.04 |
| 86653 | $18.43 | $19.04 |
| 86654 | $18.43 | $19.04 |
| 86658 | $18.20 | $18.81 |
| 86663 | $18.33 | $18.94 |
| 86664 | $21.38 | $22.09 |
| 86665 | $25.35 | $26.20 |
| 86666 | $8.11 | $8.38 |
| 86668 | $14.53 | $15.01 |
| 86671 | $17.13 | $17.70 |
| 86674 | $19.64 | $20.29 |
| 86677 | $20.28 | $20.96 |
| 86682 | $18.17 | $18.78 |
| 86684 | $22.14 | $22.88 |
| 86687 | $11.72 | $12.11 |
| 86688 | $19.57 | $20.22 |
| 86689 | $27.05 | $27.95 |
| 86692 | $23.98 | $24.78 |
| 86694 | $20.11 | $20.78 |
| 86695 | $18.43 | $19.04 |
| 86696 | $27.05 | $27.95 |
| 86698 | $17.46 | $18.04 |
| 86701 | $12.41 | $12.82 |
| 86701QW | $12.41 | $12.82 |
| 86702 | $18.88 | $19.51 |
| 86703 | $19.17 | $19.81 |
| 86704 | $16.84 | $17.40 |
| 86705 | $16.44 | $16.99 |
| 86706 | $15.01 | $15.51 |
| 86707 | $16.16 | $16.70 |
| 86708 | $17.31 | $17.89 |
| 86709 | $15.73 | $16.25 |
| 86710 | $18.94 | $19.57 |
| 86713 | $21.39 | $22.10 |
| 86717 | $17.12 | $17.69 |
| 86720 | $18.43 | $19.04 |
| 86723 | $18.43 | $19.04 |
| 86727 | $17.98 | $18.58 |

*Clinical Laboratory Services (continued)*

| Code/MD | 60% | 62% |
|---|---|---|
| 86729 | $16.69 | $17.25 |
| 86732 | $18.43 | $19.04 |
| 86735 | $18.23 | $18.84 |
| 86738 | $18.51 | $19.13 |
| 86741 | $18.43 | $19.04 |
| 86744 | $18.43 | $19.04 |
| 86747 | $21.00 | $21.70 |
| 86750 | $13.00 | $13.43 |
| 86753 | $17.32 | $17.90 |
| 86756 | $18.01 | $18.61 |
| 86757 | $27.05 | $27.95 |
| 86759 | $18.43 | $19.04 |
| 86762 | $20.11 | $20.78 |
| 86765 | $18.00 | $18.60 |
| 86768 | $16.26 | $16.80 |
| 86771 | $18.33 | $18.94 |
| 86774 | $20.68 | $21.37 |
| 86777 | $20.11 | $20.78 |
| 86778 | $20.12 | $20.79 |
| 86781 | $18.50 | $19.12 |
| 86784 | $11.31 | $11.69 |
| 86787 | $18.00 | $18.60 |
| 86790 | $18.00 | $18.60 |
| 86793 | $18.33 | $18.94 |
| 86800 | $22.22 | $22.96 |
| 86803 | $19.94 | $20.60 |
| 86804 | $21.64 | $22.36 |
| 86805 | $73.05 | $75.49 |
| 86806 | $66.49 | $68.71 |
| 86807 | $55.29 | $57.13 |
| 86808 | $41.47 | $42.85 |
| 86812 | $36.06 | $37.26 |
| 86813 | $81.02 | $83.72 |
| 86816 | $38.92 | $40.22 |
| 86817 | $89.95 | $92.95 |
| 86821 | $78.88 | $81.51 |
| 86822 | $51.07 | $52.77 |
| 86880 | $7.50 | $7.75 |
| 86885 | $7.99 | $8.26 |
| 86886 | $7.23 | $7.47 |
| 86900 | $4.17 | $4.31 |
| 86903 | $8.46 | $8.74 |
| 86904 | $13.28 | $13.72 |
| 86905 | $5.34 | $5.52 |
| 86906 | $10.83 | $11.19 |
| 86940 | $11.46 | $11.84 |
| 86941 | $13.27 | $13.71 |
| 87001 | $18.47 | $19.09 |
| 87003 | $23.52 | $24.30 |
| 87015 | $9.33 | $9.64 |
| 87040 | $14.42 | $14.90 |
| 87045 | $13.18 | $13.62 |
| 87046 | $13.18 | $13.62 |
| 87070 | $12.03 | $12.43 |
| 87071 | $13.18 | $13.62 |
| 87073 | $13.18 | $13.62 |
| 87075 | $13.22 | $13.66 |
| 87076 | $11.29 | $11.67 |
| 87077 | $11.29 | $11.67 |
| 87077QW | $11.29 | $11.67 |
| 87081 | $9.26 | $9.57 |
| 87084 | $12.03 | $12.43 |
| 87086 | $11.28 | $11.66 |
| 87088 | $11.31 | $11.69 |
| 87101 | $10.77 | $11.13 |
| 87102 | $11.74 | $12.13 |
| 87103 | $12.60 | $13.02 |
| 87106 | $14.42 | $14.90 |
| 87107 | $14.42 | $14.90 |
| 87109 | $21.50 | $22.22 |
| 87110 | $23.73 | $24.52 |
| 87116 | $15.10 | $15.60 |
| 87118 | $15.29 | $15.80 |
| 87140 | $7.79 | $8.05 |
| 87143 | $17.51 | $18.09 |
| 87147 | $7.23 | $7.47 |
| 87149 | $17.79 | $18.38 |
| 87152 | $7.31 | $7.55 |
| 87158 | $7.31 | $7.55 |
| 87164 | $15.01 | $15.51 |
| 87166 | $15.78 | $16.31 |
| 87168 | $5.96 | $6.16 |
| 87169 | $5.96 | $6.16 |
| 87172 | $5.96 | $6.16 |
| 87176 | $8.22 | $8.49 |
| 87177 | $12.43 | $12.84 |
| 87181 | $1.17 | $1.21 |
| 87184 | $9.63 | $9.95 |
| 87185 | $1.17 | $1.21 |
| 87186 | $12.08 | $12.48 |
| 87187 | $14.48 | $14.96 |
| 87188 | $8.12 | $8.39 |
| 87190 | $7.90 | $8.16 |
| 87197 | $20.99 | $21.69 |
| 87205 | $5.96 | $6.16 |
| 87206 | $7.50 | $7.75 |
| 87207 | $8.37 | $8.65 |
| 87210 | $5.96 | $6.16 |
| 87210QW | $5.96 | $6.16 |
| 87220 | $5.96 | $6.16 |
| 87230 | $27.59 | $28.51 |
| 87250 | $27.32 | $28.23 |
| 87252 | $36.42 | $37.63 |
| 87253 | $28.22 | $29.16 |
| 87254 | $27.32 | $28.23 |
| 87255 | $47.31 | $48.89 |
| 87260 | $16.76 | $17.32 |
| 87265 | $16.76 | $17.32 |
| 87267 | $16.76 | $17.32 |
| 87269 | $16.76 | $17.32 |
| 87270 | $16.76 | $17.32 |
| 87271 | $16.76 | $17.32 |
| 87272 | $16.76 | $17.32 |
| 87273 | $16.76 | $17.32 |
| 87274 | $16.76 | $17.32 |
| 87275 | $16.76 | $17.32 |
| 87276 | $16.76 | $17.32 |
| 87277 | $16.76 | $17.32 |
| 87278 | $16.76 | $17.32 |
| 87279 | $16.76 | $17.32 |
| 87280 | $16.76 | $17.32 |
| 87281 | $16.76 | $17.32 |
| 87283 | $16.76 | $17.32 |
| 87285 | $16.76 | $17.32 |
| 87290 | $16.76 | $17.32 |
| 87299 | $16.76 | $17.32 |
| 87300 | $16.76 | $17.32 |
| 87301 | $16.76 | $17.32 |
| 87320 | $16.76 | $17.32 |
| 87324 | $16.76 | $17.32 |
| 87327 | $16.76 | $17.32 |
| 87328 | $16.76 | $17.32 |
| 87329 | $16.76 | $17.32 |
| 87332 | $16.76 | $17.32 |
| 87335 | $16.76 | $17.32 |
| 87336 | $16.76 | $17.32 |
| 87337 | $16.76 | $17.32 |
| 87338 | $17.19 | $17.76 |
| 87339 | $16.76 | $17.32 |
| 87340 | $14.43 | $14.91 |
| 87341 | $14.43 | $14.91 |
| 87350 | $16.10 | $16.64 |
| 87380 | $22.94 | $23.70 |
| 87385 | $16.76 | $17.32 |
| 87390 | $15.61 | $16.13 |
| 87391 | $15.61 | $16.13 |
| 87400 | $16.76 | $17.32 |
| 87420 | $16.76 | $17.32 |
| 87425 | $16.76 | $17.32 |
| 87427 | $16.76 | $17.32 |
| 87430 | $16.76 | $17.32 |
| 87449 | $16.76 | $17.32 |
| 87449QW | $16.76 | $17.32 |
| 87450 | $13.39 | $13.84 |
| 87451 | $13.39 | $13.84 |
| 87470 | $17.79 | $18.38 |
| 87471 | $41.65 | $43.04 |
| 87472 | $59.85 | $61.85 |
| 87475 | $17.79 | $18.38 |
| 87476 | $41.65 | $43.04 |
| 87477 | $59.85 | $61.85 |
| 87480 | $17.79 | $18.38 |
| 87481 | $41.65 | $43.04 |
| 87482 | $58.33 | $60.27 |
| 87485 | $17.79 | $18.38 |
| 87486 | $41.65 | $43.04 |
| 87487 | $59.85 | $61.85 |
| 87490 | $17.79 | $18.38 |
| 87491 | $41.65 | $43.04 |
| 87492 | $48.84 | $50.47 |
| 87495 | $17.79 | $18.38 |
| 87496 | $41.65 | $43.04 |
| 87497 | $59.85 | $61.85 |
| 87510 | $17.79 | $18.38 |
| 87511 | $41.65 | $43.04 |
| 87512 | $58.33 | $60.27 |
| 87515 | $17.79 | $18.38 |
| 87516 | $41.65 | $43.04 |
| 87517 | $59.85 | $61.85 |
| 87520 | $17.79 | $18.38 |

*Clinical Laboratory Services (continued)*

| Code/MD | 60% | 62% |
|---|---|---|
| 87521 | $41.65 | $43.04 |
| 87522 | $59.85 | $61.85 |
| 87525 | $17.79 | $18.38 |
| 87526 | $41.65 | $43.04 |
| 87527 | $58.33 | $60.27 |
| 87528 | $17.79 | $18.38 |
| 87529 | $41.65 | $43.04 |
| 87530 | $59.85 | $61.85 |
| 87531 | $17.79 | $18.38 |
| 87532 | $41.65 | $43.04 |
| 87533 | $58.33 | $60.27 |
| 87534 | $17.79 | $18.38 |
| 87535 | $41.65 | $43.04 |
| 87536 | $98.47 | $101.75 |
| 87537 | $17.79 | $18.38 |
| 87538 | $41.65 | $43.04 |
| 87539 | $59.85 | $61.85 |
| 87540 | $17.79 | $18.38 |
| 87541 | $41.65 | $43.04 |
| 87542 | $58.33 | $60.27 |
| 87550 | $17.79 | $18.38 |
| 87551 | $41.65 | $43.04 |
| 87552 | $59.85 | $61.85 |
| 87555 | $17.79 | $18.38 |
| 87556 | $41.65 | $43.04 |
| 87557 | $59.85 | $61.85 |
| 87560 | $17.79 | $18.38 |
| 87561 | $41.65 | $43.04 |
| 87562 | $59.85 | $61.85 |
| 87580 | $17.79 | $18.38 |
| 87581 | $41.65 | $43.04 |
| 87582 | $58.33 | $60.27 |
| 87590 | $17.79 | $18.38 |
| 87591 | $41.65 | $43.04 |
| 87592 | $59.85 | $61.85 |
| 87620 | $17.79 | $18.38 |
| 87621 | $41.65 | $43.04 |
| 87622 | $58.33 | $60.27 |
| 87650 | $17.79 | $18.38 |
| 87651 | $41.65 | $43.04 |
| 87652 | $58.33 | $60.27 |
| 87660 | $17.79 | $18.38 |
| 87797 | $17.79 | $18.38 |
| 87798 | $41.65 | $43.04 |
| 87799 | $59.85 | $61.85 |
| 87800 | $35.58 | $36.77 |
| 87801 | $83.30 | $86.08 |
| 87802 | $16.76 | $17.32 |
| 87803 | $16.76 | $17.32 |
| 87804 | $16.76 | $17.32 |
| 87804QW | $16.76 | $17.32 |
| 87807 | $16.76 | $17.32 |
| 87810 | $16.76 | $17.32 |
| 87850 | $16.76 | $17.32 |
| 87880 | $16.76 | $17.32 |
| 87880QW | $16.76 | $17.32 |
| 87899 | $16.76 | $17.32 |
| 87899QW | $16.76 | $17.32 |
| 87901 | $359.69 | $371.68 |
| 87902 | $359.69 | $371.68 |
| 87903 | $682.72 | $705.48 |
| 87904 | $182.11 | $188.18 |
| 88130 | $21.02 | $21.72 |
| 88140 | $11.17 | $11.54 |
| 88142 | $28.21 | $29.15 |
| 88143 | $28.21 | $29.15 |
| 88147 | $14.76 | $14.76 |
| 88148 | $14.76 | $14.76 |
| 88150 | $14.76 | $14.76 |
| 88152 | $14.76 | $14.76 |
| 88153 | $14.76 | $14.76 |
| 88154 | $14.76 | $14.76 |
| 88155 | $8.37 | $8.65 |
| 88164 | $14.76 | $14.76 |
| 88165 | $14.76 | $14.76 |
| 88166 | $14.76 | $14.76 |
| 88167 | $14.76 | $14.76 |
| 88174 | $29.39 | $30.37 |
| 88175 | $34.70 | $35.86 |
| 88230 | $162.77 | $168.20 |
| 88233 | $196.63 | $203.18 |
| 88235 | $205.74 | $212.60 |
| 88237 | $176.47 | $182.35 |
| 88239 | $206.12 | $212.99 |
| 88240 | $14.11 | $14.58 |
| 88241 | $14.11 | $14.58 |
| 88245 | $190.23 | $196.57 |
| 88248 | $241.96 | $250.03 |
| 88249 | $241.96 | $250.03 |
| 88261 | $246.93 | $255.16 |
| 88262 | $174.14 | $179.94 |
| 88263 | $190.23 | $196.57 |
| 88264 | $174.14 | $179.94 |
| 88267 | $251.17 | $259.54 |
| 88269 | $190.23 | $196.57 |
| 88271 | $20.22 | $20.89 |
| 88272 | $35.39 | $36.57 |
| 88273 | $44.89 | $46.39 |
| 88274 | $48.63 | $50.25 |
| 88275 | $56.11 | $57.98 |
| 88280 | $35.07 | $36.24 |
| 88283 | $95.84 | $99.03 |
| 88285 | $26.54 | $27.42 |
| 88289 | $40.56 | $41.91 |
| 88371 | $31.05 | $32.09 |
| 88372 | $31.79 | $32.85 |
| 88400 | $7.02 | $7.25 |
| 89050 | $6.61 | $6.83 |
| 89051 | $7.70 | $7.96 |
| 89055 | $5.96 | $6.16 |
| 89060 | $9.99 | $10.32 |
| 89125 | $6.03 | $6.23 |
| 89160 | $5.15 | $5.32 |
| 89190 | $6.64 | $6.86 |
| 89225 | $4.67 | $4.83 |
| 89235 | $7.69 | $7.95 |
| 89300 | $12.45 | $12.87 |
| 89300QW | $12.45 | $12.87 |
| 89310 | $12.03 | $12.43 |
| 89320 | $16.84 | $17.40 |
| 89321 | $16.84 | $17.40 |
| 89325 | $14.91 | $15.41 |
| 89329 | $29.30 | $30.28 |
| 89330 | $13.83 | $14.29 |

# 2005 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

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

## Provider Types Affected

Clinical laboratories

## Provider Action Needed

This article and related CR3526 contains important information regarding the 2005 annual updates to the clinical laboratory fee schedule and for laboratory costs related to services subject to reasonable charge payments. It is important that affected laboratories understand these changes to assure correct and accurate payments from Medicare.

## Background

### Update to Clinical Laboratory Fees

In accordance with section 1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by Section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the annual update to the local clinical laboratory fees for 2005 is zero (0) percent.

Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA). For a cervical or vaginal smear test (PAP smear), section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge.

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

### National Minimum Payment Amounts

For a cervical or vaginal smear test (PAP smear), sectio0n 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The 2005 national minimum payment amount is $14.76 ($14.76 plus zero percent update for 2005). The affected codes for the national minimum payment amount include the following:

| | | | | | | |
|---|---|---|---|---|---|---|
| *88142* | *88143* | *88147* | *88148* | *88150* | *88152* | *8153* |
| *88154* | *88164* | *88165* | *88166* | *88167* | *88174* | *8175* |
| G0123 | G0143 | G0144 | G0145 | G0147 | G0148 | P3000 |

### National Limitation Amounts (Maximum)

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

### Access to 2005 Clinical Laboratory Fee Schedule

Internet access to the 2005 clinical laboratory fee schedule data file should be available after November 18, 2004, at: *http://www.cms.hhs.gov/paymentsystems*.

Interested providers should use the Internet to retrieve the 2005 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

### Public Comments

On July 26, 2004, the Centers for Medicare & Medicaid Services (CMS) hosted a public meeting to solicit input on the payment relationship between 2004 codes and new *2005 Current Procedural Terminology (CPT)* codes. The meeting announcement was published in the *Federal Register* on May 28, 2004, pages 30658-30659, and on the CMS web site.

Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations on its web site at *http://www.cms.hhs.gov/paymentsystems*. Additional written comments from the public were accepted until September 24, 2004.

Comments after the release of the 2005 laboratory fee schedule can be submitted to the following address, so that CMS may consider them for the development of the 2006 laboratory fee schedule.

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

A comment should be in written format and include clinical, coding, and costing information. To make it possible for CMS and its contractors to meet a January 3, 2006 implementation date, comments must be submitted before August 1, 2005.

### Additional Pricing Information

The 2005 laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). For dates of service January 1, 2005 through December 31, 2005, the personnel payment is $.45 per mile. For dates of service January 1, 2005 through December 31, 2005, the standard mileage rate for transportation costs is $.385. The 2005 payment for code P9603 is $.835 and for code P9604 it is $8.35.

The 2005 laboratory fee schedule also includes codes that have a "QW" modifier to both identify codes and determine payment for tests performed by a laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

*CPT* code *36415 – Collection of venous blood by venipuncture* is now payable by Medicare, but *CPT* code *36416 – Collection of capillary blood specimen (e.g., finger, heel, ear stick)* remains as not payable by Medicare as a separate service.

### Organ or Disease Oriented Panel Codes

Similar to prior years, the 2005 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were determined by Medicare by summing the lower of the fee schedule amount or the NLA for each individual test code included in the panel code.

**Mapping Information for New and Revised Codes**

New *CPT* code *82045* is priced at the same rate as *83880*
New *CPT* code *82656* is priced at the same rate as *83516*
New *CPT* code *83009* is priced at the same rate as *83013*
New *CPT* code *83630* is priced at the same rate as *83516*
New *CPT* code *84163* is priced at the same rate as *84702*
New *CPT* code *84166* is priced at the same rate as the sum of *84165* and *87015*
New *CPT* code *84450*QW is priced at the same rate as *84450*
New *CPT* code *86064* is priced at the same rate as *86359*
New *CPT* code *86335* is priced at the same rate as the sum of *86334* and *87015*
New *CPT* code *86379* is priced at the same rate as *86359*
New *CPT* code *86587* is priced at the same rate as *86359*
New *CPT* code *87807* is priced at the same rate as *87804*

**Laboratory Costs Subject to Reasonable Charge Payment in 2005**

For outpatients, the codes in the following tables are paid under a reasonable charge basis. In accordance with section 42 CFR 405.502 – 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update.

**The inflation-indexed update for year 2005 is 3.3 percent.**

Manual instructions for determining the reasonable charge payment can be found in the Medicare Claim Processing Manual, Pub. 100-04, chapter 23, section 80-80.8. (The Web address for this manual is provided in the "Additional Information" section below.) If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

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

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

**Blood Products**

P9010 P9011 P9012 P9016 P9017 P9019 P9020
P9021 P9022 P9023 P9031 P9032 P9033 P9034
P9035 P9036 P9037 P9038 P9039 P9040 P9044
P9050 P9051 P9052 P9053 P9054 P9055 P9056
P9057 P9058 P9059 P9060

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

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

**Note:** Biologic products not paid on a cost or prospective payment basis are paid based on section 1842(o) of the Act. The payment limits based on section 1842(o), including the payment limits for codes P9041, P9043, P9045, P9046, P9047 and P9048, should be obtained from the Medicare Part B Drug Pricing Files.

**Transfusion Medicine**

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

**Reproductive Medicine Procedures**

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

## Implementation

The changes for 2005 will be implemented on January 3, 2005.

## Additional Information

Instructions for calculating reasonable charges are located in the Medicare Claims Processing Manual (Pub. 100-04) Chapter 23, sections 80-80.8. at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

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

From that Web page, look for CR 3526 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 carrier or intermediary on their toll free phone 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: 3526
Related CR Release Date: November 5, 2004
Related CR Transmittal Number: 363
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 363, CR 3526

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### APPEAL RECONSIDERATIONS

**Claim Denials (outpatient services only)**

Medicare Fair Hearings (Part A)
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**Admission Questionnaires**
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**"DDE Startup"**

Direct Data Entry (DDE)
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Jacksonville, FL 32231-4071

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1-904-791-8430

### MEDICARE REGISTRATION

**American Diabetes Association Certificates**

Medicare Registration – ADA
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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

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1-904-791-6865

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