

# Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers



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

Publications issued after October 1, 1997, are available at no-cost from our provider website at [www.floridamedicare.com](http://www.floridamedicare.com).

#### Routing Suggestions:

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



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**Medicare A Bulletin**

**Vol. 7, No. 3  
Third Quarter  
2005**

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

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

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

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## Distribution of the *Medicare A Bulletin*

Use of the Internet has become an accepted standard of communication throughout the world. Publications produced by First Coast Service Options, Inc. (FCSO) for our Medicare Part A customers are available on our provider education website <http://www.floridamedicare.com>.

We post our Medicare publications to our provider education website in PDF (portable document format) and you may view, print, or download them free of charge. By contrast, hardcopy publications cost the Medicare program a substantial amount of money for printing and postage nationally. Reducing the number of hardcopies produced is one way Medicare contractors can reduce costs that may be better used elsewhere. In addition, enhancements to online publications can be made that are not possible in print.

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

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

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

### Features of the Electronic Publication

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

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

- *Articles of Interest* – The newsletter table of contents includes hyperlinks to each article, therefore providers can choose an article(s) of particular interest to their line of business or type of facility.
- *Third-Party Websites* – All third-party websites referenced within articles include hyperlinks to the applicable information on that website. (*Online publications only.*)
- *References within the Contractor Websites* – All additional resources or reference materials mentioned in the newsletter include hyperlinks to that information within the Medicare provider education website (e.g., full-text versions of local coverage determinations, prior publications, forms, online registration, etc.). Additionally, links to unique Web pages allow access to information applicable to the user’s type of facility. (*Online publications only.*)

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

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To receive the *Medicare A Bulletin* in hardcopy or CD-ROM format, you must complete this registration form. Please complete and fax or mail it to the number or address listed at the bottom of this form. To receive a hardcopy or CD-ROM of the Fourth Quarter 2005 *Medicare A Bulletin* your form must be faxed or postmarked on or before July 1, 2005.

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

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**Please do not contact our customer service call center regarding this initiative.** Additional questions or concerns may be submitted via the website in the “contact us” section.

**About The Medicare A Bulletin**

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

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

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

**Who Receives the Bulletin?**

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

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

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

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

**What Is in the Bulletin?**

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

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

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

**The Medicare A Bulletin Represents Formal Notice of Coverage Policies**

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

**Do You Have Comments?**

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

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# GENERAL INFORMATION

## Revisions to Medicare Appeal Process for Fiscal Intermediaries

### (Change Request Title: Appeals Transition – BIPA 521 Appeals)

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

#### Provider Types Affected

All Medicare providers who submit claims to Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs)

#### Provider Action Needed

##### STOP – Impact to You

There is now a new level of the appeals process for Medicare Part A and Part B claims submitted to Medicare fiscal intermediaries (FIs). This new second level of appeal process is called a **reconsideration** (not to be confused with the previous first level of appeal for Part A claims). Qualified independent contractors (QICs) will process these **new reconsiderations**.

#### CAUTION – What You Need to Know

This change in the appeals process was governed by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 Section 521, and the Medicare Modernization Act Sections 933, 939, 940. Parties to Part A and Part B redeterminations issued by FIs on or after May 1, 2005 will have the right to appeal to a QIC. All redeterminations issued before May 1, 2005 will have appeal rights to the administrative law judge (ALJ) for Part A claims and to the hearing officer (HO) for Part B claims.

#### GO – What You Need to Do

For specific information pertaining to this change, please refer to the background and additional information sections. A copy of the new Medicare appeal decision letter is available at:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R146OTN.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R146OTN.pdf).

#### Background

**Note:** These revisions do not apply to claims submitted to Medicare carriers and/or redeterminations processed by carriers.

In addition to the new level of appeal, there are a number of other changes that will affect the process providers and FIs use for appeals of claim decisions made by FIs. This article will summarize those changes. Providers seeking full details may wish to review the official instruction (CR 3530) that Medicare issued to the FIs. That instruction is available at:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R146OTN.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R146OTN.pdf).

The key changes are as follows:

#### 1. New Language for Redetermination Letters

For redetermination decisions issued on or after May 1, 2005, FIs will change the Medicare redetermination notice (MRN) as follows:

- Language on the first page of the MRN regarding the amount in controversy will be deleted as there is no

longer a minimum amount in controversy required to move to the next appeal level, i.e., the QIC.

- The MRN will show that if providers disagree with the redetermination decision, they have 180 days to appeal to a QIC and such appeal must be filed in writing. (Under special circumstances, you may ask for more time to request an appeal.)
- The MRN will include a form to use in requesting the reconsideration by the QIC. The form presents all the information required to submit an appeal. If you do not use the form in CR 3530 to request the appeal, you must be sure to include the required information in your letter requesting the appeal, including the name of the contractor that made the redetermination.
- The MRN will include specific language about what providers must include in their request for a reconsideration by the QIC. Providers must pay special attention to the instructions on the MRN related to submission of evidence to support their appeal. All evidence must be presented before the reconsideration is issued. If a provider does not submit all evidence at this stage, they will not be able to submit any new evidence in subsequent appeal levels unless they demonstrate good cause for not presenting evidence to the QIC.
- The MRN will contain revised language to reflect the new level of appeal.

#### 2. Redetermination Letters for Fully Favorable Decisions

Previously, some FIs elected to notify providers of a fully favorable decision through a remittance advise (RA) that reflected the processed claim, instead of issuing an MRN. (Beneficiaries were advised via the Medicare summary notice (MSN).) However, the revised process requires FIs to issue an MRN on **all** redeterminations, favorable and unfavorable, within 60 days if the RA or MSN cannot be sent within 60 days.

Fully favorable decisions are those where the Medicare approved amount minus any cost sharing (coinsurance, deductibles, etc.) has been found payable. In these instances, which apply to all redetermination requests received by the FI on or after May 1, 2005, the FI will issue the MRN explaining that the decision is favorable and a remittance advice will follow. Exhibit 2 of CR 3530 contains a model of such a favorable MRN; however, your FI may choose to include additional information on their MRN.

#### 3. An Extension to the 60-day Decision-Making Time Frame

Should a provider submit additional evidence after filing the request for redetermination, the FI's 60-day decision-making time frame may be extended for 14

**Revisions to Medicare Appeal Process for Fiscal Intermediaries (continued)**

calendar days. This applies to redetermination requests received on or after May 1, 2005.

**4. Telephone Requests for Redeterminations of Initial Determinations Made on or after May 1, 2005**

Section 937 of the Medicare Modernization Act (MMA) provides that in the case of minor errors or omissions, providers must be given the opportunity to correct such errors/omissions without the need to initiate an appeal. Consistent with that section, the Centers for Medicare & Medicaid Services (CMS) requires the FIs to conduct reopenings rather than redeterminations to correct such errors and omissions.

CMS has modified the reopening regulations to allow FIs and providers to make these corrections through the reopening process and these reopening requests may be made over the telephone. However, actual redetermination requests made on all initial determinations rendered on or after May 1, 2005 must be in writing.

**5. Additional Information Requirements for Written Redetermination Requests Effective with Initial Determinations made on or after May 1, 2005**

Chapter 29, Sections 40.2.1(C) and 50.2.1(B) of the Medicare Claims Processing Manual contain the requirements for provider appeal requests. This manual may be found on the CMS website at: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp).

Note that for all requests for redeterminations received on or after May 1, 2005, the providers do not need to specify the date of the initial determination in their requests.

**6. Consolidating Requests for Multiple Parties on Redetermination Requests Received on or after May 1, 2005**

If more than one party files a redetermination request (e.g. both the beneficiary and the provider file requests) on the same claims before the FI makes a redetermination on the first request, the FI will consolidate the separate requests into one proceeding and issue one redetermination. In such cases, the 60-day decision-making time frame begins with the receipt of the second request.

Where the second request is received after a redetermination has already been made, the second request will be treated as an inquiry and the FI will inform the second requestor of the redetermination already made. The FI will also inquire, in these instances, if the party wishes to file a request for an appeal to the next level. Should the party wish to file such appeal, the FI will provide instructions for doing so.

**7. Filing Reconsideration Requests on Redeterminations Issued on or after May 1, 2005****Where Appellants Should Send Requests for Reconsideration:**

There are two QICs to handle reconsideration requests of redeterminations made by FIs, based on two QIC jurisdictions, east and west. The two QICs are Maximums and First Coast Service Options. Parties must request a reconsideration at the QIC with jurisdiction for the appeal. FIs with multiple states may have both QICs handling requests and therefore must make certain to refer the appellant to the correct QIC. In most instances, the jurisdiction for all Part A

and Part B of A QIC appeals is dependent upon the state where the service or item was rendered, with the exception of providers with multiple locations in different states (i.e., chain providers).

Chain providers have the ability to select the FI that will process its claims regardless of the state where the service or items were furnished. In such cases, the state where the FI processes the claim will dictate the QIC jurisdiction. For claims processed by Mutual of Omaha, the jurisdiction is dependent upon the state where the service or item was furnished, with no exception for chain providers.

The following are the QIC jurisdictions for the East and West:

The East QIC jurisdiction is comprised of the following states:

Colorado, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, Tennessee, South Carolina, North Carolina, Virginia, West Virginia, Puerto Rico, Virgin Islands, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New Jersey, New York, Delaware, Maryland, Pennsylvania, and Washington DC.

The QIC for the east jurisdiction is Maximus.

The West QIC jurisdiction is comprised of the following states:

Washington, Idaho, Montana, North Dakota, South Dakota, Iowa, Missouri, Kansas, Nebraska, Wyoming, Utah, Arizona, Nevada, California, Alaska, Hawaii, Oregon, Kentucky, Ohio, Indiana, Illinois, Minnesota, Michigan, Wisconsin, Guam, Northern Mariana Islands, and American Samoa.

The QIC for the west jurisdiction is First Coast Service Options.

The address for the appropriate QIC will be located in the redetermination notice.

**Requirements for Reconsideration Requests**

Only the QIC has the authority to dismiss a request for a reconsideration. This applies even when it appears that the request does not meet the requirements for requesting a reconsideration (e.g., the timely filing requirements do not appear to have been met). Even though the FI cannot dismiss a reconsideration request that does not meet the requirements, it should be aware of these requirements so that it can inform providers (and states) of the requirements.

A provider (or state) request for a reconsideration must either be made on a standard CMS form which will be available on the CMS website or as shown in CR 3530 or must contain:

- The beneficiary's name
- Medicare health insurance claim number
- The specific service(s) and item(s) for which the reconsideration is requested and the specific date(s) of service
- The name and signature of the party or representative of the party making the request
- The name of the FI that made the redetermination.

*Revisions to Medicare Appeal Process for Fiscal Intermediaries (continued)***8. Effectuation of QIC Decisions**

**(Effective date: All redeterminations issued on or after May 1, 2005)**

In many cases, the QIC's decision will require effectuation action by the FI. The FI will not effectuate based on correspondence from any party of the reconsideration, but instead takes an effectuation action only in response to a formal decision from the QIC. "Effectuate" means that the FI takes the necessary actions to issue payment (i.e., make payment on the claim).

The FI will obtain written assurance from the provider if necessary. If the QIC's decision is favorable to the appellant and specifies an amount to be paid, the FI effectuates within 30 calendar days of the date of the QIC's decision or from the date written assurance from the provider is received. If the decision is favorable, but the contractor must compute the amount, it effectuates the decision within 30 days after it computes the amount to be paid. The amount must be computed as soon as possible, but no later than 30 calendar days of the date of receipt of the QIC's decision (or date of receipt of written assurance from the provider has been obtained).

**9. New Appeal Rights for Medicare Providers and New Assignment Rights for Medicare Providers**

**(Effective date: May 1, 2005)**

**A. New Appeal Rights for Medicare Providers**

Previously, providers could only appeal a claim determination when the determination involved a finding that:

- (1) The item or service was not covered because it constituted custodial care, was not reasonable and necessary, or for certain other reasons; and
- (2) The provider knew or could reasonably be expected to know that the service in question was not covered under Medicare (that is, a finding with respect to the limitation of liability provision under section 1879 of the Act).

For initial determinations made on or after May 1, 2005, providers who submit claims to FIs will have the same right to appeal claims as beneficiaries. Accordingly, FIs will no longer use RA remark code MA44 for initial determinations made on or after May 1, 2005. This means FIs will no longer need to determine whether a provider submitting an appeal has the right to appeal. Also, FIs will no longer need to evaluate appointment of representative forms submitted by providers representing beneficiaries.

**B. New Assignment Rights for Medicare Suppliers**

Historically, nonparticipating suppliers accessed the appeals process by acting as the beneficiary's appointed representative in situations where they otherwise would not have had appeal rights. Section 1869(b)(1)(C) permits a beneficiary to assign his or her appeal rights with respect to an item or service to a provider or supplier. Such an assignment of appeal must be made using a standard form developed by CMS. This form will be made available at: <http://www.cms.hhs.gov/forms/>.

**10. New Appeal Rights for Overpayments and Reopenings**

**(Effective date: Revised initial determinations issued on or after May 1, 2005)**

Previously, revised initial determinations had appeal rights to the hearing officer for part B claims where over

\$100 remained in controversy and appeal rights to the review level for part B claims where under \$100 remained in controversy. For Part A claims with revised initial determinations, appeal rights were provided at the reconsideration level. For all revised initial determinations issued on or after May 1, 2005, the first level of appeal will be a redetermination. Your FI will change appeals language in all demand letters or other notices of revised initial determinations (including remittance advice notices and Medicare summary notices if used) in accordance with this section.

Additional instructions regarding changes to the MSN and RA remarks will be forthcoming (e.g., revising the terminology for the levels of appeal and time frames to appeal).

**11. New Appeal Rights for Dismissals**

**(Effective date: All redeterminations issued on or after May 1, 2005)**

**A. Appealing a Dismissal**

For redeterminations issued on or after May 1, 2005, parties to the redetermination will have the right to appeal a dismissal of a redetermination request to the QIC. A party to the redetermination may appeal the dismissal if they believe the dismissal is incorrect. The reconsideration request must be filed at the QIC within 60 days of the date of the dismissal. When the QIC performs its reconsideration of the dismissal, it will decide if the dismissal was correct. If it determines that the FI incorrectly dismissed the redetermination, it will vacate the dismissal and remand the case to the FI for reopening. It is mandatory for the FI to reopen any case that is remanded to it and issue a new decision. A QIC's reconsideration of an FI's dismissal of a redetermination request is final and not subject to any further review.

**B. Vacating a Dismissal**

A party to the redetermination may also request the FI to vacate its dismissal if good and sufficient cause is established. The FI determines if there is good and sufficient cause and if there is, the contractor reopens the dismissal and issues a new decision. If a QIC reconsideration has been requested, the contractor no longer has jurisdiction and cannot vacate a dismissal unless directed to do so through a QIC remand.

**C. Dismissal Letters**

For any dismissal issued on or after May 1, 2005, your FI will include the following information or similar language in dismissal letters (also see the model dismissal letter in exhibit 4 of CR 3530):

If you disagree with this dismissal, you have two options:

1. If you think you have good and sufficient cause, you may ask your FI to vacate their dismissal. The FI will vacate the dismissal if it determines that you have good and sufficient cause. If you would like to request the FI to vacate this dismissal, you must file a request within six months of the date of this notice. In your request, please explain why you believe you have good and sufficient cause. Your FI will provide the address to which such a request should be sent.
2. If you think the FI has incorrectly dismissed your request, you may request a reconsideration of the



**Revisions to Medicare Appeal Process for Fiscal Intermediaries (continued)**

dismissal by a QIC. Your request must be filed within 60 days of receipt of this letter. The QIC will have 60 incorrect. Please note that the QIC will not consider any evidence for establishing coverage of the claim(s) being appealed. Their examination will be limited to whether the dismissal was appropriate.

**D. Incomplete Requests**

The requirements for written requests for redeterminations are included in the Medicare Claims Processing Manual, Chapter 29, sections 40.2.1 and 50.3.1. As noted previously, this manual may be found on the CMS website at: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp).

For all redetermination requests received on or after May 1, 2005, providers (and states) no longer are required to include the date of initial determination in their requests. Previously, FIs were instructed to return requests that did not meet the manual requirements for a complete request. For redetermination requests received on or after May 1, 2005, FIs must handle and count incomplete redetermination requests as dismissals. The above requirements under (C) for vacating and appealing dismissals apply to incomplete requests as well. Parties to the redetermination also have the option to refile their request if any time remains in the filing period (i.e., 120 days of receipt of the initial determination).

When a request is refiled that meets the requirements, the previous dismissal is vacated and reopened. FIs must notify parties of their options in the dismissal notice. (Please see the model dismissal notice for an incomplete request in Exhibit 3 in CR 3530.)

**12. Preparing Case Files for Administrative Law Judge (ALJ) Hearings**

**(Effective date: All redeterminations issued on or after May 1, 2005)**

For Part A and Part B redeterminations issued before May 1, 2005, FIs will continue to be responsible for accepting ALJ hearing requests and for preparing case files for the hearing. FIs will continue to follow instructions in the Medicare Claims Processing Manual, Chapter 29, sections 50 and 60 in preparing case files.

For redeterminations issued on or after May 1, 2005, the QIC will be responsible for accepting ALJ hearing requests and for preparing case files for the hearing.

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**13. Effectuation of ALJ Decisions**

In many cases, the ALJ's decision will require an effectuation action on the FI's part. As with QIC decisions, the FI does not effectuate based on correspondence from any party of the ALJ hearing. It takes an effectuation action only in response to a formal decision by the ALJ. The FI will obtain written assurance from the provider if necessary. If the ALJ's decision is favorable to the appellant and gives a specific amount to be paid, the FI effectuates within 30 calendar days of the date of the ALJ's decision or from the date written assurance from the provider is received. If the decision is favorable but the FI must compute the amount, it effectuates the decision within 30 days after it computes the amount to be paid. The amount must be computed as soon as possible, but no later than 30 calendar days of the date of receipt of the ALJ's decision (or date of receipt of written assurance from the provider).

**14. Redetermination Acknowledgement Letters**

**(Effective date: All redeterminations received on or after May 1, 2005)**

FIs are not required to send or mail acknowledgment letters for redetermination requests received on or after May 1, 2005.

**Additional Information**

The official instruction (CR 3530) issued to your FI regarding this change may be found by going to: [http://www.cms.hhs.gov/manuals/pm\\_trans/R146OTN.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R146OTN.pdf).

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

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

Related Change Request (CR) Number: 3530

Related CR Release Date: March 25, 2005

Related CR Transmittal Number: 146

Effective Date: Varied, as noted in article

Implementation Date: April 25, 2005

Source: CMS Pub. 100-20, Transmittal 146, CR 3530

**Update to the Frequency of Billing**

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

**Note:** On April 20, 2005, this article was updated to reflect that instructions provided in CR 3382, Transmittal 270, issued on August 3, 2004, (and on which this article was based) have been revised by CR 3633 (Titled: Hospital Billing for Repetitive Services). Instructions addressing CR 3382 were published in the [First Quarter 2005 Medicare A Bulletin \(page 9\)](#). Instructions addressing CR 3633 were published in the [January 2005 Medicare A Bulletin Special Issue \(pages 40-41\)](#).

To see CR 3633, Transmittal 407, dated December 17, 2004, go to the following CMS website: [http://www.cms.hhs.gov/manuals/pm\\_trans/R407CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R407CP.pdf).

**Also, to see the Medlearn Matters article related to CR 3633, go to the following CMS website:** <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3633.pdf>.

*Update to the Frequency of Billing (continued)***Provider Types Affected**

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

**Provider Action Needed**

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

**Background**

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

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

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

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

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

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

**Additional Information**

To view the official instruction and revised manual pages issued to your intermediary on this issue, see CR 3382, which may be found at:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R239CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R239CP.pdf).

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

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

Related Change Request (CR) Number: 3382

Related CR Release Date: August 3, 2004

Related CR Transmittal Number: 239

Effective Date: January 1, 2005

Implementation Date: January 3, 2005

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

**Clarification to Change Request 3267**

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

**Provider Types Affected**

Hospitals and independent laboratories billing Medicare carriers or fiscal intermediaries (FIs) for laboratory services

**Provider Action Needed**

This article contains information provided in Change Request (CR) 3729 that clarifies policies previously issued in CR 3267 (Transmittal 228, July 16, 2004). It also informs hospitals and independent labs that 1) they may use collected and retained Medicare Secondary Payer (MSP) information for the billing of nonface-to-face reference lab services, and 2) they are required to collect MSP information from the beneficiary when billing for face-to-face encounters with Medicare patients for lab services.

**Background**

Treatment of hospitals for certain services under Medicare Secondary Payer (MSP) provisions of the Medicare Prescription Drug Improvement & Modernization Act of 2003 (MMA) states:

"(a) IN GENERAL. – The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to Medicare Secondary Payer provisions) in the case of reference lab services described in subsection (b), if the Secretary does not impose such

**Clarification to Change Request 3267 (continued)**

requirement in the case of such services furnished by an independent laboratory.”

“(b) REFERENCE LABORATORY SERVICES DESCRIBED. – Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.”

The Centers for Medicare & Medicaid Services (CMS) will not require independent reference laboratories to collect MSP information in order to bill Medicare for reference laboratory services as described in subsection (b).

Therefore, pursuant to the MMA (Section 943), CMS **will not require hospitals to collect MSP information** in order to bill Medicare for reference laboratory services (as described in subsection (b) above). **This policy, however, will not be a valid defense to Medicare’s right to recover when a mistaken payment situation is later found to exist.**

**Therefore, in situations where hospital and independent labs have already collected and retained MSP information for beneficiaries, they may use the collected and retained MSP information for the billing of non-face-to-face reference lab services.**

In addition, **in situations when there is a face-to-face encounter with the beneficiary, hospitals and independent labs are required to collect MSP information from the beneficiary when billing for face-to-face lab services.**

This clarification should have been made as part of CR 3267 (which clarified CR 3064, Transmittal 11, February 27, 2004).

**Implementation**

The implementation date for this instruction is June 6, 2005.

**Additional Information**

CR 3267 (Transmittal 228, July 16, 2004) can be reviewed at the following CMS website:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R228CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R228CP.pdf).

CR 3064, Transmittal 11, February 27, 2004) can be reviewed at the following CMS website:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R11MSP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R11MSP.pdf).

The Medicare Secondary Payer Manual (Pub. 100-5) can be found at the following CMS website: [http://www.cms.hhs.gov/manuals/105\\_msp/msp105index.asp](http://www.cms.hhs.gov/manuals/105_msp/msp105index.asp).

The Medicare Claims Processing Manual (Pub. 100-04), Chapter 26 (Completing and Processing Form CMS-1500 Data Set) provides instructions on how to process reference lab claims submitted on Form CMS-1500, and may be found at the following CMS website: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c26.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c26.pdf).

After you get to Chapter 26, click on Section 10.2 (Items 1-11 - Patient and Insured Information) in the Table of Contents.

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

That instruction may be viewed by going to:

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

From that Web page, look for CR 3729 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: 3729

Related CR Release Date: March 4, 2005

Related CR Transmittal Number: 26

Effective Date: June 6, 2005

Implementation Date: June 6, 2005

Source: CMS Pub. 100-5, Transmittal 26, CR 3729

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**Correction to Healthcare Common Procedure Coding System Code A4217**

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

**Provider Types Affected**

Providers billing Medicare fiscal intermediaries (FIs) for HCPCS code A4217

**Provider Action Needed**

This article is based on information contained in Change Request (CR) 3714, which revises prior instructions included in CR 3300 (Transmittal 236, July 23, 2004) that required using modifier AU (Item furnished in conjunction with a urological, ostomy, or tracheostomy supply) with HCPCS code A4217 (Medical, surgical, and self-administered injection supplies). Information related to CR 3300 was published in the January 2005 *Medicare A Bulletin* Special Issue (page 30).

**Background**

Change Request 3300 (Business Requirement 3300.6) instructed that modifier AU (Item furnished in conjunction with a urological, ostomy, or tracheostomy supply) must be present on claims containing HCPCS code A4217 (Medical, surgical, and self-administered injection supplies).

However, it has come to the attention of the Centers for Medicare & Medicaid Services (CMS) that HCPCS code A4217, **without the presence of modifier AU**, can be used in conjunction with durable medical equipment (DME).

Therefore, **this article removes the requirement that modifier AU always be present with HCPCS code A4217. Claims received on or after January 1, 2005 with**

**Correction to Healthcare Common Procedure Coding System Code A4217 (continued)****HCPCS Code A4217 (and no modifier) may be considered a DME supply and processed accordingly.**

All other policies as outlined in the Medicare Claims Processing Manual (Pub. 100-04), Chapter 20, Section 30.9 regarding the presence of modifier AU with HCPCS code A4217 remain the same.

**Implementation**

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

**Additional Information**

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to

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

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From that Web page, look for CR 3714 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: 3714

Related CR Release Date: March 4, 2005

Related CR Transmittal Number: 489

Effective Date: January 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 489, CR 3714

**Billing for Hemophilia Blood Clotting Factors**

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

**Provider Types Affected**

Physicians and providers billing Medicare carriers and intermediaries for blood clotting factors

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

Physicians and providers should note that this instruction is based on information contained in Change Request (CR) 3755 which states that **blood clotting factors** not paid on a cost or prospective payment system basis are priced as a drug/biological under the drug pricing fee schedule effective for the specific date of service.

**CAUTION – What You Need to Know**

**Note:** 1) Medicare carriers process claims from noninstitutional providers for blood clotting factors, while 2) blood clotting factor claims from institutional (including claims from hospital-based hemophilia centers) are processed by Medicare fiscal intermediaries (FIs).

**GO – What You Need to Do**

Be sure billing staff is aware of this requirement.

**Background**

Blood clotting factors not paid on a cost or prospective payment system basis are priced as a drug/biological under the drug pricing fee schedule effective for the specific date of service. As of January 1, 2005, the ASP (average sales price) plus 6 percent is used.

If a beneficiary is in a covered Part A stay in a prospective payment system (PPS) hospital, the clotting factors are

paid in addition to the DRG/HIPPS payment. For FY 2005, this payment is based on 95 percent of average wholesale prices (AWP). For a skilled nursing facility (SNF) subject to SNF/PPS, the payment is bundled into the SNF/PPS rate.

For hospitals subject to the outpatient prospective payment system (OPPS), the clotting factors, when paid under Part B, are paid based on an ambulatory payment classification (APC). For SNFs, the clotting factors, when paid under Part B, are paid based on cost.

**Additional Information**

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

From that Web page, look for CR 3755 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3755

Related CR Release Date: April 8, 2005

Related CR Transmittal Number: 521

Effective Date: May 9, 2005

Implementation Date: May 9, 2005

Source: CMS Pub. 100-4, Transmittal 521, CR 3755

**Additional Information from the Fiscal Intermediary**

With the implementation of CR 3755, CMS has notified contractors that FIs will no longer divide by 100 when using the claim form 837I.

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## Update to the National Uniform Billing Committee Codes for Reporting on Claim Form CMS-1450

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

### Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs)

### Provider Action Needed

#### STOP – Impact to You

There are patient status, condition, value code, and type of bill code changes approved by the National Uniform Billing Committee (NUBC), which are effective on October 1, 2005.

#### CAUTION – What You Need to Know

Effective October 1, 2005, the NUBC approved the deletion of patient status code 08 and discontinued types of bill 17x, 24x, 27x, and 5xx. Additionally, new designations were set for condition codes E1 through FZ, N0 through ZZ and in value codes H0 through ZZ. Usage note language was changed for revenue code 019x. Related to that change, type of bill type X7x is discontinued as of October 1, 2005.

#### GO – What You Need to Do

Be aware of these changes and how they affect your billing processes in order to assure correct and timely processing of your claims.

### Background

The key changes are as follows:

#### New Patient Status Code Information

Patient status code 08 is discontinued as of October 1, 2005. Claims submitted with code 08 on or after October 1, 2005, will not be processed and will be returned to the provider.

#### Type of Bill Changes

Effective October 1, 2005, types of bill 17x, 24x, 27x, X7x, and 5xx are deleted from Medicare systems and Medicare will return claims with these bill types to the provider.

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### New Condition/Value Code Information

Effective October 1, 2005, condition codes N0 through ZZ are designated as "reserved for national assignment" and value codes H0 through ZZ are also designated as "reserved for national assignment." Claims submitted with value or condition codes in these ranges will not be processed and will be returned to the provider.

### New Revenue Code Information

**Revenue Code**    **New Usage Note**  
019x    Revenue code 019x may be used in multiple types of bills. However, if type of bill X7x is used in form locator 4, revenue code 019x must be used. Note: Type of b X7x will be **discontinued as of October 1, 2005.**

### Additional Information

For instructions to complete Form CMS 1450, see Chapter 25, Section 60, of the Medicare Claims Processing Manual: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c25.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c25.pdf).

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

From that Web page, look for CR 3794 in the CR NUM column on the right, and click on the file for that CR.

For additional information relating to this issue, please refer to your local FI toll free phone number at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3794

Related CR Release Date: April 22, 2005

Related CR Transmittal Number: 529

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 529, CR 3794

## Revisions to Payment for Services Provided Under a Contractual Arrangement

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

### Provider Types Affected

Physicians, providers, and suppliers billing Medicare carriers provided under a contractual arrangement

### Provider Action Needed

This article includes information provided in Change Request (CR) 3628 which makes a slight revision to the language in the Centers for Medicare & Medicaid Services (CMS) Manual System on payment for services provided under a contractual arrangement.

### Background

The Medicare Claims Processing Manual (Pub. 100-04, Chapter 1 (General Billing Requirements), Section 30.2.7 (Payment for services provided under a contractual arrangement)) has been revised as a result of the language published in the November 15, 2004 physician fee schedule final rule (CMS-1429F) concerning section 952 of the Medicare Modernization Act (MMA). Instead of stating that the contractual arrangement between an entity and the other physician or provider should include pertinent Medicare program integrity safeguards, CMS is now stating that the

**Revisions to Payment for Services Provided Under a Contractual Arrangement (continued)**

entity and the physician or other person are subject to those program integrity safeguards per the following:

- The entity receiving payment and the physician or other person that furnished the service are both subject to the following program integrity safeguard requirements:
  - ♦ The entity receiving payment and the person that furnished the service are jointly and severally responsible for any Medicare overpayment to that entity; and,
  - ♦ The person furnishing the services has unrestricted access to claims submitted by an entity for services provided by that person.

The entity billing and receiving payment and the person reassigning his or her billing and payment rights are both responsible for compliance with the Medicare program integrity safeguards beginning on January 1, 2005 (the effective date of CMS-1429-F).

Also, a Medicare carrier may make payment to an entity (i.e., a person, group, or facility enrolled in the Medicare program) that submits a claim for services provided by a physician or other person under a contractual arrangement with that entity, regardless of where the service is furnished. Thus, the service may be furnished on or off the premises of the entity submitting the bill and receiving payment (excluding billing agents).

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**Implementation**

The implementation date for this instruction is March 15, 2005.

**Additional Information**

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

From that Web page, look for CR 3628 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: 3628

Related CR Release Date: February 11, 2005

Related CR Transmittal Number: 472

Effective Date: January 1, 2005

Implementation Date: March 15, 2005

Source: CMS Pub. 100-4, Transmittal 472, CR 3628

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

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

**Provider Types Affected**

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

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

The net national claims error rate under the comprehensive error-rate testing program (CERT) for fiscal year 2004 was 9.3 percent. A portion of this error rate was due to providers not sending requested supporting documentation to the designated CERT contractor. Medicare FFS physicians, providers and suppliers must provide documentation and medical records that support their claims for covered Medicare services to the designated CERT contractor upon request. If you fail to submit documentation, the claim will be considered an error and you will receive a demand letter requesting refund of payment received for the “erroneous” claim.

**CAUTION – What You Need to Know**

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

**GO – What You Need to Do**

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

**Background**

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

**Methodology**

The CERT program was originally administered by the Department of Health and Human Services, Office of the

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

Inspector General (OIG) from 1996 - 2002. During this period, the OIG designed a sampling method that estimated only a national FFS paid claims error rate (the percentage of dollars that Medicare contractors erroneously allowed). Currently, CMS calculates a national paid claims error rate, a contractor specific error rate, services processed error rate (which measures whether the Medicare contractor made appropriate payment decisions on claims) and a **provider compliance error rate** (which measures how well providers prepared claims for submission). The CMS methodology includes:

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

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

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

**Your Role Is Critical To Improvement**

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

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

Medicare beneficiaries have consented to the release of medical information necessary to process their Medicare claims. **Providers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor.** Be assured that forwarding specifically requested records to the designated CERT contractor does not violate HIPAA Privacy statutes.

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

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

**Additional Information**

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

- CERT Web page (<http://www.cms.hhs.gov/cert>)
- CERT Newsletters (<http://www.cms.hhs.gov/cert/letters.asp>)
- A designated telephone number for Medicare physicians, providers and suppliers for general information and questions regarding the CERT initiative – 1-8041-864-9968.

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

**REMEMBER:**

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

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

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

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

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

Source: CMS Special Edition Medlearn Article SE0526

## Tool Available for Registering Patients with Implantable Cardioverter Defibrillators

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

### Provider Types Affected

Physicians and other providers needing to register Medicare patients receiving the implantable cardioverter defibrillator (ICD) as primary prevention of sudden cardiac death

### Provider Action Needed

#### STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) requires that any Medicare patient receiving an ICD as primary prevention of sudden cardiac death be enrolled in a data collection system. CMS has an electronic tool available to Medicare participating hospitals to assist in submitting this data to the data collection system, also referred to as the registry.

#### CAUTION – What You Need to Know

CMS identifies Medicare patients receiving an ICD for primary prevention indications and requiring participation in a registry in the coverage policy at: <http://www.cms.hhs.gov/mcd/viewimplementation.asp?id=148>.

#### GO – What You Need to Do

Review this article for more details and work closely with your hospital to ensure it is participating in data collection and you are providing necessary data.

### Background

CMS has released an implantable cardioverter defibrillator abstraction (ICDA) tool to facilitate the collection of information related to ICDs. The tool is available for download by each hospital’s QualityNet Exchange administrator from the following Internet location: <http://www.qnetexchange.org/icda>.

Please note that users must utilize this direct link to access the ICDA information. Once at this page, you will see a brief overview of the tool and then click on “ICDA Tools” to begin the download process for the tool and associated guides for using the tool. Also available on the website is a “paper” tool. This is a one-page, printable version of the ICDA and contains a list of all data elements collected in the tool.

Providers are not required to use the paper tool. In addition, Frequently Asked Questions are available at the same Web location.

CMS has already notified many providers of the availability of this tool through the hospital data collection auto-notification public list and the inpatient point of contact ListServe.

CMS covers ICDs for certain populations of patients as both primary and secondary prevention of sudden cardiac arrest. However, Medicare requires that any Medicare patient receiving an ICD or replacement ICD as primary prevention be enrolled in a data collection system. Submitting patient information through the ICDA tool satisfies the coverage requirement. The complete document describing the coverage policy and data submission requirements is located on the CMS website at: <http://www.cms.hhs.gov/mcd/viewimplementation.asp?id=148>.

Beneficiaries receiving an ICD for primary prevention can be identified through the absence of ICD-9-CM diagnosis codes for secondary prevention from the claim. A patient claim for which at least one of the following codes does not appear for secondary prevention could signify that the patient should be enrolled in a registry. Medicare Part B claims submitted on or after April 1, 2005 for implantation of an ICD for primary prevention should include a QR modifier to signify that the patient is enrolled in a registry. Although CMS does not have a coding mechanism for Part A claims that is similar to the function of modifier QR on Part B claims, CMS will have the ability to match inpatient claims to identify and review registry participation through other mechanisms.

Because coding practices may vary slightly, providers should rely primarily on the coverage guidance provided at <http://www.cms.hhs.gov/mcd/viewimplementation.asp?id=148> to determine whether data submission is required.

The following codes serve to assist in identifying patients with previous arrhythmias (secondary prevention) however depending on coding practices may not accurately reflect the requirements for coverage:

- 427.1 – Ventricular tachycardia
- 427.41 – Ventricular fibrillation
- 427.42 – Ventricular flutter
- 427.5 – Cardiac arrest
- 427.9 – Cardiac dysrhythmia, unspecified

The ICDA tool allows for on-line collection of registry information, including patient identifiers, history and clinical characteristics, medications, ICD indications, device information, complications, and facility and provider information. The ICDA tool allows for the ability to import and export data utilizing existing XML standards.

Using the ICDA tool to collect standardized data assists CMS in making a reasonable and necessary determination for Medicare patients. At this time, users are encouraged to utilize the tool for data collection activities, as it is a requirement of Medicare coverage for patients who receive the device for primary prevention of sudden cardiac arrest (patients without history of an arrest or arrhythmia).

Three individually recorded ICDA training sessions will be available for viewing and/or downloading from the ICDA site in the near future. Physicians and providers with dial-up Internet connections can download the recordings for viewing. QIOs can also download the recordings and transfer them to a CD for distribution to providers.

The three individual recorded sessions, which allow for subject matter-specific viewing, are as follows:

- ICDA 1.0 Installation and Setup
- ICDA 1.0 Abstraction Processes (New, Edit)
- ICDA 1.0 Import and Export



**Tool Available for Registering Patients with Implantable Cardioverter Defibrillators (continued)**

In addition, the ICDA User's Guide, available from the ICDA site, provides detailed instructions on the installation, set-up, and utilization of the tool.

**Location of Software and Documents**

The following software and associated documents are accessed from the "Tools" option available from the ICDA Overview page at <http://www.qnetexchange.org/icda>:

- Access the ICDA Version 1.0 Installation Instructions (pdf)
- Access the ICDA Installation (exe)
- User's Guide Download Instructions (pdf)
- ICDA User's Guide (exe)
- Using the ICDA User's Guide (pdf)

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Complete, detailed installation instructions, including screen prints, are also provided in Chapter 2 of the ICDA Version 1.0 User's Guide.

**Launching the ICDA Application**

Users must launch the ICDA application using the shortcut/icon provided on their desktop, or through the ICDA Program Group in the Windows Start menu. Please refer to the ICDA User's Guide for instructions on setting up providers and users within the tool.

Please notify your internal point of contact if you have any questions. They may contact the QualityNet Help Desk if additional information and/or assistance are needed.

Related Change Request (CR) Number: N/A

Effective Date: N/A

Source: CMS Special Edition Medlearn Matters SE0517

**First Update to the 2005 Medicare Physician Fee Schedule Database**

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

**Provider Types Affected**

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

**Provider Action Needed**

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

**Background**

CR 3726 amends payment files issued based upon the November 15, 2004, Final Rules for the 2005 Medicare physician fee schedule database. Many of the changes relate to a national coverage determination (NCD) related to G codes and CPT codes for positron emission tomography (PET), which was effective January 28, 2005.

**Additional Information**

The actual changes to the fee schedule involve numerous CPT/HCPCS codes. These changes to the first update to the 2005 Medicare physician fee schedule database are described in an attachment to CR 3726.

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

From that Web page, look for CR 3276 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your Medicare FI/carrier at their toll-free number, which may be found 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: 3726

Related CR Release Date: February 11, 2005

Related CR Transmittal Number: 475

Effective Date: January 1, 2005

Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 475, CR 3726

## Modified Edits for Matching Claim Data to Beneficiary Records

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

### Provider Types Affected

All Medicare physicians, providers, and suppliers

### Provider Action Needed

#### STOP – Impact to You

Claims submitted to Medicare must match a Medicare beneficiary record on health insurance claim number, beneficiary's last name (surname) and the beneficiary's first name.

#### CAUTION – What You Need to Know

The name reported on the claim should always be the name shown on the beneficiary's Medicare card. If the name submitted does not match the name on Medicare's files for that beneficiary claim number, Medicare will return the claim as unprocessed.

#### GO – What You Need to Do

Be aware of this issue and advise your billing staff they should always use the name from the Medicare card when submitting the claim, even if the patient indicates the name on the Medicare card is incorrect.

### Background

Over the past several months, the Centers for Medicare & Medicaid Services (CMS) reviewed its personal characteristics editing logic for processing Medicare claims. The review identified a weakness where processed claims were approved for payment under the wrong beneficiary account number. One of Medicare's key claims processing systems, known as the common working file (CWF), was approving claims where the beneficiary name and health insurance claim number did not match the name and number on the Medicare card.

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The Office of the Inspector General in the Department of Health and Human Services recommended that CMS implement a modified process for matching the claim information to the beneficiary information on CWF files to eliminate erroneous payments caused by the existing matching criteria.

In October 2004, CMS made a software change to require an exact match on beneficiary first initial, surname, and health insurance claim number submitted on the claim. Since this change was implemented the number of unprocessable claims because of name/number mismatch tripled.

To resolve these claim denials, providers should bill using the name and number as it appears on the beneficiary Medicare card. If the beneficiary insists the Medicare card is incorrect, the provider should advise the beneficiary to contact his or her local servicing Social Security field office to obtain a new Medicare card.

If you have any questions regarding this issue, contact your Medicare intermediary, carrier, or durable medical equipment regional carrier at their toll free number. You may find that number on CMS website at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

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

Source: CMS Special Edition Medlearn Matters SE0516

## Billing Instructions for Unlisted Procedure Codes

First Coast Service Options, Inc. has identified an increase in the number of Medicare Part A providers billing unlisted procedure (HCPCS/CPT) codes. The Centers for Medicare & Medicaid Services (CMS) has specific instructions for billing unlisted procedure codes. This should be a rare occasion; examples of this are new technology or drugs without a HCPCS/CPT code. Providers are responsible to provide the fiscal intermediary (FI) with valid information and codes that best represent the service or procedure provided and billed. Providers should not routinely submit unlisted procedure codes to FI.

### Action Required by Providers

If you bill an unlisted procedure, the line item containing the unlisted procedure will be rejected with reason code 77799. When you receive a line rejection with this reason code, you need to bill a more appropriate procedure code as an adjustment transaction with the type of bill ending in a '7'.

If there is not another procedure code that describes the service performed, submit an adjustment and provide comments on page 7 of the claim. FCSO will review the comments and may still need to generate an additional development request form asking for additional documentation. For example, for an unlisted surgical procedure, FCSO will request the operative report.

There are some unlisted procedure codes where CMS has given instructions to bill under certain conditions. Those unique guidelines should still be followed. These types of situations should not receive a line reject.

Additional information will be forthcoming relative to unlisted HCPCS/CPT codes for unlisted drugs. This will be provided under a separate article.

## April 2005 Quarterly Average Sales Price Medicare Part B Drug Pricing File Effective April 1, 2005, and New January 2005 Quarterly ASP File

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

CR 3667 discusses updates to the new methodology of paying for Medicare Part B covered drugs not paid on the basis of cost or prospective payment.

#### CAUTION – What You Need to Know

Effective January 1, 2005, Part B covered drugs and biologicals (that are not paid on a cost or prospective payment basis) are paid based on the new average sales price (ASP) drug payment system, described below.

#### GO – What You Need to Do

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

### Background

The Medicare Modernization Act of 2003 (MMA), Section 303(c), revises the methodology of paying for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Effective January 1, 2005, these drugs are paid based on the new average sales price (ASP) drug payment methodology.

The ASP file, used in the ASP methodology, is based on data CMS receives quarterly from manufacturers. Each quarter, the Centers for Medicare & Medicaid Services (CMS) will update your fiscal intermediary (FI) and carrier payment allowance limits with the ASP drug pricing files based on these manufacturers' data.

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP, and CMS will update the payment allowance limits quarterly. However, there are exceptions to this general rule as summarized below:

- For **blood and blood products** (with certain exceptions like blood clotting factors), payment allowance limits are determined in the same manner they were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. **The payment allowance limits will be updated on a quarterly basis.**
- For **infusion drugs** furnished through a covered item of durable medical equipment (DME) on or after January 1, 2005, payment allowance limits will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003 regardless of whether or not the DME is implanted. **The payment allowance limits will not be updated in 2005.**
- For **influenza, pneumococcal, and hepatitis B vaccines** payment allowance limits are 95 percent of the AWP as reflected in the published compendia. **The payment allowance limits will be updated on a quarterly basis.**
- For drugs, other than new drugs, not included in the ASP Medicare Part B drug pricing file or not otherwise classified (NOC) pricing file payment allowance limits are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, FIs/carriers will follow the methodology specified in the Medicare Claims Processing Manual for calculating the AWP, but substitute WAC for AWP. Please see Pub. 100-04, Chapter 17 (Drugs and Biologicals) at the following CMS website: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c17.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c17.pdf). The payment limit is 100 percent of the WAC for the lesser of the lowest brand or median generic. Your carrier or FI may, at their discretion, contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files. If available, CMS will provide the payment limits either directly to the requesting carrier/FI or via posting an MS Excel file on the CMS web site. If the payment limit is available from CMS, carriers/Fis will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.
- For **new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File**, payment allowance limits are based on 106 percent of the WAC. This policy applies only to new drugs that were first sold on or after December 1, 2004.  
  
The April 2005 and new January 2005 ASP drug pricing files will contain three decimal places in the currency fields. In addition, the new January file contains revised payment limits for some drugs. The codes with a revised payment limit are identified in the column titled "Notes."  
The absence or presence of a HCPCS code and its associated payment limit in the pricing files do 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 carrier/FI processing your claim will make these determinations.  
  
In addition, your FI or carrier is required to accomplish the following:
  - Use the April 2005 ASP and NOC drug pricing files to pay for Medicare Part B drugs effective April 1, 2005. This file shall be used for dates of service from April 1, 2005 through June 30, 2005.
  - Determine for any drug or biological not listed in the ASP or NOC drug pricing files, the payment allowance limits in accordance with the policies described in this transmittal, CR 3539, dated October 29, 2004 (see [http://www.cms.hhs.gov/manuals/pm\\_trans/R348CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R348CP.pdf)), and CR3232, dated December 16, 2004 (see [http://www.cms.hhs.gov/manuals/pm\\_trans/R397CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R397CP.pdf)), and FIs should seek payment allowances from their local carrier.

**April 2005 Quarterly Average Sales Price Medicare Part B Drug Pricing File (continued)**

- Use the new January 2005 ASP drug pricing file for (1) those claims where the carriers/FIs are asked to retroactively adjust claims processed with the original January 2005 file and (2) those claims with dates of service on or after January 1, 2005 and before April 1, 2005 that are processed after April 4, 2005. **Your FI or carrier shall not search and adjust claims that have already been processed unless brought to their attention;**
- Overlay the old January 2005 file with the new January 2005 file; and
- For any drug or biological for which they (your FI or carrier) calculates a payment allowance limit, forward to CMS the following:
  - ♦ The drug name,
  - ♦ Dosage,
  - ♦ Payment allowance limit, and
  - ♦ National Drug Code (if available).

**Note:** The ASP and NOC drug pricing files will contain the 106 percent ASP, 106 percent WAC or WAC based payment allowance limits; therefore, no additional payment calculation is required by your carrier or FI. The payment limits for the blood clotting factor codes includes the \$0.14 per I.U. furnishing fee.

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**Additional Information**

The new January 2005 and April 2005 ASP and NOC pricing files are available from the following CMS website on or after March 17, 2005:

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

You may find more information about the April 2005 quarterly ASP Medicare Part B drug pricing file, effective April 1, 2005, and the new January 2005 quarterly ASP file at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3667 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3667  
 Related CR Release Date: February 25, 2005  
 Related CR Transmittal Number: 480  
 Effective Date: January 1, 2005  
 Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 480, CR 3667

**July 2005 Quarterly Average Sales Price Medicare Part B Drug Pricing File**

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

**Provider Types Affected**

All Medicare providers

**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 July 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) supplies 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**

Exceptions to this general rule are:

- 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.

- 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. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003 (i.e., new drugs) are 95 percent of the first published AWP.
- 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.
- The payment allowance limits for drugs, other than new drugs, not included in the ASP Medicare Part B drug

**July 2005 Quarterly Average Sales Price Medicare Part B Drug Pricing File (continued)**

pricing file or not otherwise classified (NOC) pricing file are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, the carriers/intermediaries follow the methodology specified in Chapter 17, Drugs and Biologicals, of the Medicare Claims Processing Manual for calculating the AWP but substitute WAC for AWP. Chapter 17 may be found at on the CMS web site at: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c17.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c17.pdf).

- The payment limit is 100 percent of the WAC for the lesser of the lowest brand or median generic. Carriers/intermediaries, at their discretion, may contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files or otherwise made available by CMS on the CMS website. If the payment limit is available from CMS, carriers/intermediaries will substitute CMS provided payment limits for pricing based on WAC or invoice pricing. CMS will provide the payment limits either directly to the requesting carrier/intermediary or via posting an MS Excel file on the CMS website.
- The payment allowance limits for new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 percent of the WAC. This policy applies only to new drugs that were first sold on or after January 1, 2005.
- The payment allowance limits for radiopharmaceuticals are not subject to ASP. Medicare carrier/intermediaries will determine payment limits for radiopharmaceuticals based on invoice pricing.

**Note:** The absence or presence of a HCPCS code and its associated payment limit in the payment 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 carrier/intermediary processing the claim shall make these determinations.

**Implementation**

The implementation date is July 5, 2005. The July 2005 ASP and NOC drug pricing files will be used by your carrier/intermediary to pay for Medicare Part B drugs from July 1, 2005 through September 30, 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](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3783 in the CR NUM column on the right and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3783  
 Related CR Release Date: April 22, 2005  
 Related CR Transmittal Number: 528  
 Effective Date: July 1, 2005  
 Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 528, CR 3783

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

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

**Provider Types Affected**

All Medicare physicians, providers, and suppliers

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

The Centers for Medicare & Medicaid Services (CMS) is revising certain payment limits included in the first quarter 2005 (1Q05) Medicare Part B drug pricing file used by Medicare carriers and intermediaries, including durable medical equipment regional carriers (DMERCs) and regional home health intermediaries (RHHIs).

**CAUTION – What You Need to Know**

Medicare carriers and intermediaries, including DMERCs and RHHIs, will not apply these limits to claims already processed unless brought to their attention by the provider/supplier.

**GO – What You Need to Do**

Medicare carriers and intermediaries, including DMERCs and RHHIs, will not apply these limits to claims already processed unless brought to their attention by the provider/supplier.

**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 new average sales price (ASP) method. The ASP method is based on data submitted to CMS by manufacturers at the 11-digit national drug code (NDC) level. CMS then determines the number of billable units per NDC based on published drug pricing information as well as other sources available to CMS.

Revisions to January 2005 Quarterly Average Sales Price Medicare Part B Drug Pricing File (continued)

Through receipt of additional information, CMS has determined certain payment limits in the 1Q05 Medicare Part B drug pricing file need revision. Tables 1 and 2 below identify the revised payment limits. The limits apply to dates of service on or after January 1, 2005, and on or before March 31, 2005. The revised payment limits in this notification supersede the payment limits for these codes in any publication published prior to CR 3728.

Also, note that the ASP-based 1Q05 payment limit for J7510, Q4054, and Q4055 are now provided. The revised payment limit for 90740, a vaccine, is based on 95 percent of the average wholesale price (AWP). The revised payment limits for the blood clotting factor codes includes the \$0.14 per I.U. furnishing fee. The payment limits in Table 2 are for certain new drugs.

Table 1

HCPCS	Short Description	HCPCS Code Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit	1Q05 Vaccine Limit
90740	Hepb vacc, ill pat 3 dose im	3 DOSE SCH	\$113.91	\$113.91	\$113.91
J7190*	Factor VIII	I.U.	\$0.66	\$0.66	
J7191*	Factor VIII (porcine)	I.U.	\$1.86	\$1.86	
J7192*	Factor VIII recombinant	I.U.	\$1.06	\$1.06	
J7193*	Factor IX non-recombinant	I.U.	\$0.89	\$0.89	
J7194*	Factor IX complex	I.U.	\$0.63	\$0.63	
J7195*	Factor IX recombinant	I.U.	\$0.98	\$0.98	
J7197*	Antithrombin III injection	I.U.	\$1.72	\$1.72	
J7198*	Anti-inhibitor	I.U.	\$1.23	\$1.23	
J7510	Prednisone oral per 5 mg	5 mg	\$0.05	\$0.05	
Q0187*	Factor VIIa recombinant	1.2 mg	\$1,051.45	\$1,051.45	
Q2022*	Von Willebrand Factr Cmplx per IU	I.U.	\$0.86	\$0.86	
Q4054	Darbepoetin alfa, ESRD use	1 mcg	\$3.54	\$3.54	
Q4055	Epoetin alfa, ESRD use	1,000 units	\$9.32	\$9.76	

\*The ASP-based payment allowance limit for blood clotting factors and the furnishing fee for the blood clotting factors do not apply to inpatient claims.

Table 2

HCPCS Code	Drug Name	Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit	1Q05 Vaccine Limit
J3490	Pegaptamib sodium	0.3 mg	\$1,054.70	\$1,054.70	
J9999	Histrelin implant	5 mg	\$530.00	\$530.00	
J9999	Natalizumab	5 mg	\$31.94	\$31.94	

**Note:** The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological.

**Implementation**

The implementation date is February 4, 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](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3728 in the CR NUM column on the right and click on the file for that CR.

CMS will also update the Microsoft Excel files on the CMS website to reflect these revised payment limits.

Those files are at:

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

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: 3728

Related CR Release Date: February 3, 2005

Related CR Transmittal Number: 140

Effective Date: January 1, 2005

Implementation Date: February 5, 2005

Source: CMS Pub. 100-20, Transmittal 140, CR 3728

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## April 2005 Quarterly Fee Schedule Update 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 billing durable medical equipment regional carriers (DMERCs) and/or intermediaries

### Provider Action Needed

This article is based on Change Request (CR) 3669, and it provides specific information regarding the April quarterly update for the 2005 durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule.

### Background

This article provides specific information regarding the April quarterly update for the 2005 DMEPOS fee schedule. The DMEPOS fee schedules are updated on a quarterly basis in order to 1) implement fee schedule amounts for new codes and 2) to revise any fee schedule amounts for existing codes that were calculated in error. Payment on a fee schedule basis is required for:

- Durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a)(h)(i)), and
- Parenteral and enteral nutrition (PEN) by regulations contained in the *Code of Federal Regulations* (42 CFR 414.102).

**Note:** There are no changes to the PEN fee schedule file for April 2005.

**HCPCS code K0670 (addition to lower extremity prosthesis...) is added, effective April 1, 2005,** to the list of Healthcare Common Procedural Coding System (HCPCS) accepted by DMERCs and intermediaries.

Also, **HCPCS code K0671 is being added to the HCPCS effective April 1, 2005,** as an accepted code by DMERCs and regional home health intermediaries. This code:

- Describes a rental portable oxygen concentrator system and
- Is to be used when billing Medicare for the portable equipment add-on fee for patients using lightweight oxygen concentrators that can function as both the patient's stationary equipment and portable equipment.

**The following HCPCS codes are to be used to describe combination stationary/portable oxygen concentrators** for Medicare billing purposes.

- **For claims for combination stationary/portable oxygen concentrators with dates of service prior to April 1, 2005,** use:
  - ♦ HCPCS Code E1390 (stationary oxygen concentrator) **with**
  - ♦ HCPCS Code E0431 (portable gaseous oxygen system).

- For claims with dates of service **on or after April 1, 2005,** use
  - ♦ HCPCS Code E1390 (stationary oxygen concentrator) in conjunction **with**
  - ♦ HCPCS Code K0671 (portable oxygen concentrator system).

**Note:** Payment for HCPCS code K0671 will be based on the current add-on fee schedule amounts for portable oxygen equipment.

Also, the quarterly updates process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual (Pub 100-04, Chapter 23, Section 60). This manual can be accessed at: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp).

### Implementation

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

### Additional Information

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

From that Web page, look for CR 3669 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/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: 3669

Related CR Release Date: January 28, 2005

Related CR Transmittal Number: 451

Effective Date: April 1, 2005, for new codes added to the HCPCS, and January 1, 2005, for all other HCPCS codes on the fee schedule

Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 451, CR 3669

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## Facts for Providers Regarding the Medicare Prescription Drug Plans That Will Become Available in 2006

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

*The second article in a series of Medlearn Matters Articles for Providers on Medicare New Prescription Drug Coverage*

### Provider Types Affected

All Medicare providers and any staff who have contact with Medicare beneficiaries

### Provider Action Needed

This special edition article provides updated information regarding the Medicare Prescription Drug Plans that will be available to Medicare beneficiaries in 2006. This new benefit was established by the Medicare Modernization Act (MMA), which was enacted in 2003.

This new drug coverage requires **every** Medicare beneficiary to make a decision this fall. As a trusted source, your patients may turn to you for information about this new coverage. Because of this, we're looking to you and your staff to take advantage of this "teachable moment" and help your Medicare patients. Help can be as simple as referring them to CMS beneficiary educational resources such as 1-800-MEDICARE and <http://www.medicare.gov>. It is important to encourage your patients to learn more about the new coverage as it may save them money on prescription drug costs.

### The Basic Plan

Beginning January 1, 2006, new Medicare prescription drug plans will be available to all people with Medicare. Insurance companies and other private companies will be working with Medicare to offer these drug plans and negotiate discounts on drug prices. These plans are different from the Medicare-approved drug discount cards that phase out by May 15, 2006, or when a beneficiary's enrollment in a Medicare prescription drug plan takes effect, if earlier. The cards offered discounts, while the plans offer insurance coverage for prescription drugs.

Medicare prescription drug plans provide insurance coverage for prescription drugs, and like other insurance plans, participating beneficiaries will pay:

- A monthly premium (generally around \$37 in 2006); and
- A share of the cost of their prescriptions (with costs varying depending on the drug plan chosen by the beneficiary).

In addition, drug plans can vary depending on the following:

- What prescription drugs are covered,
- How much the beneficiary pays, and
- Which pharmacies the beneficiary can use.

All drug plans will provide a standard level of coverage, which Medicare will set. However, for a higher monthly premium, some plans might offer more coverage and additional medications.

When a Medicare beneficiary joins a drug plan, it is important that they choose one that meets their prescription drug needs.

The following questions and answers provide key information that might be of interest to you, your staff, or your patient.

### When can your patients enroll in this new plan?

If a beneficiary currently has Medicare Part A (hospital insurance) and/or Medicare Part B (medical insurance), the beneficiary can join a Medicare prescription drug plan between November 15, 2005, and May 15, 2006. In general, a beneficiary can join or change plans once each year between November 15 and December 31. If they join a Medicare prescription drug plan:

- By December 31, 2005, their coverage will begin on January 1, 2006; and
- After December 31, 2005, their coverage will be effective the first day of the month after the month they join.

Even if a beneficiary does not use many prescription drugs now, they still should consider joining a plan. If they don't join a plan by May 15, 2006, and they don't have a drug plan that covers as much or more than a Medicare prescription drug plan, they will have to pay more each month to join later.

### What if the Medicare beneficiary can not pay for a Medicare prescription drug plan?

Some people with an income at or below a set amount and with limited assets (including their savings and stocks, but not counting their home) will qualify for extra help.

The exact income amounts will be set in early 2005. People who qualify will get help paying for their drug plan's monthly premium, and/or for some of the cost they would normally have to pay for their prescriptions. The type of extra help received will be based on income and assets. In mid-2005, SSA will send people with certain incomes information about how to apply for extra help in paying for their prescription drug costs. If they think they may qualify for extra help, they can sign up with the Social Security Administration (SSA) or their local Medicaid office as early as the summer of 2005.

### Will this new plan work with other Medicare coverage that your patients may have?

Yes, Medicare prescription drug plans work with all types of Medicare health plans, and there will be:

- Medicare prescription drug plans that add coverage to the original Medicare plan (these plans will be offered by insurance companies and other private companies); and
- Medicare prescription drug plans that are a part of Medicare Advantage plans (like HMOs), in some areas.

### What if a Medicare beneficiary has a Medigap policy with drug coverage or prescription drug coverage from an employer or union?



**Facts for Providers Regarding the Medicare Prescription Drug Plans Available in 2006 (continued)**

The Medicare beneficiary will get a detailed notice from their insurance company or the employer or union informing them whether or not their policy covers as much or more than a Medicare prescription drug plan.

This notice will explain their rights and choices.

If a Medicare beneficiary's employer or union plan covers as much as or more than a Medicare prescription drug plan, they can:

- Keep their current drug plan. If they join a Medicare prescription drug plan later, their monthly premium won't be higher; or
- Drop their current drug plan, and join a Medicare prescription drug plan. However, they may not be able to get their employer or union drug plan back.

If a Medicare beneficiary's employer or union plan covers less than a Medicare prescription drug plan, they can:

- Keep their current drug plan, and join a Medicare prescription drug plan to give them more complete prescription drug coverage; or
- Keep their current drug plan. However, if they join a Medicare prescription drug plan later, they will have to pay more for the monthly premium; or

- Drop their current drug plan and join a Medicare prescription drug plan. However, they may not be able to get their employer or union drug plan back.

**Additional Information**

More information on provider education and outreach regarding drug coverage can be found at:

<http://www.cms.hhs.gov/medlearn/drugcoverage.asp>.

The information contained in this article is based on a fact sheet for beneficiaries. To obtain a copy of this fact sheet for your patients, visit: <http://www.medicare.gov/Publications/Pubs/pdf/11065.pdf>.

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

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

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Matters SE0502

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**Your Important Role—Medicare Prescription Drug Plan**

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

***The third article in a series of: Information for Providers, Physicians, Pharmacists and Their Staffs About Medicare Prescription Drug Coverage***

**Provider Types Affected**

Medicare physicians, institutional providers, pharmacists, and any staff who have contact with Medicare beneficiaries

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

On January 1, 2006, a new benefit will be available to the 41 million Americans who receive health insurance coverage through the Medicare program. Medicare Prescription Drug Plans will help reduce the cost of prescription drugs. Your patients may ask you about this new benefit.

**CAUTION – What You Need to Know**

We need your help to make sure Medicare patients know about and understand this new benefit—information is just a click away. Through *Medlearn Matters* articles, we will give you access to various levels of information. You decide the level of involvement you want to have in helping Medicare patients.

**GO – What You Need to Do**

Stay informed, visit: <http://www.cms.hhs.gov/medlearn/drugcoverage.asp> on the Web. This website includes links to all articles in this series and information providers need about the new coverage. At a minimum, refer your Medicare patients to 1-800-MEDICARE and <http://www.medicare.gov> on the Web.

**Background**

You and your staff are trusted sources of information for your patients. You may be the first source of information that Medicare beneficiaries use to explain Medicare Prescription Drug Coverage. Please encourage your Medicare patients to learn more about this new coverage because it may save them money on prescription drugs. **If a beneficiary fails to actively choose a prescription drug plan, they may miss out on cost savings for prescription drugs.** Medicare Prescription Drug Coverage will:

- Help pay for prescriptions
- Provide extra help for people with limited income and resources
- Cover brand name and generic drugs.

CMS will include Medicare Prescription Drug Coverage details in the *2006 Medicare & You Handbook*, and send it to beneficiaries in October 2005.

**Your Role and Involvement – You Choose**

Your interest may range from wanting basic to detailed information on this coverage. For example, if you work in a rural locale, or in areas that serve a large population of beneficiaries with limited income and resources, you may have a greater interest in counseling your patients.

**Your Important Role—Medicare Prescription Drug Plan (continued)**

- **Basic** – You know that Medicare Prescription Drug Coverage exists and where to send people to learn about benefit details. You may display a poster (available later this spring) in your office or clinic, and make beneficiary-focused materials available in your office.
- **Intermediate** – You know more about Medicare Prescription Drug Coverage, such as:
  - ♦ How beneficiaries can enroll
  - ♦ Copayment amounts
  - ♦ Where to find additional help for people with limited income and resources
  - ♦ Where to find information on the following websites: <http://www.medicare.gov>  
<http://www.cms.hhs.gov/medlearn/drugcoverage.asp>
  - ♦ How to answer the basic questions.
- **Advanced** – You know detailed information about Medicare Prescription Drug Coverage and the plans available in your area. You, or someone on your staff, can answer detailed questions about the drug benefit. In some cases, you or your staff may counsel beneficiaries on their particular situation and the options that will work best for them.

**To Stay Updated on New Information and Educational Resources**

- Pay attention to correspondence from your national professional associations – they are part of the information stream from CMS to the community of professionals who serve people with Medicare; sign up for their listservs and read their newsletters.
- Keep current with information from your Medicare fee-for-service claims processing contractor; bookmark their website, read their bulletins, and register to receive electronic listserv messages.
- Bookmark and visit the provider educational Web page on Medicare Prescription Drug Coverage on the website: <http://www.cms.hhs.gov/medlearn/drugcoverage.asp>.
- Register to receive listserv email messages to alert you when new *Medlearn Matters* articles have been released

on the new drug benefit (and other Medicare information); register at the website: <http://www.cms.hhs.gov/medlearn/matters>.

- Participate in CMS Open Door Forums, to hear from and ask questions of CMS leadership on topics of interest to your particular provider type; for information about these forums visit the website: <http://www.cms.hhs.gov/opendoor>.

**Get Your Staff Involved**

In addition, inform members of your staff who interact with Medicare patients every day about the information in this article:

- Physicians – supply this information to nursing and front office staff.
- Hospitals – supply this information to nursing, discharge planning, financial, and emergency room staff.
- Pharmacists - supply this information to your pharmacy technicians and front counter staff.

If you or your staff are willing to further advise and counsel people with Medicare, CMS will have tools to help you do this on <http://www.cms.hhs.gov/partnerships> (toolkit available by April 1, 2005).

**Summary**

CMS asks you to:

- Respond to questions from your patients in a way that encourages them to seek more information from the Medicare program.
- Inform members of your staff who interact with Medicare patients about the information resources available to them, and where they may refer patients to learn more about Medicare Prescription Drug Coverage.
- At a minimum, refer your Medicare patients who are looking for information on Medicare Prescription Drug Coverage to 1-800-MEDICARE or visit the website at: <http://www.medicare.gov>.

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Article SE0520

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**CMS Seeks Provider Input on Satisfaction with Medicare Fee-for-Service Contractors**

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

**Provider Types Affected**

A sample of 8,200 (or 2 percent of) Medicare providers served by 12 Medicare fee-for-service contractors (carriers and fiscal intermediaries), including hospitals, skilled nursing facilities (SNFs), rural health clinics, home health clinics, end-stage renal disease (ESRD) facilities, physicians, nonphysicians, durable medical equipment (DME) suppliers, and ambulance service providers

**Provider Action Needed**

**STOP – Impact to You**

The Centers for Medicare & Medicaid Services (CMS) would like to provide a channel for you to voice your opinions about the services you receive from your Medicare fee-for-service (FFS) contractors (carriers and fiscal intermediaries [FIs], including durable medical equipment regional carriers [DMERCs] and regional home health intermediaries [RHHIs]). The Medicare Contractor Pro-

***CMS Seeks Provider Input on Satisfaction with Medicare Fee-for-Service Contractors (continued)***

vider Satisfaction Survey (MCPSS) will be CMS's initial effort to use provider satisfaction as a standard of measurement to evaluate our FFS contractors' performance.

CMS values the opinions of the Medicare physician and provider community and understands the important role that FFS contractors play in representing the Medicare program to providers. The MCPSS represents an important opportunity for you to be heard.

**CAUTION – What You Need to Know**

The first year of the MCPSS is a pilot. CMS has selected 12 FFS contractors to participate in the pilot:

- Four FIs: AdminaStar Federal, Noridian Administrative Services L.L.C., Riverbend GBA, and Empire Medicare Services
- Four carriers: National Heritage Insurance Company (NHIC), Wisconsin Physician Services (WPS), TrailBlazer Health, and Empire Medicare Services
- Two DMERCs: Health Now New York and AdminaStar Federal
- Two RHHIs: Palmetto GBA and Anthem Health Plans of Maine.

A random sample of 8,200 providers (approximately two percent of providers) served by these twelve FFS contractors has been selected to participate in the pilot. If you have been selected, you should have received a notification packet with background information about the pilot, as well as an instruction sheet with information on how to access and complete the survey instrument via a secure Internet website. The letter also includes a phone number that you can call to request a paper copy of the survey instrument to submit your responses by mail or fax, if you prefer to do so.

**GO – What You Need to Do**

Be alert for a notification packet in the mail. If you are selected and receive the notification packet, please take the

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time to complete and submit your survey responses as soon as possible. The data collection period for the pilot will continue through the end of March.

**Background**

On January 17, 2005, CMS launched a pilot of the MCPSS. The survey will give providers the opportunity to rate their Medicare contractor on seven administrative functions: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider reimbursement.

The survey contains a total of 76 questions and takes approximately 22 minutes to complete. Sampled providers will be able to access the survey on a secure Internet web site or may request a paper copy of the survey and submit via mail or fax. Data collection for the pilot will continue through March 2005.

CMS will use the results of the pilot to evaluate and refine the survey instrument, data collection procedures, analysis, and reporting of results for the national survey implementation. The results of the pilot will not be used to evaluate the Medicare contractors' performance. In the future, CMS plans to use the MCPSS to support and assist contractors in using provider feedback to identify and implement "best practices" and quality or process improvement initiatives.

CMS has awarded a contract to Westat, a survey research firm, to administer the MCPSS.

**Additional Information**

For questions or additional information about the MCPSS, please visit: <http://www.cms.hhs.gov/providers/mcpss/default.asp>.

Related Change Request (CR) Number: N/A

Effective Date: N/A

Source: CMS Special Edition Medlearn Article SE0513

**Consolidation of the Claims Crossover Process**

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

**Provider Types Affected**

All Medicare physicians, providers, and suppliers

**Provider Action Needed**

Physicians, providers, and suppliers should note that this special edition article is to inform you of system changes to implement a switch from 1) Medicare intermediaries, carriers, and durable medical equipment regional carriers (DMERCs) crossing supplemental claims to supplemental insurers to 2) a single entity, the coordination of benefits contractor (COBC), doing the same from one location.

**Background**

The Centers for Medicare & Medicaid Services (CMS) is consolidating the Medicare claims crossover process under a special coordination of benefits contractor by means of the Coordination of Benefits Agreement (COBA) initiative.

**Currently, supplemental payers/insurers** (including eligibility-file-based Medigap, Medicaid and employer plans) **must sign multiple crossover agreements** with Part A intermediaries and Part B carriers and DMERCs to accomplish an automatic, or eligibility-file based, crossover to other insurers that pay after Medicare has made its payment decision on a claim.

*Consolidation of the Claims Crossover Process (continued)*

**In the future** (under the new consolidated claims crossover process) **supplemental payers/insurers will sign one national crossover agreement** and work directly with the COBC (which represents CMS). The supplemental payer/insurer will:

- Send eligibility files to identify its covered members, and
- Receive outbound HIPAA ANSI X-12N 837 Coordination of Benefits (COB) claims and National Council for Prescription Drug Programs (NCPDP) claims for use in calculating their secondary payment liability.

On July 6, 2004, CMS began testing the consolidated crossover process with approximately ten supplemental payers/insurers. Note the following:

- Testing is focused on the outbound HIPAA ANSI X-12 837N COB claims that are translated from Medicare's Part A intermediary, Part B carrier, and DMERC processed claims.
- Initial -implementation will take place after successful testing is completed, and the 10 supplemental payers/insurers will be moved to full COBA crossover production through one entity, the COBC.
- Throughout the course of fiscal year 2005, CMS will begin transitioning all supplemental payers/insurers from the existing eligibility file-based crossover process to the national COBA process.

Detailed requirements for 1) eligibility file-based crossover and 2) claim-based (mandatory Medigap) crossover were previously issued by CMS in Change Request (CR) 3109 (Transmittal 98), and CMS subsequently issued CR 3218 (Transmittal 138) to communicate the new implementation strategy for the COBA initiative. Transmittal 138 may be accessed at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R138CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R138CP.pdf).

CR 3218 (Transmittal 138) provided:

- Major changes to many of the requirements previously published in CR 3109 (Transmittal 98) and
- Moved the implementation of claim-based crossover to a future date.

### Physician, Provider, and Supplier Action

**Note:** Physicians, providers, and suppliers will not need to take any new actions with respect to the COBA automatic (or eligibility-file-based) crossover process.

**The key difference between the existing automatic crossover process and the new COBA automatic crossover process is that,** when a supplemental payer/insurer provides CMS with specific claim types and member information for those claims they wish to receive, **the claims will be crossed over to the supplemental payers/insurers only after the claims have left the Medicare claims payment floor.**

Thus, **physician, provider, and supplier offices should receive payment and/or processing information** from a patient's supplemental payer/insurer **after the Medicare**

**payment has been received** (once the supplemental payer/insurer has transitioned to the COBA crossover process).

Physicians, providers, and suppliers will be able to reference a listing of eligibility file-based COBA trading partners on the COBA portion of the following CMS COB web site as supplemental payers/insurers are scheduled to move to full eligibility-file-based crossover production under the COBC:

<http://www.cms.hhs.gov/medicare/cob/coba/coba.asp>.

(This listing is not currently available but will be available after supplemental payers/insurers have moved to full production with the COBC.)

**Physicians, providers, and suppliers should note that the following important information will require your attention when a supplemental payer/insurer 1) has transitioned to the COBA eligibility-file-based crossover process and 2) is listed on the website noted in the previous paragraph.**

- Although the claim may cross to multiple supplemental payers/insurers, only one will print on your remittance advice. In this situation, if one of the supplemental payers/insurers is Medigap, the Medigap insurer will always print.
- Since payment from the supplemental payer/insurer should occur only after the Medicare payment has been issued, it is advised that you do not bill the supplemental payer/insurer for a minimum of 15 work days after receiving the Medicare payment. This will allow sufficient time for the claim to cross to the supplemental payer/insurer and the subsequent actions necessary to issue payment from the supplemental payer/insurer.
- In addition, prior to submitting a claim to the supplemental payer/insurer, it is advised that you use available self-service tools to research the status of your supplemental payment, e.g., the supplemental payer/insurer's website, claims automated "hot line," etc.
- There may be situations (such as claim errors related to HIPAA) that prevent the automatic crossover from occurring after you have received a Medicare remittance advice (electronic or supplemental paper) notifying you that the claim has crossed to the supplemental payer/insurer.
- Again, it is advised that you allow a minimum of 15 work days after Medicare payment has been issued before billing the supplemental payer/insurer to ensure that an automatic supplemental payment will not be issued. In addition, it is advised that you use the self-service tools of the supplemental payer/insurer to research the status of your supplemental claim prior to submitting it for supplemental payment.
- As a reminder, only the "official" Medicare remittance advice or HIPAA 835 electronic remittance advice should be used for supplemental billing purposes. CMS requests that copies of screen prints from any system that is used to access Medicare claim status not be submitted to a supplemental payer/insurer for billing purposes even if:

*Consolidation of the Claims Crossover Process (continued)*

- ♦ You are billing the supplemental payer/insurer after the 15 work days from the Medicare- issued payment have expired, and
- ♦ You have used the available self-service tools to research the status of your supplemental payment,

**Special Note for Physicians and Suppliers**

Currently, Part B carriers and DMERCs assign identification numbers (known as In-key or OCNA numbers) to Medigap insurers that do **not** participate in the automatic, or eligibility-file-based, crossover process.

**There are no current changes to this process and no current action is required of physicians, providers, and suppliers to change internal procedures related to Medigap claim-based crossovers.**

**Participating physicians and suppliers that bill Part B carriers and DMERCs for claim-based crossover will be informed approximately 90 days prior to implementing any changes to the claim based crossover process.** CMS expects this method of crossover to decrease sharply under the consolidated COBA crossover process, since most Medigap insurers will now have a single entity to which they can submit eligibility files to identify their covered members.

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

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

**Provider Types Affected**

All Medicare providers

**Provider Action Needed**

The Centers for Medicare & Medicaid Services (CMS) has begun a Medicare Disease Management Demonstration to improve care for chronically ill fee-for-service Medicare beneficiaries who suffer from advanced stage heart disease or diabetes. The Disease Management Organization, LifeMasters, is currently enrolling beneficiaries in Florida.

This Disease Management Organization is not an HMO, but is being paid, using the CMS Group Health System/ MMCS, to pay a fixed monthly payment for disease management services as an “OPTION 1” cost plan or as an “OPTION 4” plan, which will be a phase in over the next few months. “OPTION 4” means the same as “OPTION 1” but will reference “Chronic Care Organizations” and will also help to differentiate the demonstration enrollees from an HMO enrollee.

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

**LifeMasters = H5413 (plan number) in the Medicare systems**

**Related Instructions**

On April 9, 2004, CMS issued CR 3218 (Transmittal 138) to communicate the new implementation strategy for the COBA initiative. CR 3218 (Transmittal 138) may be viewed at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3218 in the CR NUM column on the right, and click on the file for that CR.

**Additional Information**

If you have any questions, please contact your 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: N/A

Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Article SE0504

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

**Background**

This population based demonstration is intended to evaluate how disease management services can improve the health outcomes of Medicare beneficiaries diagnosed with advanced-stage illness from congestive heart failure, diabetes, or coronary heart disease. Up to 30,000 eligible Medicare fee-for service beneficiaries will be enrolled in the treatment arm of the study during the three-year project in Florida.

The project will help Medicare:

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

The disease management participants will receive disease management services in addition to their usual Medicare benefits. All participants remain in the traditional

*Use of GHP Payment System for Medicare Disease Management Demonstration Serving FFS Beneficiaries (continued)*

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

**Demonstration Location**

**Florida** – LifeMasters will be providing services to 30,000 eligible Medicare beneficiaries with congestive heart failure, diabetes, and coronary heart disease in Florida. (Questions? Call 1-888-716-2838).

**Medicare Eligibility File Inquiry Screens**

When confirming eligibility of a beneficiary participating in the Medicare Disease Management Demonstration, Medicare systems screens will display a line item indicating enrollment in an “Option 1” HMO Cost Plan or an “Option

4” plan. The definition of Option 1 means that Medicare is still primary and fee-for-service benefits are covered; no referrals for care are needed. Claims continue to be processed by Medicare as primary under the traditional fee-for-service program. **Even though this demonstration is coded with an HMO plan number, the beneficiaries are not enrolled in an HMO.** Beneficiaries or providers calling to confirm Medicare eligibility should be informed that they/the patient are Medicare eligible and that they are fee-for-service beneficiaries, not enrolled in an HMO cost plan.

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

Source: CMS Special Edition Medlearn Article SE0519

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

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

**Note:** CMS has revised this article on March 10, 2005 to add “OPTION 4” as a code to help differentiate the demonstration enrollees from an HMO enrollee. This article was published in the [Fourth Quarter 2004 Medicare A Bulletin \(page 5\)](#).

**Provider Types Affected**

All Medicare providers

**Provider Action Needed**

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

These disease management organizations are not HMOs, but are being paid, using the CMS Group Health System/MMCS to pay a fixed monthly payment for disease management services as an “OPTION 1” cost plan or as an “OPTION 4”, which will be a phase in over the next few months. “OPTION 4” means the same as “OPTION 1” but will reference “Chronic Care Organizations.” “OPTION 1” and “OPTION 4” are used to help differentiate the demonstration enrollees from an HMO enrollee.

With the exception of how CMS is paying these private organizations, beneficiaries enrolled in these programs will be considered covered under the traditional Medicare FFS program for all other purposes.

Beneficiaries will only receive coordinated care/disease management services from these chronic care organizations and they are not restricted in any way on how they receive their other Medicare services. The organizations and their respective plan numbers are:

HeartPartners = SeniorCo identified as H5408 in the Medicare systems.

CorSolutions identified as H1902 in the Medicare systems.

XLHealth identified as H4519 in the Medicare systems.

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

**Background**

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

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

The project will help Medicare:

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

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

*Use of GHP Payment System for Medicare Disease Management Demonstration Serving FFS Beneficiaries (continued)*

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

**Demonstration Locations**

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

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

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

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**Medicare Eligibility File Inquiry Screens**

When confirming eligibility of a beneficiary participating in the Medicare Disease Management Demonstration, Medicare systems screens will display a line item indicating enrollment in an “Option 1” HMO Cost Plan. The definition of “Option 1” means that Medicare is still primary and fee-for-service benefits are covered; no referrals for care are needed. Claims continue to be processed by Medicare as primary under the traditional fee-for-service program. Even though these demonstrations are coded with an HMO plan number, the beneficiaries are not enrolled in an HMO. Beneficiaries or providers calling to confirm Medicare eligibility should be informed that they/the patient are Medicare eligible and that they are fee-for-service beneficiaries, not enrolled in an HMO cost plan.

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

Source: CMS Special Edition Medlearn Article SE0425

**Medicare Advantage Organizations for National Coverage Determination Services**

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

**Note:** CMS revised this article on April 22, 2005, to reflect that the correct effective date for the NCD on ventricular assist devices is October 1, 2003. This article was published in the [First Quarter 2005 Medicare A Bulletin \(page 20\)](#).

**Provider Types Affected**

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

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

Medicare Advantage (MA) rates were recently adjusted to account for three national coverage determination (NCD) services. These services are implantable automatic defibrillators (effective October 1, 2003), ventricular assist devices (effective October 1, 2003), and lung volume reduction surgery (effective January 1 2004). MA organizations are liable for payment for these NCD services beginning January 1, 2005.

**CAUTION – What You Need to Know**

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

**GO – What You Need to Do**

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

lung volume reduction surgery services must receive these services in designated hospitals.

**Background**

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

**Additional Information**

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

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

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

Source: Medlearn Matters Article MM3301

## Coordination of Benefits Agreement Detailed Error Report Notification Process

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

### Provider Types Affected

All physicians, providers, and suppliers billing Medicare fiscal intermediaries (FIs) and carriers

### Provider Action Needed

This instruction includes information contained in Change Request (CR) 3709 which directs Medicare contractors (carriers, intermediaries, and durable medical equipment regional carriers [DMERCs]) to issue special automated correspondence from their internal systems to physicians, providers, and suppliers informing them that claims that were expected to be crossed over to supplemental payers/insurers (as indicated on a previous remittance advice) were not crossed.

### Background

Through the national coordination of benefits agreement (COBA) process, Medicare will automatically cross claims over to a supplemental payer/insurer that may pay after Medicare has made its payment decision on the claim. There may be situations (such as claim errors related to HIPPA) that prevent Medicare from crossing a claim over to the supplemental payer/insurer.

In those situations where Medicare is unable to cross the claim, CR 3709 directs Medicare contractors to issue special automated correspondence to notify physicians, suppliers, and providers when claims previously selected for crossover by Medicare were subsequently unable to be crossed to the supplemental payer/insurer.

The correspondence sent to the physician, supplier, or provider will contain specific claim information, including the internal control number (ICN)/document control number (DCN), health insurance claim (HIC) number, medical record number (if the letter is from an intermediary and the claim was for Part A services), patient control number (if present on the claim), beneficiary name, date of service, and

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## AMBULANCE SERVICES

### Medical Review of Rural Air Ambulance Service

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

#### Provider Types Affected

Providers billing Medicare carriers or fiscal intermediaries (FIs) for rural air ambulance services

**Note:** CMS revised this article on February 2, 2005 to reflect that CR 3571 was re-issued on February 1, 2005. The CR release date and transmittal number have changed. The article and the related CR3571 were revised to show that the issue applies to rural air ambulance services billing Medicare carriers, as well as those billing Medicare fiscal intermediaries. All other information remains the same. This article was republished in the [Second Quarter 2005 Medicare A Bulletin](#) (pages 17-18).

the date the claim was processed. In addition, the letter will include the following message:

"The above claim(s) was/were not crossed over to the patient's supplemental insurer due to claim data errors."

Upon receipt of such correspondence, the physician, supplier, or provider is advised that the claim is not being crossed automatically and the provider may take appropriate action to obtain payment from the supplemental payer/insurer.

### Implementation

The implementation date for CR 3709 is July 5, 2005.

### Additional Information

Complete details of the COBA error notification process are included in the official instruction issued to your intermediary/carrier/DMERC. That instruction may be viewed at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3709 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/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: 3709

Related CR Release Date: February 11, 2005

Related CR Transmittal Number: 474

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 474, CR 3709



*Medical Review of Rural Air Ambulance Service (continued)***Provider Action Needed****STOP – Impact to You**

Providers of rural air ambulance services should note that Section 415 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 includes new instructions regarding rural air ambulance services.

**CAUTION – What You Need to Know**

The Centers for Medicare & Medicaid Services (CMS) has revised Chapter 6 “Intermediary MR Guidelines for Specific Services” of the Medicare Program Integrity Manual to include Section 6.4 – Medical Review of Rural Ambulance Services.

**GO – What You Need to Do**

Be sure to understand these new rules surrounding billing for and medical review of rural air ambulance services as a result of changes in the MMA.

**Background**

This article provides information on Medicare’s implementation of Section 415 of the MMA, which amends the Social Security Act (SSA) (Section 1834(l)) to provide appropriate coverage of rural air ambulance services. A summary of these changes include:

**Reasonable Requests**

When performing a medical review of rural air ambulance claims, your fiscal intermediary/carrier must determine if a physician or other qualified medical personnel who reasonably determined or certified that the individual’s condition required air transport due to time or geographical factors requested the transport. Medicare considers the following to be qualified personnel to order air ambulance services:

- Physician
- Registered nurse practitioner (from the transferring hospital)
- Physician’s assistant (from the transferring hospital)
- Paramedic or emergency medical technician (EMT) (at the scene)
- Trained first responder (at the scene)

**Emergency Medical Services (EMS) Protocols**

Please note that the reasonable and necessary requirement for rural air transport can be “deemed” to be met when service is provided pursuant to an established state or regional protocol that has been recognized or approved by the Secretary of the Department of Health and Human Services, which administers Medicare through its Centers for Medicare & Medicaid Services.

Air ambulance providers anticipating transports will be made pursuant to such a state or regional protocol must submit the written protocol to their FI/carrier in advance for review and approval. Your Medicare intermediary/carrier will post instructions for submission of the protocol on its website.

Your Medicare intermediary/carrier must review the protocol to ensure the contents are consistent with the statutory requirements of 1862(l)(A) directing that all services paid for by Medicare must be reasonable and

necessary for the diagnosis or treatment of an illness or injury. The intermediary/carrier will notify you of its protocol review determinations within 30 days of receipt of the protocol.

**Remember:** You must adhere to all requirements in the Act at 1861 (s) (7) and regulatory requirements at 42CFR 424.10 which directs that all services paid by Medicare must be reasonable and necessary including the requirement that payment can be made only to the closest facility capable of providing the care needed by the beneficiary.

**Prohibited Air Ambulance Relationships**

Your intermediary/carrier will not apply the “deemed” reasonable and necessary determination in the following cases:

- If there is a financial or employment relationship between the person requesting the air ambulance service and the entity furnishing the service;
- If an entity is under common ownership with the entity furnishing the service; or
- If there is a financial relationship between an immediate family member of the person requesting the service and the entity furnishing the service.

The only exception to this provision occurs when the referring hospital and the entity furnishing the air ambulance service are under common ownership. Then the above limitation does not apply to remuneration by the hospital for provider based physician services furnished in a hospital reimbursed under Part A and the amount of the remuneration is unrelated directly or indirectly to the provision of rural air ambulance services.

**Reasonable and Necessary Services**

Medicare intermediaries and carriers may perform medical review of rural air ambulance claims with “deemed” medical necessity status when there are questions as to whether:

- the decision to transport was reasonably made;
- the transport was made pursuant to an approved protocol; or
- the transport was inconsistent with an approved protocol.

In addition, the intermediary/carrier may conduct a medical review in those instances where there is a financial or employment relationship between the person requesting the air ambulance transport and the person providing the transport.

**Additional Information**

For purposes of these revised sections of the Medicare Program Integrity Manual, the term “rural air ambulance service” means fixed wing and rotary wing air ambulance services in which the point of pick up of the individual occurs in a rural area (as defined in Section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the

**Medical Review of Rural Air Ambulance Service (continued)**

Goldsmith Modification published in the *Federal Register* on February 27, 1992 (57 Fed. Reg. 6725).

The official instruction issued to your intermediary/carrier regarding this change, including the revised portion of Chapter 6 of the Medicare Program Integrity Manual may be found at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3571 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>.

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

Related Change Request (CR) Number: 3571

Related CR Release Date: February 1, 2005

Related CR Transmittal Number: 102

Effective Date: January 1, 2005

Implementation Date: February 14, 2005

Source: CMS Pub. 100-8, Transmittal 102, CR 3571

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## Submission of Rural Air Ambulance Service Protocol for Contractor Review

According to Section 415 of the Medicare Modernization Act of 2003, the reasonable and necessary requirement for rural air ambulance transport may be “deemed” to be met when the service is provided pursuant to an established state or regional emergency medical services (EMS) agency protocol. The protocol must be recognized or approved by the Secretary of the Department of Health and Human Services, which administers Medicare through the Centers for Medicare & Medicaid Services (CMS).

CMS defines “established” to mean those protocols that have been reviewed and approved by the state EMS agencies or have been developed according to state EMS umbrella guidelines. Submission of protocols for review and subsequent approval will “deem” that the reasonable and necessary requirement for rural air ambulance transport has been met by the provider.

Providers that anticipate rural air ambulance transports pursuant to such a protocol may submit their written protocol to their fiscal intermediary for review and approval in advance. Providers may submit protocols for review as follow:

**By e-mail:** [medicalpolicy@fcso.com](mailto:medicalpolicy@fcso.com)

Please include **Air Ambulance Protocol** in the subject line.

**By USPS:** First Coast Service Options, Inc  
Medical Policy and Procedures ROC 19T  
ATTN: Juanita R. Mitchell, RN  
P.O. Box 2078  
Jacksonville, FL 32231-0048

**By FAX:** 1-904-997-5665

Providers will be notified of all protocol review decisions in writing within 30 days of receipt by FCSO.

**Please include a contact name, telephone number and address with your submissions. Review decisions will be mailed to this address.**

CMS has issued a “Medlearn Matters...Information for Providers” article pertaining to this requirement, which may be viewed at: <http://www.cms.hhs.gov/medlearn/matters/marticles/2005/MM3571.pdf>.

If additional information is needed, you may contact Juanita R. Mitchell, RN via e-mail at [Juanita.Mitchell@fcso.com](mailto:Juanita.Mitchell@fcso.com) or by telephone at 1-904-791-8015.

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## Billing Edits for Ambulance Transports to or from a Diagnostic or Therapeutic Site

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

Full replacement of change request 3427, transmittal 342, issued on October 29, 2004 – Change to the common working file skilled nursing facility consolidated billing edits. The original article addressing billing for ambulance transports to or from a diagnostic or therapeutic site was published in the Second Quarter 2005 *Medicare A Bulletin* (pages 55-56).

### Provider Types Affected

Providers and suppliers billing Medicare fiscal intermediaries (FIs) for ambulance transports of Medicare patients in a covered Part A SNF stay

### Provider Action Needed STOP – Impact to You

CR 3676 replaces CR 3427, which is rescinded. This change in the business requirement language of CR 3427 could impact your reimbursement.

### CAUTION – What You Need to Know

Related CR 3676 provides a correction to the business requirements in CR 3427 (Transmittal 342), which was issued on October 29, 2004. The language in the business requirements of CR 3427 incorrectly required the rejection of **claims** containing revenue code 054x, in addition to an origin/destination modifier of “ND” or “DN,” when the beneficiary is in a covered Part A SNF stay. CR 3676 revises this business requirement language to require the rejection of only **line items** that contain these codes and modifiers.

**Billing Edits for Ambulance Transports to or from a Diagnostic or Therapeutic Site (continued)**

Be aware, however, that the manual section for CR 3427, Transmittal 342, is still in effect, and all other information in the CR remains the same.

**GO – What You Need to Do**

Make sure that your billing staffs are aware of this correction in the business requirements in CR 3427, and prepare your bills accordingly. Additionally, you should review the background material in this article to refresh your knowledge about payment for ambulance services for beneficiaries in Part A SNF stays.

**Background**

CR 3427, Transmittal 342, issued on October 29, 2004, incorrectly stated the requirement to reject **claims containing revenue code 054x, in addition to an origin/destination modifier of “ND” (SNF/Diagnostic site or therapeutic site other than P or H) or “DN” (Diagnostic or therapeutic site other than P or H/SNF) when the beneficiary is in a covered Part A SNF stay.** The Centers for Medicare & Medicaid Services (CMS) is modifying that requirement to reject only line items (not claims) containing revenue code 054x, in addition to an origin/destination modifier of “ND” or “DN,” when the beneficiary is in a covered Part A SNF stay. All other information remains the same.

As further background, we would remind the reader that Section 4432(b) of the Balanced Budget Act (BBA) requires consolidated billing (CB) for SNFs. Under CB requirements, except for certain excluded services, the SNF must submit to the Medicare intermediary, under Part A, all Medicare claims for all the services its residents receive. Further, the SNF must submit, under inpatient Part B, Medicare claims for all physical and occupational therapies, and speech-language pathology services its residents receive. Finally, all Medicare-covered Part A services that are deemed to be within a SNF’s scope or capability are considered paid in the SNF prospective payment system (PPS) rate.

Except for specific exclusions, SNF CB includes those medically necessary ambulance trips that are furnished during the course of a covered Part A stay, including those to and from independent diagnostic testing facilities (IDTFs).

Specifically, ambulance transports to or from an IDTF are considered paid in the SNF PPS rate when the beneficiary is in a covered Part A stay and may **not** be paid separately as Part B services. The ambulance transport is included in the SNF PPS rate if the first or second character (origin or destination) of any HCPCS code ambulance modifier is “D” (Diagnostic or therapeutic site other than P or H), and the other modifier (origin or destination) is “N” (SNF). The “D” origin/destination modifier includes cancer treatment centers, wound care centers, radiation therapy centers, and all other diagnostic or therapeutic sites. In these instances, SNFs are responsible for the costs of the transport.

**Note, however, that ambulance transports to and from renal dialysis facilities for the purpose of receiving dialysis are excluded from SNF CB. In these cases, the first or second character (origin or destination) of any HCPCS code ambulance modifier is a “G” (hospital-based ESRD facility) or “J” (freestanding ESRD facility), and the other modifier (origin or destination) is “N” (SNF). SNFs are not responsible for the costs of these transports.**

Further, effective for claims with dates of service on or after October 1, 2004, CR 3196 included that new edits be installed in the Medicare’s systems to deny Part B ambulance claims that meet the above criteria when billed to the carrier by ambulance suppliers. Effective for claims with dates of service on or after April 1, 2005, the same edits apply to ambulance service line items billed to the FI by institutional providers.

**This change does not replace existing CB policies as they relate to critical access hospitals and ESRD facilities.**

Under this instruction, when Medicare denies a claim for services that are covered under SNF CB, your intermediary will reflect reason code 97, “Payment is included in the allowance for another service/procedure” on the remittance advice; and remittance advice remark code N106, “Payment for services furnished to skilled nursing facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.”

**Implementation**

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

**Additional Information**

Updated manual instructions are 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](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3676 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.

Medlearn Matters Number: MM3676  
Related CR Release Date: February 4, 2005  
Related CR Transmittal Number: 459  
Effective Date: April 1, 2005  
Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 459, CR 3676

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# GENERAL COVERAGE

## Diabetes Screening Tests

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

**Note:** CMS revised this article on January 24, 2005 to reflect a new release date and transmittal number for CR 3637. CR 3637 was re-issued on January 21, 2005. The article was also revised to show that type of bill 12x will also be paid in accordance with the clinical laboratory fee schedule when these services are billed on that claim type. This article was published in the [January 2005 Medicare A Bulletin Special Issue \(pages 27-28\)](#).

### Provider Types Affected

All Medicare providers billing fiscal intermediaries or carriers for diabetes screening tests

### Provider Action Needed

#### STOP – Impact to You

This article notifies providers that Medicare permits coverage for the following diabetes screening tests for services provided 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.

#### 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/m<sup>2</sup>)

- 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/m<sup>2</sup>)
- 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 12x, 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 Noncovered 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 noncovered.

#### Implementation

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

*Diabetes Screening Tests (continued)***Related Instructions**

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

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

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

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

Related Change Request (CR) Number: 3637

Related CR Release Date: Reissued on January 21, 2005

Related CR Transmittal Number: 446

Effective Date: January 1, 2005

Implementation Date: January 3, 2005

Source: CMS Pub. 100-4 Transmittal 446, CR 3637,

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## Diabetes Screening Tests—Further Guidance and Clarification

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

**Provider Types Affected**

All Medicare providers billing Medicare carriers or fiscal intermediaries for diabetes screening tests for Medicare patients

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

This article provides further guidance and clarification of new Medicare coverage rules for diabetes screening tests performed on or after January 1, 2005.

**CAUTION – What You Need to Know**

The amount of testing covered by Medicare for qualified individuals is changed to one screening test every six months for individuals diagnosed with pre-diabetes and one screening test every twelve months for individuals not diagnosed with pre-diabetes or who were never tested before.

**GO – What You Need to Do**

Please refer to the Background and Additional Information sections of this article 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 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 article and related CR 3677 clarify that, for individuals diagnosed with pre-diabetes, the two screening tests per year are further limited to one screening test every six months. And, providers should note that these tests for individuals with a pre-diabetes diagnosis must be billed with diagnosis code V77.1 and modifier “TS” to reflect follow-up service.

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

- Hypertension
- Dyslipidemia
- Obesity (with a body mass index greater than or equal to 30 kg/m<sup>2</sup>), or

- Previous identification of elevated impaired fasting glucose or glucose intolerance.

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

- Overweight (a body mass index >25, but <30kg/m<sup>2</sup>)
- A family history of diabetes
- Age 65 years or older
- A history of gestational diabetes mellitus or giving birth to a baby weighing > 9 lbs.

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. The following Health Care Common Procedure Coding System (HCPCS) codes for diabetes screening are to be billed for diabetes screening:

- 82947 Glucose, quantitative, blood (except reagent strip)
- 82950 Post-glucose dose (includes glucose)
- 82951 Glucose tolerance test (GTT), three specimens (includes glucose)

Providers submitting pre-diabetes and diabetes screening claims should note that claims must contain the appropriate HCPCS codes listed above along with diagnosis code V77.1.

No coverage is permitted under the MMA benefit for individuals previously diagnosed as diabetic since these individuals do not require screening. Other diabetes screening blood tests for which the Centers for Medicare & Medicaid Services (CMS) has not specifically indicated national coverage continue to be noncovered.

CMS also provides the following definitions for the purpose of this article:

**Diabetes:** diabetes mellitus, a condition of abnormal glucose metabolism diagnosed from a fasting blood sugar > 126 mg/dL on two different occasions; a two-hour post-glucose challenge > 200 mg/dL on two different occasions; or a random glucose test > 200 mg/dL for an individual with symptoms of uncontrolled diabetes.

**Diabetes Screening Tests—Further Guidance and Clarification (continued)**

**Pre-diabetes:** abnormal glucose metabolism diagnosed from a previous fasting glucose level of 100 to 125 mg/dL, or a two-hour post-glucose challenge of 140 to 199 mg/dL. The term “pre-diabetes” includes impaired fasting glucose and impaired glucose tolerance.

**Post-glucose challenge test:** an oral glucose tolerance test with a glucose challenge of 75 gms. of glucose for non-pregnant adults, or a two-hour post-glucose challenge test alone.

**Implementation**

The implementation date for this article is April 4, 2005. It applies to services furnished on or after January 1, 2005.

**Additional Information**

Official manual instructions are issued to your fiscal intermediary or carrier may be found at:

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

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From that Web page, look for CR 3677 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, 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: 3677

Related CR Release Date: January 28, 2005

Related CR Transmittal Number: 457

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 457, CR 3677

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

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

**Provider Types Affected**

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

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

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

**CAUTION – What You Need to Know**

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

**GO – What You Need to Do**

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

**Background**

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

Effective for services performed on or after December 17, 2004, in addition to meeting criterion A or B, the beneficiary with diabetes must be insulinopenic per the

fasting C-peptide testing requirement or, as an alternative must be beta cell autoantibody positive. Insulinopenia is defined as a fasting C-peptide level that is less than or equal to 110 percent of the lower limit of normal of the laboratory’s measurement method. For patients with renal insufficiency and a creatinine clearance (actual or calculated from age, gender, weight, and serum creatinine) < 50 ml/minute, insulinopenia is defined as a fasting C-peptide level that is less than or equal to 200 percent of the lower limit of normal of the laboratory’s measurement method. CMS establishes that fasting C-peptide levels will only be considered valid when a concurrently obtained fasting glucose is < 225 mg/dL.

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

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

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

**Additional Information**

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

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

*C-Peptide Levels as a Criterion for Use with Infusion Pumps (continued)*

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

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

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Related Change Request (CR) Number: 3705  
 Related CR Release Date: March 30, 2005  
 Related CR Transmittal Number: 27 and 513  
 Effective Date: December 17, 2005  
 Implementation Date: February 18, 2005

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

## Anti-Cancer Chemotherapy for Colorectal Cancer

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

### Provider Types Affected

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

### Provider Action Needed

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

This national coverage decision does not:

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

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

### Background

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

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

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

- They are used in accordance with Food and Drug Administration (FDA)-approved labeling;
- Their use is supported in one of the authoritative drug compendia; or

- The Medicare contractor (carriers, FIs or DMERCs) determines an off-label use is medically accepted based on guidance provided by Secretary of DHHS.

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

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

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

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

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

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

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

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

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

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

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

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

- FIs will accept claims for these drugs on types of bill (TOB) 11x, 12x, 13x, 18x, 21x, 22x, 23x, and 85x. Revenue code 0636 should be used.
- When billing carriers, DMERCs and FIs, on a claim other than an inpatient claim, include modifier **QR** to show the drug was furnished during a clinical trial.
- Claims submitted to FIs should also contain an ICD-9-CM diagnosis code of V70.7 in the second diagnosis code position to show that the claim involves a clinical trial.
- When using modifier **QR**, also be sure to include a HCPCS code of J9035, J9055, J9206, J9263, J8520, J8521, J9190, or J9201, as appropriate for the anti-cancer drug being billed.
- Providers are also to include modifier **QR** when billing for nonroutine costs associated with these clinical trials.
- DMERCs will accept claims with HCPCS codes of J8520 and J8521 as clinical trial codes for **oral anticancer** drugs, when accompanied by modifier **QR** to show use in a clinical trial.

- When billing for covered routine costs associated with clinical trials as described in section 310 of the NCD Manual, be sure to include modifier **QV** on the claim.
- Submit an appropriate cancer diagnosis code for the clinical trial on the claim.

**Note:** While this NCD is effective as of January 28, 2005, Medicare systems will be unable to process claims containing modifier **QR** received before April 1, 2005. For that reason, do not send in claims for drugs or other nonroutine services covered under this NCD until April 1, 2005.

Do not hold claims for nonroutine services containing modifier **QV** associated with this NCD.

### Additional Information

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

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

You should see two versions of CR 3742 on this website. The version of CR 3742 with a transmittal number of R30NCD will contain the NCD information and the version with a transmittal number of R512CP will contain the Medicare claims processing instructions.

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

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

Related Change Request (CR) Number: 3742  
 Related CR Release Date: March 29, 2005  
 Related CR Transmittal Number: 30 and 512  
 Effective Date: January 28, 2005  
 Implementation Date: April 18, 2005

Source: CMS Pub. 100-4, Transmittal 512, CR 3742,

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## Expanded Coverage and Billing Requirements for PET Scans for Cervical and Other Cancers

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

### Provider Types Affected

Physicians, providers, and suppliers billing Medicare carriers and fiscal intermediaries for the subject PET scans

### Provider Action Needed

CR 3741, as summarized by this instruction, changes the national coverage for the use of 2-[F-18] fluoro-D-glucose positron emission tomography (FDG-PET) scans for certain cancer indications.

Effective for services performed on or after January 28, 2005, the Centers for Medicare & Medicaid Services (CMS) expands national coverage of FDG-PET to include:

- Specific indications in patients with cervical cancer.
- Indications not previously specified in **five** other cancer diagnoses; brain, ovarian, pancreatic, small cell lung, and testicular (**but only when you and your patients are participating in specifically defined prospective clinical studies/trials**).
- Monitoring response to treatment when a change in therapy is indicated in a number of cancers that are already covered for diagnosis, staging, and restaging.
- A broad range of other cancers not previously specified (**but only when you and your patients are participating in specifically defined prospective clinical studies/trials**).

**Note:** For the coverage of specific indications, see table 1.

### Background

Positron emission tomography (PET) is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems. In this procedure, a positron camera produces cross-sectional tomographic images obtained from intravenous positron emitting radioactive tracer substances (radiopharmaceuticals), such as 2-[F-18] fluoro-D-glucose (FDG). In general, FDG PET is covered in the following clinical situations:

#### Diagnosis

When the results may help avoid an invasive diagnostic procedure, or help determine the best anatomic location for an invasive diagnostic procedure.

#### Staging

When a cancer’s stage remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound); when using PET could potentially replace one or more conventional imaging studies if it is expected that conventional study information is not sufficient for the patient’s clinical management, and when the patient’s clinical management would differ depending on the cancer’s stage.

#### Restaging

After the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or metastasis, to determine the extent of a known recurrence, or if it could potentially replace one or more

conventional imaging studies when it is expected that conventional study information is not adequate to determine the extent of a known recurrence, or if study information is not sufficient for the patient’s clinical management. Restaging applies to testing after a course of treatment is completed and is covered subject to the above conditions.

### Monitoring

Monitoring refers to evaluating tumor response to treatment during the planned course of therapy (i.e., when a change in therapy is anticipated).

CR 3741 expands the FDG PET national coverage policy (by revisions to the National Coverage Determinations (NCD) Manual – CMS Publication (Pub.) 100-03 and the Medicare Claims Processing Manual – CMS Pub. 100-04) by providing general Medicare coverage and billing requirements for FDG PET usage for brain, cervical, ovarian, pancreatic, small cell lung, testicular, and other cancer indications both previously specified and not previously specified.

In newly diagnosed and locally advanced cervical cancer (after negative conventional imaging for extrapelvic metastasis) CMS determines that the evidence is adequate to conclude that FDG PET to detect pretreatment metastases (staging) is reasonable and necessary as an adjunct test.

In addition, for brain, ovarian, pancreatic, small cell lung, and testicular cancers, CMS determines that the evidence is sufficient to conclude that FDG PET is reasonable and necessary only when the provider is participating in, and patients are enrolled in, one of the following types of prospective clinical studies:

- A clinical trial of FDG PET that meets the requirements of the Food and Drug Administration (FDA) category B investigational device exemption (42 CFR 405.201); or
- A FDG PET clinical study that is designed to collect additional information at the time of the scan to assist in patient management. Qualifying clinical studies must ensure that specific hypotheses are addressed; appropriate data elements are collected; hospitals and providers are qualified to provide the PET scan and interpret the results; participating hospitals and providers accurately report data on all enrolled patients not included in other qualifying trials through adequate auditing mechanisms; and, all patient confidentiality, privacy, and other federal laws must be followed.

In addition, coverage is also expanded under clinical studies (as defined above) for certain indications of brain, cervical, colorectal, esophageal, head and neck, lymphoma, melanoma, non-small cell lung, ovarian, pancreatic, small-cell lung, soft tissue sarcoma, thyroid, testicular, and other cancers not previously identified. Monitoring response to treatment when a change in therapy is indicated is now covered in a number of cancers (cervical, colorectal, esophageal, head and neck, lymphoma, melanoma, non-small cell lung, and thyroid) only in the context of a clinical study. Lastly, this guidance expands coverage in the context of a clinical study for a broad range of other cancers not previously specified. The following table has these changes.

## GENERAL COVERAGE

### Expanded Coverage and Billing Requirements for PET Scans for Cervical and Other Cancers (continued)

#### Coverage of FDG PET for Cancer Indications – Effective January 28, 2005

Indication	Covered <sup>1</sup>	Nationally Noncovered <sup>2</sup>	Coverage with Evidence Development <sup>3</sup>
Brain			X
Breast -Diagnosis -Initial staging of axillary nodes -Staging of distant metastasis -Restaging, monitoring *	X X	X X	
Cervical -Staging as adjunct to conventional imaging -Other staging -Diagnosis, restaging, monitoring *	X		X X
Colorectal -Diagnosis, staging, restaging -Monitoring *	X		X
Esophagus -Diagnosis, staging, restaging -Monitoring *	X		X
Head and Neck (non-CNS/thyroid) -Diagnosis, staging, restaging -Monitoring *	X		X
Lymphoma -Diagnosis, staging, restaging -Monitoring *	X		X
Melanoma -Diagnosis, staging, restaging -Monitoring *	X		X
Non-Small Cell Lung -Diagnosis, staging, restaging -Monitoring *	X		X
Ovarian			X
Pancreatic			X
Small Cell Lung			X
Soft Tissue Sarcoma			X
Solitary Pulmonary Nodule (characterization)	X		
Thyroid -Staging of follicular cell tumors -Restaging of medullary cell tumors -Diagnosis, other staging & restaging -Monitoring *	X		X X X
Testicular			X
All other cancers not listed herein (all indications)			X

<sup>1</sup> Covered nationally based on evidence of benefit. Refer to National Coverage Determination Manual Section 220.6 in its entirety for specific coverage language and limitations for each indication.

<sup>2</sup> Noncovered nationally based on evidence of harm or no benefit

<sup>3</sup> Covered only in specific settings discussed above if certain patient safeguards are provided. Otherwise, noncovered nationally based on lack of evidence sufficient to establish either benefit or harm or no prior decision addressing this cancer. Medicare will notify providers and beneficiaries where these services can be accessed, as they become available, via *Federal Register Notice* and the CMS coverage website at: <http://www.cms.hhs.gov/coverage>.

\* **Monitoring = monitoring response to treatment when a change in therapy is anticipated.**

A quick review of the term national coverage determination (NCD) would be helpful at this point. NCDs grant, limit, or exclude Medicare coverage for a specific medical item/service. They apply nationwide and are binding on all Medicare carriers, FIs, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans for purposes of Medicare coverage. Moreover, an administrative law judge may not review an NCD.

Here are some specific details about the NCD issued as part of CR 3741 of which you should be aware:

**Expanded Coverage and Billing Requirements for PET Scans for Cervical and Other Cancers (continued)**

- A particular use of FDG PET scans is not covered unless the NCD Manual specifically provides coverage of that use.
- All currently noncovered FDG PET indications based on lack of evidence or benefit remain in effect (i.e., HCPCS G0219 and G0252 remain in effect as non-covered PET indications).
- For all other currently noncovered FDG PET indications (not based on lack of evidence or benefit), Medicare will cover FDG PET scans meeting the clinical study/trial criteria outlined in this NCD.
- Effective for claims with dates of service on or after January 28, 2005, all HCPCS codes listed in Table 2 (below) will be used for all covered PET scan indications specified, and those listed in Table 3 (below) will become invalid. Additionally, a new HCPCS code (G0235 – PET not otherwise specified) has been added for noncoverage of PET scan indications not otherwise specified.

**Note:** While G0336 for coverage of PET scans for dementia and neurodegenerative diseases will be replaced with a CPT code for services on or after January 28, 2005, all other limiting conditions and indications for coverage apply. Refer to the National Coverage Determinations Manual, section 220.6.13, for complete coverage conditions for PET scans for dementia and neurodegenerative diseases.

**CPT Codes for Covered PET Scan Indications – Effective for dates of service on or after January 28, 2005**

<b>CPT Code</b>	<b>Description</b>
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation
78491	Myocardial imaging, positron emission tomography (PET), perfusion, single study at rest or stress
78492	Myocardial imaging, positron emission tomography (PET), perfusion, multiple studies at rest and/or stress
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation
78811	Tumor imaging, positron emission tomography (PET); limited area (eg, chest, head/neck)
78812	Tumor imaging, positron emission tomography (PET); base to mid thigh
78813	Tumor imaging, positron emission tomography (PET); whole body
78814	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (eg chest, head/neck)

- 78815 Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid thigh
- 78816 Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body

**HCPCS Codes Not Valid for Medicare for Dates of Service on or after January 28, 2005**

G0030	G0031	G0032	G0033	G0034	G0035
G0036	G0037	G0038	G0039	G0040	G0041
G0042	G0043	G0044	G0045	G0046	G0047
G0125	G0210	G0211	G0212	G0213	G0214
G0215	G0216	G0217	G0218*	G0220	G0221
G0222	G0336	G0223	G0224	G0225	G0226
G0227	G0228	G0229	G0230	G0231	G0232
G0233	G0234	G0253	G0254	G0296	G0296

\* Please note brake in sequence

**Additional Information**

**CMS reminds providers to issue advanced beneficiary notices (ABNs) to Medicare patients advising them of potential financial liability if all specified conditions for coverage of PET are not met.**

You may find more information about the billing requirements for FDG PET scans for brain, cervical, ovarian, pancreatic, small cell lung, soft tissue sarcoma, testicular, and all other cancer Indications by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3741 in the CR NUM column on the right, and click on the file for that CR.

Please note that there will be two transmittals with CR 3741, one for the NCD issuance itself and the other for the changes to Medicare claims processing as a result of the NCD. The revised portion of the NCD Manual will be attached to CR 3741, transmittal number 31. The billing/claim processing changes to the Medicare Claims Processing Manual will be attached to CR 3741, transmittal number 518.

Finally, if you have 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: 3741  
 Related CR Release Date: April 1, 2005  
 Related CR Transmittal Number: 31 and 527  
 Effective Date: January 28, 2005  
 Implementation Date: April 18, 2005

Source: CMS Pub. 100-4, Transmittal 527, CR 3741  
 CMS Pub. 100-3, Transmittal 31, CR 3741

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## Positron Emission Tomography Scans for Dementia and Neurodegenerative Diseases

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

**Note:** This article was revised on April 22, 2005, to show that Change Request (CR) 3426 was revised by CR 3640 (Transmittal 428, dated January 14, 2005). CR 3640 revised billing requirements in CR 3426 for positron emission tomography (PET) scans for Alzheimer’s Disease (AD) by 1) removing the edit for one scan per beneficiary’s lifetime for PET AD scans, and 2) adding requirements for specifying ICD-9-CM diagnosis coding. In addition, Section 60.1 of the Medicare Claims Processing Manual (Pub. 100-04) was updated to include specific payment information for claims for all PET scans for services submitted by critical access hospitals (CAHs). To see CR 3640, go to the following CMS website: [http://www.cms.hhs.gov/manuals/pm\\_trans/R428CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R428CP.pdf).

Also, the Medlearn Matters article related to CR 3640 is located at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3640.pdf>.

The article related to CR 3640 was published in the [Second Quarter 2005 Medicare A Bulletin \(page 22\)](#).

The article related to CR 3426 was published in the [First Quarter 2005 Medicare A Bulletin \(pages 23-24\)](#).

### Provider Types Affected

Physicians and providers

### Provider Action Needed

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

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

### Background

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

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

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

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

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

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

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

Key portions of these revised manuals are as follows:

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

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

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

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

- a. The patient’s onset, clinical presentation, or course of cognitive impairment is such that FTD is suspected as an alternative neurodegenerative cause of the cognitive decline. Specifically, symptoms such as social disinhibition, awkwardness, difficulties with language, or loss of executive function are more prominent early in the course of FTD than the memory loss typical of AD.
- b. The patient has had a comprehensive clinical evaluation (as defined by the American Academy of Neurology) encompassing a medical history from the patient and a well-acquainted informant (including assessment of activities of daily living), physical and mental status examination (including formal documentation of cognitive decline occurring over at least six months) aided by cognitive scales or neuropsychological testing, laboratory tests, and structural imaging such as magnetic resonance imaging (MRI) or computed tomography (CT).

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

- c. The evaluation of the patient has been conducted by a physician experienced in the diagnosis and assessment of dementia.
- d. The evaluation of the patient did not clearly determine a specific neurodegenerative disease or other cause for the clinical symptoms, and information available through FDG-PET is reasonably expected to help clarify the diagnosis between FTD and AD and help guide future treatment.
- e. The FDG-PET scan is performed in a facility that has all the accreditation necessary to operate nuclear medicine equipment. The reading of the scan should be done by an expert in nuclear medicine, radiology, neurology, or psychiatry, with experience interpreting such scans in the presence of dementia
- f. A brain single photon emission computed tomography (SPECT) or FDG-PET scan has not been obtained for the same indication. The indication can be considered to be different in patients who exhibit important changes in scope or severity of cognitive decline, and meet all other qualifying criteria listed above and below (including the judgment that the likely diagnosis remains uncertain). The results of a prior SPECT or FDG-PET scan must have been inconclusive or, in the case of SPECT, difficult to interpret due to immature or inadequate technology. In these instances, an FDG-PET scan may be covered after one year has passed from the time the first SPECT or FDG-PET scan was performed.
- g. The referring and billing provider(s) have documented the appropriate evaluation of the Medicare beneficiary. Providers should establish the medical necessity of an FDG-PET scan by ensuring that the following information has been collected and is maintained in the beneficiary medical record:
  - Date of onset of symptoms
  - Diagnosis of clinical syndrome (normal aging; mild cognitive impairment or MCI; mild, moderate or severe dementia)
  - Mini mental status exam (MMSE) or similar test score
  - Presumptive cause (possible, probable, uncertain AD)
  - Any neuropsychological testing performed
  - Results of any structural imaging (MRI or CT) performed
  - Relevant laboratory tests (B12, thyroid hormone)
  - Number and name of prescribed medications.
  - The billing provider must furnish a copy of the FDG-PET scan result for use by CMS and its contractors upon request.

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

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

With regard to use of the FDG-PET in the context of a CMS-approved clinical trial, the clinical trial must compare patients who do and those who do not receive an FDG-PET scan and have as its goal to monitor, evaluate, and improve

clinical outcomes. In addition, it must meet the following basic criteria:

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

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

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

Once the clinical trial facilities have been identified, a list of the participating facilities will be available on CMS website at: <http://www.cms.hhs.gov/coverage>.

**Implementation**

Implementation date for this instruction is October 4, 2004.

**Additional Information**

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

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

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

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

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

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

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

**New Contrast Agents Healthcare Common Procedure Coding System Codes**

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

**Provider Types Affected**

All providers, suppliers and physicians billing Medicare fiscal intermediaries (FIs) or carriers for contrast agents

**Provider Action Needed**

**STOP – Impact to You**

As of April 1, 2005, you must use the new “Q” codes that will be added to the HCPCS when you bill for contrast agents

**CAUTION – What You Need to Know**

Beginning on April 1, 2005, the new HCPCS codes for contrast agents will become effective, **except for hospital outpatient departments, which should continue to use the current “A” codes.**

**GO – What You Need to Do**

Physicians, suppliers, and providers should make sure your billing staff knows that they must use the new codes that have been added to the Healthcare Common Procedure Coding System as of **April 1, 2005** in order to bill for contrast agents.

**Background**

**Effective April 1, 2005**, the HCPCS codes for contrast agents in the following table will be added to the HCPCS.

HCPCS Code	Short Descriptor	Long Descriptor
Q9945	LOCM <=149 mg/ml iodine, 1ml	Low osmolar contrast material, up to 149 mg/ml iodine concentration, per ml
Q9946	LOCM 150-199mg/ml iodine, 1 ml	Low osmolar contrast material, 150 - 199 mg/ml iodine concentration, per ml
Q9947	LOCM 200-249mg/ml iodine, 1 ml	Low osmolar contrast material, 200 - 249 mg/ml iodine concentration, per ml
Q9948	LOCM 250-299mg/ml iodine, 1 ml	Low osmolar contrast material, 250 - 299 mg/ml iodine concentration, per ml
Q9949	LOCM 300-349mg/ml iodine, 1 ml	Low osmolar contrast material, 300 - 349 mg/ml iodine concentration, per ml
Q9950	LOCM 350-399mg/ml iodine, 1 ml	Low osmolar contrast material, 350 - 399 mg/ml iodine concentration, per ml
Q9951	LOCM >= 400 mg/ml iodine, 1 ml	Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml
Q9952	Inj Gad-base MR contrast, ml	Injection, gadolinium-based magnetic resonance contrast agent, per ml
Q9953	Inj Fe-based MR contrast, ml	Injection, iron-based magnetic resonance contrast agent, per ml
Q9954	Oral MR contrast, 100 ml	Oral magnetic resonance contrast agent, per 100 ml
Q9955	Inj perflexane lip micros, ml	Injection, perflexane lipid microspheres, per ml
Q9956	Inj octafluoropropane mic, ml	Injection, octafluoropropane microspheres, per ml
Q9957	Inj perflutren lip micros, ml	Injection, perflutren lipid microspheres, per ml

To view payments for these new Q-codes, go to: <http://www.cms.hhs.gov/providers/drugs/default.asp> on the CMS website and look in the respective quarterly Medicare Part B drug pricing files posted there. In accordance with the standard methodology for drug pricing established by the Medicare Modernization Act of 2003 (MMA), the payment for these contrast agents will be based on the average sales price (ASP) plus six percent effective April 1, 2005.

**Implementation**

This change will be implemented in Medicare claims processing systems on April 4, 2005.

**Related Instructions**

Please note that:

- HCPCS codes Q9945 – Q9951 will replace codes A4644 – A4646; and
- HCPCS codes Q9952 – Q9954 will replace codes A4643 and A4647; **except that**
- **Hospital outpatient departments shall continue to bill codes A4644 – A4646, A4643, and A4647 and shall not report codes Q9945 – Q9957.**
- Non-institutional providers billing the carriers shall use Q9955-Q9957 to report specific echocardiography contrast agents.
- All other echocardiography contrast agents not described by Q9955-Q9957 shall be reported with A9700.

*New Contrast Agents Healthcare Common Procedure Coding System Codes (continued)***Additional Information**

The official instruction issued to your intermediary/carrier regarding this change may be found on the Web at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R502CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R502CP.pdf).

Also 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: 3748

Related CR Release Date: March 11, 2005

Related CR Transmittal Number: 502

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 502, CR 3748

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## Billing for Implantable Automatic Defibrillators for Beneficiaries in a Medicare Advantage Plan

### Use of Modifier QR to Identify Patient Registry Participation

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

#### Provider Types Affected

All Medicare providers billing either a Medicare carrier or Fiscal Intermediary (FI) for Implantable Automatic Defibrillators for Medicare beneficiaries who are members of Medicare Advantage plans

#### Provider Action Needed

##### STOP – Impact to You

Be aware that CMS is expanding the set of medical indications for the use of implantable automatic defibrillators and this instruction discusses the impact of this change for beneficiaries who are members of a MA plan and receive these services.

#### CAUTION – What You Need to Know

Effective January 27, 2005, CMS is expanding national coverage for implantable automatic defibrillators by including the following new indications:

1. Patients with ischemic dilated cardiomyopathy (IDCM), documented prior myocardial infarction (MI), New York Heart Association (NYHA) class II and III heart failure, and measured left ventricular ejection fraction (LVEF)  $\leq$  35%
2. Patients with nonischemic dilated cardiomyopathy (NIDCM)  $>$  9 months, NYHA class II and III heart failure, and measured LVEF  $\leq$  35%
3. Patients who meet all current CMS coverage requirements for a cardiac resynchronization therapy (CRT) device and have NYHA class IV heart failure
4. Patients with NIDCM  $>$  3 months, NYHA class II or III heart failure, and measured LVEF  $\leq$  35%.  
(See Note below)

#### GO – What You Need to Do

Make sure that your billing staffs are aware of these new indications and also the basis for billing Medicare.

**Note:** For beneficiaries under a MA plan, payment for defibrillator use effective January 27, 2005 is different for these new indications than it is for previously covered indications. When the beneficiary is under an MA plan, defibrillator use for these new indications is not part of the capitated rates and is to be paid fee-for-service (FFS). However, payment for previously covered indications for defibrillators implanted in these beneficiaries will be part of the MA capitated rates and is not to be paid FFS. In addition, data must be collected and reported through an approved data collection mechanism for beneficiaries who receive an implantable automatic defibrillator for the primary prevention (as opposed to secondary prevention) of sudden cardiac death. The above indications are considered primary prevention indications. Additional information regarding the ICD abstraction tool is available through a previously issued Special Edition MedLearn Matters Article SE0517, which is available at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0517.pdf>.

#### Background

The implantable automatic defibrillator, consisting of a pulse generator and electrodes for sensing and defibrillating, is an electronic device designed to detect and treat life-threatening tachyarrhythmias.

Medicare pays for the use of these defibrillators only for certain clinical indications.

Here is a synopsis of the history of indications and payment policies (indicating the effective dates) for implantable defibrillators, leading up to Change Request (CR) 3604:

#### Indications

##### July 1, 1991

Documented episode of cardiac arrest due to ventricular fibrillation (VF), not due to a transient or reversible cause.

## Billing for Implantable Automatic Defibrillators for Beneficiaries in a Medicare Advantage Plan (continued)

### July 1, 1999

Documented sustained ventricular tachyarrhythmia (VT), either spontaneous or induced by an electrophysiology (EP) study, not associated with an acute myocardial infarction (MI) and not due to a transient or reversible cause.

Documented familial or inherited conditions with a high risk of life-threatening VT, such as long QT syndrome or hypertrophic cardiomyopathy.

### October 1, 2003

Coverage was expanded to include coronary artery disease with a documented prior MI, a measured left ventricular ejection fraction  $\leq 0.35$ , and inducible, sustained VT or VF at EP study. (The MI must have occurred more than four weeks prior to defibrillator insertion. The EP test must be performed more than four weeks after the qualifying MI).

### Payment Policies

#### October 1, 2003 (CRs 2880 & 2992)

For covered defibrillator claims made on behalf of MA (formerly known as M+C) beneficiaries, payment for the expanded coverage (above) would be made on an FFS basis until Medicare capitation rates to MA organizations were adjusted to account for expanded coverage.

Also at this time, system changes were implemented to enable the automatic processing and payment of covered defibrillator claims on an FFS basis when the beneficiary was under an MA plan and the claims included either a modifier KZ attached to the defibrillator procedure codes when billing a carrier or a condition code of 78 when billing a fiscal intermediary.

#### January 1, 2005 (CR 3301)

Because MA rates have been appropriately adjusted to account for the defibrillator coverage described in CRs 2880 and 2992, covered services for the indications in these CRs will no longer be paid FFS when the beneficiary is under an MA plan.

Now in CR 3604, Medicare announces expanded coverage for implantable defibrillators for additional indications, effective January 27, 2005. These indications are:

- Patients with ischemic dilated cardiomyopathy (IDCM), documented prior myocardial infarction (MI), New York Heart Association (NYHA) class II and III heart failure, and measured left ventricular ejection fraction (LVEF)  $\leq 35\%$ .
- Patients with nonischemic dilated cardiomyopathy (NIDCM)  $> 9$  months, NYHA class II and III heart failure, and measured LVEF  $\leq 35\%$ .
- Patients who meet all current CMS coverage requirements for a cardiac resynchronization therapy (CRT) device and have NYHA Class IV heart failure.
- Patients with NIDCM  $> 3$  months, NYHA Class II or III heart failure, and measured LVEF  $\leq 35\%$ .

Please note this additional information:

- Since this new coverage exceeds the significant cost threshold for managed care organizations, services related to the newly covered indications will be paid

only on a fee-for-service basis for patients enrolled in a managed care plan. To reiterate, for these new indications, Medicare will pay for covered defibrillators on a FFS basis for claims for beneficiaries under MA plans through December 31, 2005. (Coverage guidelines may be found in the National Coverage Determination Manual (NCDM), Section 20.4.). **As a reminder, remember that MA plan beneficiaries are responsible for paying applicable coinsurance, but are not responsible for paying Part A or Part B deductibles (so you should assume that the Part A or Part B deductible has been met). To indicate that the beneficiary is under an MA plan and the services provided are for one of the new indications, providers are to include modifier KZ for carrier claims and condition code of 78 for fiscal intermediary claims until the MA capitated rates are adjusted.**

- Payment for previously covered indications for defibrillator use, i.e., those indications approved prior to January 27, 2005, will be part of the MA capitated rates and are not to be paid on an FFS basis for beneficiaries under a MA plan.
- Except for reimbursing for the use of the defibrillators for the new indications, the processing of defibrillator claims for non-MA beneficiaries remains unchanged.
- For indications effective after January 27, 2005, patients must **not** have:
  - ♦ Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm;
  - ♦ Had a coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) within the past three months;
  - ♦ Had an acute MI within the past 40 days;
  - ♦ Clinical symptoms or findings that would make them a candidate for coronary revascularization; or
  - ♦ Any disease, other than cardiac disease (e.g., cancer, uremia, liver failure), associated with a likelihood of survival less than 1 year.
- All patients considered for implantation of a defibrillator must be able to give informed consent.
- Myocardial infarctions must be documented and defined according to the consensus document of the Joint European Society of Cardiology/American College of Cardiology Committee for the Redefinition of Myocardial Infarction.
- Ejection fractions must be measured by angiography, radionuclide scanning, or echocardiography.
- Providers must be able to justify the medical necessity of devices other than single lead devices. This justification should be available in the medical record.

You should also be aware that Medicare is requiring that patients receiving a defibrillator for the new indications (or for any other indication that is for the primary prevention of sudden cardiac arrest [no history of a previous cardiac



**Billing for Implantable Automatic Defibrillators for Beneficiaries in a Medicare Advantage Plan (continued)**

arrest]) be enrolled in either a Food and Drug Administration-approved Category B Investigational Device Exemption (IDE) clinical trial, a trial under the CMS clinical trial policy, or a qualifying data collection system including approved clinical trials and registries to ensure the safety and quality of care.

Initially, CMS will maintain an implantable automatic defibrillator registry using a mechanism that Medicare participating hospitals already use to submit quality data to the quality improvement organizations (QIOs). Hospital staff will fill out the data collection form (supplied by CMS) using the ICD abstraction tool and transmit it via QNet (Quality Network Exchange) to the QIO. Iowa Foundation for Medical Care (IFMC) will collect and maintain registry data and the QIOs will be able to ensure the quality of the data by sampling charts. Additional information regarding the ICD abstraction tool is available through a previously issued special edition MedLearn article (SE0517), which is available at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0517.pdf>.

Additional data collection systems (trials or registries) addressing at a minimum the hypotheses specified in this decision must meet the following basic criteria:

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

For purposes of this coverage decision, CMS will determine whether specific registries or clinical trials meet these criteria.

Also, remember that **modifier QR** was created for use on Part B claims to identify protocol-covered services. The appropriate use of modifier QR, in defibrillator claims, is to identify patients whose data is being submitted to a registry and to document meeting the coverage requirement for devices implanted for primary prevention of sudden cardiac arrest. Providers should only append modifier QR on claims submitted **on or after April 1, 2005**. This modifier is not required when ICD-9-CM codes 427.1 ventricular tachycardia; 427.41 ventricular fibrillation; 427.42 ventricular flutter; 427.5 cardiac arrest; 427.9 cardiac dysrhythmia,

unspecified appear on the claim, as these codes identify a patient receiving the device as secondary, not primary prevention, of sudden cardiac arrest.

On the other hand, if none of the above ICD-9-CM diagnosis codes applies to the device implant, patient data should be submitted to a registry and modifier QR is required for claims submitted on or after April 1, 2005.

One final note:

- Providers billing Medicare fiscal intermediaries should:
  - ♦ Use the following G codes (payable under OPPTS effective October 1, 2003): G0297, G0298, G0299, and G0300.
 

**Note:** These G codes are not payable under the Medicare Physician Fee Schedule and, therefore, should not be billed to Medicare carriers.
  - ♦ Use the following ICD-9-CM procedure code on 11x type of bills: 37.94
- Providers billing carriers should use procedure code 33249.

**Additional Information**

You may find more information about billing for implantable automatic defibrillators for beneficiaries in an MA plan by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3604 in the CR NUM column on the right, and click on the file for that CR.

Finally, if you have any questions, please contact your 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: 3604

Related CR Release Date: March 8, 2005

Related CR Transmittal Number: 497

Effective Date: January 27, 2005

Implementation Date: January 27, 2005

Implementation Date for QR Modifier: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 497, CR 3604

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**New HCPCS Codes for Intravenous Immune Globulin**

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

**Provider Types Affected**

Physicians, providers, and suppliers billing Medicare for intravenous immune globulin (IVIG)

**Provider Action Needed**

**STOP – Impact to You**

New HCPCS codes for IVIG will be effective April 1, 2005.

**CAUTION – What You Need to Know**

Effective April 1, 2005, for dates of service on or after April 1, 2005, codes J1563 and J1564 will no longer be paid by Medicare fiscal intermediaries (FIs) and carriers, including durable medical equipment regional carriers (DMERCs). Codes J1563 and J1564 will be replaced with HCPCS codes Q9941 – Q9944.

**GO – What You Need to Do**

These new HCPCS codes are needed to appropriately distinguish between the lyophilized and non-lyophilized form of IVIG. Be sure to bill the new codes when providing these services.

**Additional Information**

Effective April 1, 2005, the following codes are being added to the Healthcare Common Procedure Coding System (HCPCS) to appropriately distinguish between the lyophilized and non-lyophilized form of IVIG.

HCPCS Code	Short Descriptor	Long Descriptor
Q9941	IVIG lyophil 1G	Injection, immune globulin, intravenous, lyophilized, 1g
Q9942	VIG lyophil 10 MG	Injection, immune globulin, intravenous, lyophilized, 10 mg
Q9943	IVIG non-lyophil 1G	Injection, immune globulin, intravenous, non-lyophilized, 1g
Q9944	IVIG non-lyophil 10 MG	Injection, immune globulin, intravenous, non-lyophilized, 10 mg

- Based on the above table, providers must bill Q9941 or Q9943, as appropriate, in place of J1563.
- Similarly, those providers should bill Q9942 or Q9944, as appropriate, instead of J1564.
- Payments for the new Q-codes can be found in the respective quarterly Medicare Part B drug pricing files posted on the CMS website at: <http://www.cms.hhs.gov/providers/drugs>.
- The Medicare outpatient code editor (OCE) will be updated to include these coding changes upon installation of the April 2005 software version 6.1.
- The outpatient prospective payment system (OPPS) for the new Q-codes can be found in the April update of OPPS Addendum A and Addendum B on the hospital outpatient website. OPPS payment is based on the ambulatory payment classification (APC).
- Coverage requirements for IVIG can be found in Chapter 15 of the Medicare Benefit Policy Manual. This manual may be found at: [http://www.cms.hhs.gov/manuals/102\\_policy/bp102index.asp](http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp).
- Additional information on IVIG may be found in Chapter 17 (Drugs and Biologicals), Section 80.6 of the Medicare Claims Processing Manual at: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp).
- The official instruction issued to your carrier regarding this change may be found at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).
- From that Web page, look for CR 3745 in the CR NUM column on the right, and click on the file for that CR.
- For additional information relating to this issue, please refer to your local FI or carrier. You may find the toll free phone number for your local contractor at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3745

Related CR Release Date: March 18, 2005

Related CR Transmittal Number: 507

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 514, CR 3756

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## Abarelix for the Treatment of Prostate Cancer

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

### Provider Types Affected

Providers who care for Medicare beneficiaries with prostate cancer

### Provider Action Needed

#### STOP – Impact to You

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

#### CAUTION – What You Need to Know

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

#### GO – What You Need to Do

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

### Background

#### Treatment Options for Prostate Cancer

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

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

#### Abarelix

More recently, newer GnRH receptor antagonist compounds, such as abarelix (Plenaxis™), are, in contrast, thought to be devoid of agonist activity and to lack an initial androgen-stimulating effect. Abarelix (Plenaxis™) has been proposed as a substitute for GnRH agonists (with and without antiandrogens) in the treatment of patients with advanced prostate cancer, for whom a surge in androgen blood levels may pose a risk of “clinical flare.” For this indication, abarelix is the first GnRH receptor antagonist that the Food and Drug Administration (FDA) has approved.

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

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

Please note that the following additional conditions for coverage must be met, in accordance with the Food and Drug Administration (FDA) labeling requirements, to ensure

that abarelix (Plenaxis™) is used only in patients for whom the drug is indicated:

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

The physician must attest willingness and ability to:

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

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

#### Additional Information

The following claims processing points should be noted:

- Use HCPCS code J0128 for claims when billing Medicare for abarelix used for treatment of prostate cancer patients in accordance with the requirements specified by the NCD.
- Medicare fiscal intermediaries will accept abarelix claims on types of bill 11x, 13x, 18x, 83x, and 85x. Also, use revenue code 0636 on the claim to reflect a drug requiring detailed coding.
- Medicare carriers and intermediaries will pay separately for abarelix chemotherapy injections when billed using an appropriate chemotherapy administration procedure code in addition to the visit furnished on the same day.
- For services performed **on or after March 15, 2005**, Medicare will deny claims for uses of abarelix that are not covered under the NCD, (NCD Manual Section 110.18). An appropriate remittance advice code will be

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

sent to reflect the denial using MSN 6.5 (*Medicare cannot pay for this in injection because one or more requirements for coverage were not met, reason code 47 (this, these) diagnosis(es) is (are) not covered, missing, or are invalid*), and remark code M76 — *missing/incomplete invalid diagnosis or condition*.

You may find more information about abarelix for the treatment of prostate cancer by going to:  
[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

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

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

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

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

Related Change Request (CR) Number: 3775

Related CR Release Date: April 25, 2005

Related CR Transmittal Number: 532

Effective Date: March 15, 2005

Implementation Date: May 25, 2005

Source: CMS Pub. 100-4, Transmittal 532, CR 3775

# HOSPITAL SERVICES

## Clarification of the Verification Process To Determine if the Inpatient Rehabilitation Facility Meets the IRF Classification Criteria

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

### Provider Types Affected

Inpatient rehabilitation facilities (IRFs)

### Provider Action Needed

This article includes information contained in Change Request (CR) 3704 that clarifies certain portions of the verification process used to determine if an IRF meets the classification criteria needed to be paid under the IRF prospective payment system (PPS), especially issues regarding the time spans associated with an IRF's compliance review period. For earlier information regarding IRF classification requirements, see related Medlearn Matters article MM3503, which is available at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3503.pdf>.

### Background

The Social Security Act (Sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii)) gives the Centers for Medicare & Medicaid Services (CMS) the discretion to define an IRF. In addition, the Code of Federal Regulations (CFR, Title 42, Sections 412.22, 412.23(b), 412.25, 412.29, and 412.30) specifies that the criteria for a provider be classified as an IRF. Hospitals and units meeting those criteria are eligible to be paid on a PPS basis as an IRF (under the IRF PPS).

When a determination has been made by the CMS regional office (RO) that a facility is classified as an IRF, the classification applies to the entire cost reporting period for which the determination is made. Also, 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.

ROs generally make these determinations on an annual basis at the start of a facility's cost reporting period, and the hospital's or unit's classification takes effect only at the start of the facility's cost reporting period.

### Clarification of the General Guideline to Determine the Compliance Review Period

In general, the RO and your Medicare fiscal intermediary (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 of the criteria used to classify a facility as an IRF. If for any reason the RO or FI require 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.

The table below, titled "Table of Compliance Review Periods," illustrates the time spans associated with an IRF's compliance review period.

The compliance percentage that the IRF must meet for a specific cost reporting period will gradually increase until the compliance threshold that must always be met is 75 percent. The 75 percent threshold must be met for cost reporting periods that begin on or after July 1, 2007. (For cost reporting periods that start on or after July 1, 2004, and on or before June 30, 2007, the compliance percentage threshold that an IRF must meet changes in accordance with the requirements specified in *Chapter 3, Section 140.1.1B* of the Medicare Claims Processing Manual.)

Depending on the specific compliance review period, a compliance review period may:

- Include a span of time from only one cost reporting period; or
- Span periods of time from two cost reporting periods.

When a compliance review period spans time periods from two cost reporting periods:

- One portion of a compliance review time period will be part of a span of time from one cost reporting period; and
- The other portion of the same compliance review time period will be part of a span of time from a different cost reporting period.

The weighed averages of each portion of the compliance review period are added together to determine if a compliance percentage as specified in section 140.1.1B (Medicare Claims Processing Manual (Pub 100-04), Chapter 3) was met during the entire compliance review period when:

- An IRF has a cost reporting period that starts on or after July 1, 2004; and
- The compliance review period has portions of time that are associated with only one cost reporting period (such as, but not only, a new IRF); and
- The IRF had a patient population in each portion of the compliance review period used to calculate the compliance threshold percentage.

The weighed averages for each portion of the compliance review period represents the percentage of patients in that portion of the compliance review period that met one or more

*Clarification of the Verification Process To Determine if the IRF Meets the IRF Classification Criteria (continued)*

of medical conditions listed in section 140.1.1C (Medicare Claims Processing Manual (Pub 100-04), Chapter 3).

**Example**

Below is one method for calculating the compliance percentage for each portion of the compliance review period and adding the portion percentages together. In this example:

- The compliance review period is a total of 12 months:
  - ♦ One portion of the compliance review period is 4 months; and
  - ♦ The other portion is 8 months.
- The total number of patients in the entire compliance review period is 314:
  - ♦ 114 of the total 314 patients are associated with the 4- month portion of the compliance review period; and
    - 57 of these 114 patients met one or more of the conditions listed in §140.1.1C (Pub 100-04, Chapter 3);
  - ♦ 200 of the total 314 patients are associated with the 8- month portion of the compliance review period; and
    - 140 of these 200 patients met one or more of the conditions listed in §140.1.1C (Pub 100-04, Chapter 3).
- Calculations:
  - 1)  $57/114=0.5000$  and  $140/200=0.7000$
  - 2)  $114/314=0.36305$  and  $200/314=0.63694$
  - 3)  $0.5000 \times 0.36305=0.181525$ , and  $0.7000 \times 0.63694=0.445858$
  - 4)  $0.181525 + 0.445858 = 0.627383$ , which is rounded to 63 percent

**Note:** A discussion of the actual report used by FIs to determine eligibility may be found in CR 3704.

The weighed averages of each portion of the compliance review period are added together to determine if a compliance percentage as specified in section 140.1.1B (Medicare Claims Processing Manual (Pub 100-04), Chapter 3) was met during the entire compliance review period when an IRF has the following:

- A cost reporting period that starts on or after July 1, 2004, and on or before June 30, 2005;
- The compliance review period has portions of time that are associated with two cost reporting periods; and
- The IRF had a patient population in each portion of the compliance review period used to calculate the compliance threshold percentage.

**For cost reporting periods starting on or after July 1, 2005 and the compliance review period spans two cost reporting periods:** It will be determined that the compliance percentage was met for the entire compliance percentage review period when an IRF has the following:

- A cost reporting period that starts on or after July 1, 2005; and
- The compliance review period has portions of time that are associated with two cost reporting periods; and
- The IRF had a patient population in each portion of the compliance review period; and
- Each portion of the compliance review period separately met the compliance percentage threshold of the cost reporting period that includes that portion of time of the compliance review period.

Part of the above calculation method may be used to determine what compliance percentage was met in each portion of the entire compliance review period.

For example, as illustrated in the table below titled Table of Compliance Review Periods.

- An IRF that has a cost reporting period that started on July 1, 2004, must meet, as described more fully in section 140.1.1B (Pub 100-04, Chapter 3), a compliance threshold of 50 percent for the cost reporting period of July 1, 2004, to June 30, 2005;
- In addition, for the next cost reporting period that starts on July 1, 2005, the IRF must meet, as described more fully in section 140.1.1B (Pub 100-04, Chapter 3), a compliance threshold of 60 percent for the cost reporting period of July 1, 2005, to June 30, 2006; and
- For the cost reporting period that starts on July 1, 2005, the IRF has a compliance review period consisting of March 1, 2005, to February 28, 2006.

In this example, the time period:

- From March 1, 2005, to June 30, 2005, is part of IRF's cost reporting period that started on July 1, 2004, and ends on June 30, 2005; and
- From July 1, 2005, to February 28, 2006, is part of the IRF's cost reporting period that starts on July 1, 2005, and ends on June 30, 2006.

Therefore, for the portion of the compliance review period from March 1, 2005, to June 30, 2005, the compliance percentage threshold that must be met is 50 percent. Similarly, for the portion of the compliance review period from July 1, 2005, to February 28, 2006, the compliance percentage threshold that must be met is 60 percent.

It will be determined that the IRF failed to meet the compliance percentage threshold for the entire compliance review period consisting of March 1, 2005, to February 28, 2006:

- If the IRF does not meet the compliance percentage threshold of 50 percent for the March 1, 2005, to June 30, 2005, portion of the compliance review time period; or
- The compliance percentage threshold of 60 percent for the July 1, 2005, to February 28, 2006, portion of the compliance review time period.

*Clarification of the Verification Process To Determine if the IRF Meets the IRF Classification Criteria (continued)*

**Table of Compliance Review Periods**

For a facility that has been classified as an IRF, but is not a “new” IRF as defined in section 140.1.7 (Pub 100-04, Chapter 3), the following table illustrates the “General Guideline To Determine the Compliance Review Period.” (Note that CR 3704, which may be accessed at [http://www.cms.hhs.gov/manuals/pm\\_transR478CP.pdf](http://www.cms.hhs.gov/manuals/pm_transR478CP.pdf) provides more details for facilities whose cost reporting periods begin between July 1, 2004, and October 31, 2004.): For cost reporting periods that start on or after July 1, 2004, the following are the compliance review periods.

**Table of Compliance Review Periods**

<b>For Cost Reporting Periods Beginning On:</b>	<b>Review Period: (Admissions or Discharges During)</b>	<b># of Months in Review Period</b>	<b>Compliance Percentage Threshold Associated with a Compliance Review Period or Portions of the Compliance Review Period</b>	<b>Compliance Determination Applies to Cost Reporting Period Beginning On:</b>
07/01/2004	07/01/2004-02/28/2005	8	07/01/2004 to 02/28/2005: 50%	07/01/2005
08/01/2004	07/01/2004-03/31/2005	9	07/01/2004 to 03/31/2005: 50%	08/01/2005
09/01/2004	07/01/2004-04/30/2005	10	07/01/2004 to 04/30/2005: 50%	09/01/2005
10/01/2004	07/01/2004-05/31/2005	11	07/01/2004 to 05/31/2005: 50%	10/01/2005
11/01/2004	07/01/2004-06/30/2005	12	07/01/2004 to 06/30/2005: 50%	11/01/2005
12/01/2004	08/01/2004-07/31/2005	12	08/01/2004 to 07/31/2005: 50%	12/01/2005
01/01/2005	09/01/2004-08/31/2005	12	09/01/2004 to 08/31/2005: 50%	01/01/2006
02/01/2005	10/01/2004-09/30/2005	12	10/01/2004 to 09/30/2005: 50%	02/01/2006
03/01/2005	11/01/2004-10/31/2005	12	11/01/2004 to 10/31/2005: 50%	03/01/2006
04/01/2005	12/01/2004-11/30/2005	12	12/01/2004 to 11/30/2005: 50%	04/01/2006
05/01/2005	01/01/2005-12/31/2005	12	01/01/2005 to 12/31/2005: 50%	05/01/2006
06/01/2005	02/01/2005-01/31/2006	12	02/01/2005 to 01/31/2006: 50%	06/01/2006
07/01/2005	03/01/2005-02/28/2006	12	03/01/2005 to 06/30/2006: 50% 07/01/2005 to 02/28/2006: 60%	07/01/2006
08/01/2005	04/01/2005-03/31/2006	12	04/01/2005 to 07/31/2005: 50% 08/01/2005 to 03/31/2006: 60%	08/01/2006
09/01/2005	05/01/2005-04/30/2006	12	05/01/2005 to 08/31/2005: 50% 09/01/2005 to 04/30/2006: 60%	09/01/2006
10/01/2005	06/01/2005-05/31/2006	12	06/01/2005 to 09/30/2005: 50% 10/01/2005 to 05/31/2006: 60%	10/01/2006
11/01/2005	07/01/2005-06/30/2006	12	07/01/2005 to 10/31/2005: 50% 11/01/2005 to 06/30/2006: 60%	11/01/2006
12/01/2005	08/01/2005-07/31/2006	12	08/01/2005 to 11/30/2005: 50% 12/01/2005 to 07/31/2006: 60 %	12/01/2006
01/01/2006	09/01/2005-08/31/2006	12	09/01/2005 to 12/31/2005: 50% 01/01/2006 to 08/31/2006: 60 %	01/01/2007
02/01/2006	10/01/2005-09/30/2006	12	10/01/2005 to 01/31/2006: 50% 02/01/2006 to 09/30/2006: 60%	02/01/2007
03/01/2006	11/01/2005-10/31/2006	12	11/01/2005 to 02/28/2006: 50% 03/01/2006 to 10/31/2006: 60%	03/01/2007
04/01/2006	12/01/2005-11/30/2006	12	12/01/2005 to 03/31/2006: 50% 04/01/2006 to 11/30/2006: 60%	04/01/2007
05/01/2006	01/01/2006-12/31/2006	12	01/01/2006 to 04/30/2006: 50% 05/01/2006 to 12/31/2006: 60%	05/01/2007
06/01/2006	02/01/2006-01/31/2007	12	02/01/2006 to 05/31/2006: 50% 06/01/2006 to 01/31/2007: 60%	06/01/2007
07/01/2006	03/01/2006-02/28/2007	12	03/01/2006 to 06/30/2006: 60% 07/01/2006 to 02/28/2007: 65%	07/01/2007
08/01/2006	04/01/2006-03/31/2007	12	04/01/2006 to 07/31/2006: 60% 08/01/2006 to 03/31/2007: 65%	08/01/2007
09/01/2006	05/01/2006-04/30/2007	12	05/01/2006 to 08/31/2006: 60% 09/01/2006 to 04/30/2007: 65%	09/01/2007
10/01/2006	06/01/2006-05/31/2007	12	06/01/2006 to 09/30/2006: 60% 10/01/2006 to 05/31/2007: 65%	10/01/2007

*Clarification of the Verification Process To Determine if the IRF Meets the IRF Classification Criteria (continued)*

<b>For Cost Reporting Periods Beginning On:</b>	<b>Review Period: (Admissions or Discharges During)</b>	<b># of Months in Review Period</b>	<b>Compliance Percentage Threshold Associated with a Compliance Review Period or Portions of the Compliance Review Period</b>	<b>Compliance Determination Applies to Cost Reporting Period Beginning On:</b>
11/01/2006	07/01/2006-06/30/2007	12	07/01/2006 to 10/31/2006: 60% 11/01/2006 to 06/30/2007: 65%	11/01/2007
12/01/2006	08/01/2006-07/31/2007	12	08/01/2006 to 11/30/2006: 60% 12/01/2006 to 07/31/2007: 65%	12/01/2007
01/01/2007	09/01/2006-08/31/2007	12	09/01/2006 to 12/31/2006: 60% 01/01/2007 to 08/31/2007: 65%	01/01/2008
02/01/2007	10/01/2006-09/30/2007	12	10/01/2006 to 01/31/2007: 60% 02/01/2007 to 09/30/2007: 65%	02/01/2008
03/01/2007	11/01/2006-10/31/2007	12	11/01/2006 to 02/28/2007: 60% 03/01/2007 to 10/31/2007: 65%	03/01/2008
04/01/2007	12/01/2006-11/30/2007	12	12/01/2006 to 03/31/2007: 60% 04/01/2007 to 11/30/2007: 65%	04/01/2008
05/01/2007	01/01/2007-12/31/2007	12	01/01/2007 to 04/30/2007: 60% 05/01/2007 to 12/31/2007: 65%	05/01/2008
06/01/2007	02/01/2007-01/31/2008	12	02/01/2007 to 05/31/2007: 60% 06/01/2007 to 01/31/2008: 65%	06/01/2008
07/01/2007	03/01/2007-02/29/2008	12	03/01/2007 to 06/30/2007: 65% 07/01/2007 to 02/29/2008: 75%	07/01/2008
08/01/2007	04/01/2007-03/31/2008	12	04/01/2007 to 07/31/2007: 65% 08/01/2007 to 03/31/2008: 75%	08/01/2008
09/01/2007	05/01/2007-04/30/2008	12	05/01/2007 to 08/31/2007: 65% 09/01/2007 to 04/30/2008: 75%	09/01/2008
10/01/2007	06/01/2007-05/31/2008	12	06/01/2007 to 09/30/2007: 65% 10/01/2007 to 05/31/2008: 75%	10/01/2008
11/01/2007	07/01/2007-06/30/2008	12	07/01/2007 to 10/31/2007: 65% 11/01/2007 to 06/30/2008: 75%	11/01/2008
12/01/2007	08/01/2007-07/31/2008	12	08/01/2007 to 11/30/2007: 65% 12/01/2007 to 07/31/2008: 75%	12/01/2008
01/01/2008	09/01/2007-08/31/2008	12	09/01/2007 to 12/31/2007: 65% 01/01/2008 to 08/31/2008: 75%	01/01/2009
02/01/2008	10/01/2007-09/30/2008	12	10/01/2007 to 01/31/2008: 65% 02/01/2008 to 09/30/2008: 75%	02/01/2009
03/01/2008	11/01/2007-10/31/2008	12	11/01/2007 to 02/29/2008: 65% 03/01/2008 to 10/31/2008: 75%	03/01/2009
04/01/2008	12/01/2007-11/30/2008	12	12/01/2007 to 03/31/2008: 65% 04/01/2008 to 11/30/2008: 75%	04/01/2009
05/01/2008	01/01/2008-12/31/2008	12	01/01/2008 to 04/30/2008: 65% 05/01/2008 to 12/31/2008: 75 %	05/01/2009
06/01/2008	02/01/2008-01/31/2009	12	02/01/2008 to 05/31/2008: 65% 06/01/2008 to 01/31/2009: 75%	06/01/2009
07/01/2008	03/01/2008-02/28/2009	12	03/01/2008 to 06/30/2008: 75% 07/01/2008 to 02/28/2009: 75%	07/01/2009
08/01/2008	04/01/2008-03/31/2009	12	04/01/2008 to 07/31/2008: 75% 08/01/2008 to 03/31/2009: 75%	08/01/2009

As illustrated in the above table, if:

- A cost reporting period starts on or after July 1, 2004, and before November 1, 2004; then 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 qualify it 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, thereby giving the ROs and FIs a four-month time period to make and administer a compliance determination.



*Clarification of the Verification Process To Determine if the IRF Meets the IRF Classification Criteria (continued)***Clarification of the Data Used to Determine Compliance with the Classification Criteria**

Starting on July 1, 2004, the FI will use certain data in the verification process as specified in section 140.1.4 (Pub 100-04, Chapter 3). The verification procedure specified in section 140.1.4B1 will be used only if the FI verifies that the IRF's Medicare Part A fee-for-service inpatient population reflects the makeup of the IRF's total inpatient population. The IRF's Medicare Part A fee-for-service inpatient population reflects the makeup of the IRF's total inpatient population only if the IRF's total inpatient population is made up of 50 percent or more of Medicare Part A fee-for-service inpatients.

To verify that the IRF's Medicare Part A fee-for-service inpatient population reflects the makeup of the IRF's total patient population, the FI in writing will instruct the IRF to send to the FI, by a specific date, a list showing the hospital number the IRF assigned to each inpatient that the IRF admitted during a most recent, consecutive, and appropriate 12-month period, as that time period is defined by the CMS or the FI.

For each inpatient represented by an inpatient hospital number on the list, the IRF must include the payer the IRF can bill, or has billed, for the treatment and services the IRF has furnished to the inpatient. If an inpatient represented by an inpatient hospital number on the list has multiple payers that the IRF can bill, or has billed, the IRF must include and specify each type of payer. In addition, for each inpatient represented by an inpatient hospital number on the list the IRF must include the IRF admission and discharge dates.

The FI will:

- Use the list of hospital numbers to determine what was the IRF's total inpatient population during a most recent, consecutive, and appropriate 12-month period, as that time period is defined by CMS or the FI;
- Determine how many inpatients represented on the list of inpatient hospital numbers are covered under Medicare Part A fee-for-service, and (using that data); then
- Determine if the IRF's Medicare Part A fee-for-service inpatient population is 50 percent or more of the IRF's total inpatient population for a most recent, consecutive, and appropriate 12-month period, as that time period is defined by CMS or the FI.

**Note:** In addition to the above process, the FI may, at the FI's discretion, sample and compare other parameters (that is, diagnoses, procedures, length-of-stay, or any other relevant parameter) to determine that the Medicare Part A fee-for-service population is representative of the IRF's total inpatient population.

The FI will inform the CMS RO if:

- An IRF fails to send the list showing the hospital number the IRF assigned to each inpatient that the IRF admitted during a most recent, consecutive, and appropriate 12-month period, as that time period is defined by the FI; or
- The list of inpatient hospital numbers does not include the payer or payers, and the admission and discharge

dates that correspond with the inpatients whose hospital numbers are shown on the list.

The RO will notify the IRF that

- Failure to send the FI the list within an additional 10 calendar days will result in a determination by the RO that the IRF has not met the requirements specified above in section 140.1.1B (Pub 100-04, Chapter 3).

**Clarification of the Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Data Records**

To determine if a facility has presumptively complied with the criteria specified in section 140.1.1B (Pub 100-04, Chapter 3), CMS will enable the FI to access CMS' IRF-PAI data records. Specifically, each FI will be allowed to access only the IRF-PAI information submitted by the IRFs that submit claims to that FI.

When the FI accesses the IRF-PAI data records the FI will be able to generate a report using the IRF-PAI information that was previously submitted by the IRFs that submit claims to that FI. The software that the FI will use to generate the report will automatically use the specific ICD-9-CM and impairment group codes that are listed in Appendix A (Pub 100-04, Chapter 3) to determine if a particular IRF is presumptively in compliance with the requirements specified in section 140.1.1B (Pub 100-04, Chapter 3).

**Note:** Appendix A is attached to CR 3704, which may be accessed at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R478CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R478CP.pdf).

Prior to generating a report that the FI will use to determine if the IRF has presumptively complied with the requirements specified in section 140.1.1B (Pub 100-04, Chapter 3), the FI must allow the IRF to decide if the IRF prefers the data records that the FI will use to generate the report to be **either** the IRF-PAI data records of:

- Patients who were admitted during the IRF's compliance review period regardless if these patients were discharged during the compliance review period; or
- Patients discharged during the IRF's compliance review period regardless if these patients were admitted during the compliance review period.

An IRF will be presumed by the FI as having a total inpatient population that meets the requirements specified in section 140.1.1B (Pub 100-04, Chapter 3) if

- Their inpatient Medicare Part A fee-for-service population reflects its total inpatient population and
- It is determined (according to the report described in CR3704 and used by FIs to determine eligibility) by the FI that the requirements specified in section 140.1.1B (Pub 100-04, Chapter 3) were presumably met.

However, even when an IRF is presumed to have met the requirements specified in section 140.1.1B (Pub 100-04, Chapter 3), the RO and FI still have the discretion to instruct the IRF to send to the RO or FI specific sections of the medical records of a random sample of inpatients, or Inpatients identified by other means by CMS or the FI.

*Clarification of the Verification Process To Determine if the IRF Meets the IRF Classification Criteria (continued)***Clarification of the Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility's Total Patient Population**

The FI must use the IRF's total patient population to verify that the IRF has met the requirements specified in section 140.1.1B (Pub 100-04, Chapter 3) if:

- The IRF's Medicare Part A fee-for-service population does not reflect its total patient population;
- The FI is unable to generate a valid report using the IRF-PAI database methodology specified previously; or
- The FI generates a report, which demonstrates that the IRF has not met the requirements specified in section 140.1.1B (Pub 100-04, Chapter 3).

The presumptive determination that the IRF did not meet the requirements specified in section 140.1.1B (Pub 100-04, Chapter 3) will occur in the case in which:

- The Medicare Part A fee-for-service inpatients make up less than 50 percent of the IRF inpatient population;
- The FI otherwise determines that the Medicare Part A fee-for-service inpatients are not representative of the overall IRF inpatient population; or
- The FI is unable to generate a valid report using the IRF-PAI methodology.

The FI will use generally accepted statistical sampling techniques to determine the makeup of a statistically appropriate random sample number of inpatients.

However, prior to selecting the sample number of inpatients, the FI must allow the IRF to decide if the IRF wants the sample to contain:

- The patients who were admitted during the IRF's compliance review period regardless if these patients were discharged during the compliance review period, or
- The patients discharged during the IRF's compliance review period regardless if these patients were admitted during the compliance review period.

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If the confidence level of the statistic derived from the sample is not at least 95 percent then the FI will adjust the sample or if necessary use the entire inpatient population to determine if the IRF meets the requirements as specified in section 140.1.1B (Pub 100-04, Chapter 3).

**Implementation**

The implementation date for this instruction is March 21, 2005.

**Additional Information**

The official instruction (CR 3704) issued to your Medicare intermediary regarding this change may be viewed by going to: [http://www.cms.hhs.gov/manuals/pm\\_trans/R478CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R478CP.pdf).

This instruction includes Appendix A, the list of ICD-9-CM and impairment group codes. It also includes key provisions of Chapter 3, Section 140 of the Medicare Claims Processing Manual, including a discussion of the report FIs use to determine a facility's eligibility. This article deals mainly with the clarifications attached to CR 3704 as the basic policies are unchanged.

Also, for earlier information regarding IRF classification requirements, see related Medlearn Matters article MM3503, available at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3503.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: 3704  
 Related CR Release Date: February 18, 2005  
 Related CR Transmittal Number: 478  
 Effective Date: June 25, 2004  
 Implementation Date: March 21, 2005

Source: CMS Pub. 100-4, Transmittal 478, CR 3704

## 2005 PRICER Update for Hospital Inpatient Prospective Payment System

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

### Provider Types Affected

Providers billing Medicare fiscal intermediaries for services paid under the hospital inpatient prospective payment system (IPPS)

### Provider Action Needed

#### STOP – Impact to You

This instruction includes information from Change Request (CR) 3784 that announces changes to the 2005 IPPS PRICER. Software.

#### CAUTION – What You Need to Know

CR 3784 is based on corrections to the *Federal Register* published on December 30, 2004, and it itemizes changes in the April 2005 release of the hospital IPPS PRICER software based on the December 30, 2004, correction notice to the *Federal Register*.

#### GO – What You Need to Do

Please see the Background and Additional Information sections of this instruction for further details regarding this update.

### Background

Change Request (CR) 3784 includes changes to the FY 2005 hospital IPPS PRICER and updates information originally published in CR 3459. Specifically, this PRICER release contains the following:

#### New Technology Add-On Payment

Effective for discharges on or after April 1, 2005, the logic for selecting cases for the add-on technology payment for the OP-1 Implant will change. PRICER will look for the presence of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) procedure codes 84.52, **and** either 81.35 **or** 81.38. The diagnostic related group (DRG) must also be 497 or 498. The maximum add-on payment for the bone growth factor osteogenic protein-1 (OP-1) remains \$1,955.00.

#### Wage Index Tables

The wage index tables loaded into PRICER now reflect the wage index changes published in the IPPS Correction Notice on December 30, 2004. The wage index changes are described in detail in CR 3672, Transmittal 422, and dated December 30, 2004. Please see: [http://www.cms.hhs.gov/manuals/pm\\_trans/R422CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R422CP.pdf).

#### Disproportionate Share Hospital Adjustment for Urban to Rural Providers

This PRICER release updates the list of providers (originally published in CR 3459) that are eligible for an urban to rural transition disproportionate share hospital (DSH) adjustment and the list now includes one additional provider: 44-0081.

#### Disproportionate Share Hospital Adjustment for Rural Referral Center providers with PTYPE 15

The Medicare Modernization Act (Section 402, Public Law 108-173) increased the DSH adjustment for rural hospitals and urban hospitals with fewer than 100 beds. Rural referral centers (RRCs) are exempt from the 12 percent cap on the DSH adjustment.

This release of PRICER adds PTYPE '15', MDH-RRC providers, to the RRC DSH logic that prevents RRCs from having their DSH adjustments capped at twelve percent. Since this provision was implemented during FY 2004, **the effective date for this change is April 1, 2004.**

**Urban providers reclassifying to rural areas under the Code of Federal Regulations (CFR) 412.103 (Sec. 401 of P.L. 106-554).**

This PRICER release updates the list of urban providers re-designated as rural under CFR 412. Previously, this list included:

050192 050286 050446 050469 050528 050618  
051301 070004 100048 100118 170137 190048  
190110 230078 260006 290038 291301 300009  
390181 380084 390106

Currently, PRICER now has the following providers listed as urban to rural designations:

030007 040075 050192 050469 050528 050618  
070004 100048 100134 130018 140167 150051  
150078 170137 190048 230078 240037 260006  
260122 300009 370054 380040 380084 390181  
390183 390201 450052 450078 450243 450276  
450348 500023 500037 500122 500147 500148

### Implementation

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

### Additional Information

Change Request (CR) 3459, Transmittal 309, dated October 1, 2004, subject: Fiscal Year (FY) 2005 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) and Other Bill Processing Changes Related to the IPPS Final Rule can be reviewed at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R309CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R309CP.pdf).

For complete details of CR 3784, on which this article is based, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3784 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: 3784  
Related CR Release Date: March 24, 2005  
Related CR Transmittal Number: 510  
Effective Date: April 1, 2005  
Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 510, CR 3784

## Use of Type of Bill 12x for Billing Vaccines (Influenza, PPV, and Hepatitis B) and Their Administration

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

### Provider Types Affected

Hospitals billing Medicare fiscal intermediaries (FIs) for these vaccines supplied to Medicare inpatients

### Provider Action Needed

#### STOP – Impact to You

Effective for services on or after July 1, 2005, hospitals must now use type of bill (TOB) 12x instead of TOB 13x for billing vaccines, including roster billing, and the administration of those vaccines **provided to hospital inpatients under Medicare Part B**.

Additionally, Healthcare Common Procedure Coding System (HCPCS) codes G0008, G0009, and G0010 should be reported, as of July 1, 2005, with revenue code 771 on a TOB 12x.

#### CAUTION – What You Need to Know

Hospitals should use the discharge date of the hospital stay or the date benefits are exhausted on TOB 12x for vaccines (influenza, PPV, and hepatitis B) and their administration when provided to hospital inpatients

Billing of vaccines (influenza, PPV, and hepatitis B) provided to other than hospital inpatients under Part B remains unchanged and the appropriate TOBs for those services remain as 13x, 22x, 23x, 34x, 72x, 75x, and 85x.

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### GO – What You Need to Do

Please make a note of this change.

### Additional Information

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

From that Web page, look for CR 3618 in the CR NUM column on the right, and click on the file for the desired CR.

For additional information relating to this issue, please refer to your local FI. To find the toll free phone number for your local FI, 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: 3618

Related CR Release Date: February 11, 2005

Related CR Transmittal Number: 473

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 473, CR 3618

## Inpatient Psychiatric Facility Prospective Payment System—Further Clarifications

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

**Note:** This instruction (CR 3752) corrects some aspects of CR 3678, “Further Information Related to Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)”, Transmittal 444, dated January 21, 2005, which may be found at the following CMS website: [http://www.cms.hhs.gov/manuals/pm\\_trans/R444CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R444CP.pdf).

### Provider Types Affected

Inpatient psychiatric facilities (IPF) billing Medicare fiscal intermediaries (FIs) for services paid under the IPF prospective payment system (PPS)

### Provider Action Needed

#### STOP – Impact to You

Physicians, suppliers and providers should note that this instruction is based on information contained in Change Request (CR) 3752 regarding the IPF PPS.

#### CAUTION – What You Need to Know

Note that CR 3752 clarifies recent questions CMS received from IPFs and Medicare FIs that service them, and corrects some aspects of Change Request (CR) 3678.

### GO – What You Need to Do

Please see the *Background* and *Additional Information* sections of this instruction for further details regarding these clarifications.

### Background

For an overview of all of the policy and billing requirements related to IPF PPS, please see Change Request (CR) 3541, “Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)”, Transmittal 384, dated December 1, 2004, at the following Centers for Medicare & Medicaid Services (CMS) website: [http://www.cms.hhs.gov/manuals/pm\\_trans/R384CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R384CP.pdf).

The corresponding Medlearn Matters article may also be reviewed at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3541.pdf>.

Please also see the November 15, 2004 final rule (69 FR 66922) regarding the IPF PPS and note that CMS will be issuing a correction notice to that final rule.

Change Request (CR) 3752 helps clarify some confusing aspects regarding the IPF PPS including:

- What constitutes a new IPF
- A ‘code first’ example

**Inpatient Psychiatric Facility Prospective Payment System—Further Clarifications (continued)**

- A fix to the comorbidity table
- Split billing instructions
- An extension to notify FIs of emergency department (ED) status.

**What Constitutes a New IPF?**

CMS defined a new IPF as a provider of inpatient hospital psychiatric services that:

- Meets the qualifying criteria for IPFs, set forth in 42 CFR section 412.22, section 412.23, section 412.25, and section 412.27; and
- Has not (under current ownership, previous ownership, or both) received payment under TEFRA for delivery of IPF services prior to the effective date of the IPF PPS, January 1, 2005.

To qualify, the first cost report period as a psychiatric hospital or a distinct part unit in an acute care hospital must have begun no earlier than January 1, 2005, coinciding with the effective date of the IPF PPS.

**Note:** This means if the provider ever had a TEFRA limit, CMS will use that TEFRA limit updated to current times. CMS will not consider the IPF to be a new provider, and the IPF therefore will receive the blended payment. This includes those providers that previously closed their psychiatric units and then reopened the units. If those facilities had a TEFRA limit established, then CMS will update that TEFRA limit.

Change of ownership will have no impact on whether an IPF is considered a new IPF provider.

**A ‘Code First’ Example**

Diagnosis code 294.11 “Dementia in conditions classified elsewhere with behavioral disturbances” is designated as “NOT ALLOWED AS PRINCIPAL DX” code.

Four digit code 294.1 “Dementia in conditions classified elsewhere,” is designated as a “code first” diagnosis indicating that all five digit diagnosis codes that fall under the 294.1 category (codes 294.10 and 294.11) must follow the “code first” rule.

The three-digit code 294 “Persistent mental disorders due to conditions classified elsewhere” appears in the ICD-9-CM as shown below:

**294 Persistent mental disorders due to conditions classified elsewhere**

**294.1 Dementia in conditions classified elsewhere**

*Code first any underlying physical condition, as: dementia in:*

- Alzheimer’s disease (331.0)
- cerebral lipidosis (330.1)
- dementia with Lewy bodies (331.82)
- dementia with Parkinsonism (331.81)
- epilepsy (345.0 – 345.9)
- frontal dementia (331.19)
- frontotemporal dementia (331.19)
- general paresis [syphilis] (094.1)
- hepatolenticular degeneration (275.1)
- Huntington’s chorea (333.4)

- Jacob-Creutzfeldt disease (046.1)
- multiple sclerosis (340)
- Pick’s disease of the brain (331.11)
- polyarteritis nodosa (446.0)
- syphilis (094.1)

294.10 *Dementia in conditions classified elsewhere without behavioral disturbances*  
NOT ALLOWED AS PRINCIPAL DX

294.11 *Dementia in conditions classified elsewhere with behavioral disturbances*  
NOT ALLOWED AS PRINCIPAL DX

According to “code first” requirements, the provider would code the appropriate physical condition first. For example, note 333.4 “Huntington’s Chorea” as the primary diagnosis code and 294.11 “Dementia in conditions classified elsewhere with behavioral disturbances” as a secondary diagnosis or comorbidity code on the patient claim.

The purpose of this example is to demonstrate proper coding of a true “Code First” situation. In this example, the principal diagnosis groups to one of the 15 DRGs (diagnosis related groups) for which Medicare pays an adjustment. Had the diagnosis code grouped to a non-psychiatric DRG, Medicare’s systems (particularly the PRICER) would search the secondary diagnosis codes for a psychiatric code listed in the “Code First” list to assign a DRG adjustment.

**A Fix to the Comorbidity Table – Comorbidity Chart (page 7 of CR 3541)**

This chart is corrected as follows:

Oncology Treatment	1400-2399 <b>with</b> a radiation therapy (92.21-92.29) or chemotherapy code (99.25)
Chronic Obstructive Pulmonary Disease	V4611, V4612, 49121, 4941,5100, 51883, and 51884
Renal Failure, Acute	5845 through 5849, 63630, 63631, 63632, 63730, 63731, 63732, 6383, 6393, 66932, 66934, and 9585
Drug and/or Alcohol Induced Mental Disorders	2910, 2920, 29212, 2922, 30300, and 30400

**Split Billing Instructions – Split Billing/Stays Prior to and Discharges After IPF PPS Implementation Date**

CMS apologizes for the confusion regarding how IPFs should bill for patients in-house when the facility’s cost report begin date triggers the transition to IPF PPS. In CR 3678, CMS stated that IPFs had to split the bill in these instances. During the CMS training session with FIs, it was determined that providers did not have to split the bill, and FIs could override reason code 32061.

Therefore, for IPFs that have already split their bill because they received reason code 32061 and/or because they followed the instructions in CR 3678, you must cancel your pre-transition bill and re-bill your claim, showing all services from the admission date through discharge, as described in CR 3541. **This must be done by April 1, 2005**, so that mass adjustments can be appropriately applied. Your FI will be instructed to override the reason code, 32061, that forces you to split the bill.

**Inpatient Psychiatric Facility Prospective Payment System—Further Clarifications (continued)**

For IPFs that have not split their bill, continue to follow the instructions in CR 3541. Your FI will override reason code 32061.

**To summarize, IPFs should follow the instructions in CR 3541 (split billing not allowed) and ignore the instruction in CR 3678 regarding this issue.**

Keep in mind that if your patient did not have Medicare benefits, exhausted his/her benefits, or is in a noncovered level of care at transition, you may continue to submit no-pay bills every 30 days.

**An Extension to Notify Fiscal Intermediaries of Emergency Department (ED) Status – Date to Notify FIs of Emergency Department**

Some FIs have requested an extension for their IPFs to notify them of their emergency room status. IPFs with cost reporting periods beginning between January 1, 2005 and March 1, 2005 shall have notified their FI by March 7, 2005. For all other cost report begin dates, IPFs should notify their FI 30 days prior to the cost report begin date.

CMS will allow FIs discretion in the manner in which they wish to be notified and the type of documentation they will require.

**Additional Corrections**

The following are also corrections to CR 3678 “Further Information Related to Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)”, Transmittal 444, dated January 21, 2005:

- Blood-clotting factors are not considered a pass-through cost paid outside the IPF PPS. Payment for the factors is made through the coagulation factor deficit comorbidity adjustment.
- Nursing and allied health education costs are pass-through costs paid outside the IPF PPS. Information regarding nursing and allied health will be placed in the IPF PPS correction notice.

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- For PIP providers, electroconvulsive therapy and outlier payments are made on the discharge bill and are not included in the PIP amount.

CR 3678 “Further Information Related to Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)”, Transmittal 444, dated January 21, 2005, may be reviewed at the following CMS website:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R444CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R444CP.pdf).

**Implementation**

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

**Additional Information**

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

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

From that Web page, look for CR 3752 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: 3752  
Related CR Release Date: March 4, 2005  
Related CR Transmittal Number: 495  
Effective Date: January 1, 2005  
Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 495, CR 3752

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## Further Information Related to Inpatient Psychiatric Facility Prospective Payment System

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

**Note:** Since CR 3678 was released, the Centers for Medicare & Medicaid Services (CMS) has issued another CR (CR 3752) that clarifies some issues further and makes several corrections to CR 3678 and this instruction. Specifically, the following are corrections to CR 3678, “Further Information Related to Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)”, Transmittal 444, dated January 21, 2005.

Blood-clotting factors are not considered a pass-through cost paid outside the IPF PPS. Payment for the factors is made through the coagulation factor deficits comorbidity adjustment.

Nursing and allied health education costs are pass-through costs paid outside the IPF PPS. Information regarding nursing and allied health will be placed in the IPF PPS Correction Notice.

For PIP providers, electroconvulsive therapy and outlier payments are made on the discharge bill and are not included in the PIP amount.

When reading this instruction, please be sure to also read the Medlearn Matters article MM3752, which contains these clarifications and corrections. You will find MM3752 at:  
<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3752.pdf>.

*Further Information Related to Inpatient Psychiatric Facility Prospective Payment System (continued)***Provider Types Affected**

Inpatient psychiatric facilities (IPF) billing Medicare fiscal intermediaries (FIs) for services paid under the IPF Prospective Payment System (PPS)

**Provider Action Needed**

This article contains additional information regarding general policy and billing issues to help clarify the processes under the IPF PPS, particularly for facilities under the IPF PPS as of January 1, 2005.

**Background**

Related CR 3678 clarifies some aspects of IPF PPS. It does **not** replace CR 3541 (Transmittal 384, dated December 1, 2004), but it clarifies recent questions CMS has received from IPFs and the Medicare FIs that service those providers in processing their Medicare claims. Information related to CR 3541 was published in the [January 2005 Medicare A Bulletin Special Issue \(pages 33-35\)](#).

You may find CR 3541 – an overview of all of the policy and billing requirements related to IPF PPS at the following CMS website: [http://www.cms.hhs.gov/manuals/pm\\_trans/R384CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R384CP.pdf).

The corresponding may also be reviewed Medlearn Matters article at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3541.pdf>.

**CMS will be issuing a correction notice to the inpatient psychiatric facility prospective payment system final rule (Volume 69, Number 219, page 66922), published November 15, 2004, to make technical corrections, which will include the following clarifications:**

**Labor-Related Share**

- There is an inconsistency in the labor-related share between portions of the final rule and CR 3541, published December 1, 2004.
  - ♦ The current labor-related share is **0.72247**.

**Teaching Status Adjustment**

Teaching facilities will receive an adjustment that is measured as one plus the ratio of interns and residents to the average daily census (ADC), the sum of which is raised to the power of 0.5150. The number of interns and residents is capped at the level indicated on the latest cost report submitted by the IPF prior to November 15, 2004.

**Calculating the Electroconvulsive Therapy (ECT) Payment**

The ECT amount of \$247.96 is subject to COLA (cost of living adjustment) and wage adjustments. To calculate the adjusted amount, multiply \$247.96 by the labor share (0.72247) and by the area wage index. Then multiply \$247.96 by the non-labor share (0.27753) and by any applicable COLA. The sum of these two products is the adjusted per-treatment ECT amount.

Multiply the amount by the number of ECT occurrences and add it to the federal per diem payment to compute the total PPS payment.

The ECT amount itself does not receive any facility or patient level adjustments; it is added to the federal per diem payment after those adjustments have been applied. ECT payments and charges are taken into account when calculating the outlier threshold and outlier payment.

**Calculating Outlier Payments**

To understand how Medicare calculates outlier payments under the IPF PPS, CMS offers the following explanation:

**Calculate the Adjusted Fixed Dollar Loss Threshold**

Threshold amount = \$5,700

- Multiply the threshold amount by the labor share (0.72247) and the area wage index.
- Multiply the threshold amount by the non-labor share (0.27753) and any applicable COLA (Alaska or Hawaii).
- Add these two products and then multiply by any applicable facility-level adjustments (teaching, rural)
- Add this amount to the sum of the federal per diem payment and ECT payment to obtain the adjusted threshold amount.

**Calculate Eligible Outlier Costs**

- Multiply reported hospital charges by the cost-to-charge ratio to calculate cost.
- Subtract the adjusted threshold amount from the cost. This is the amount subject to outlier payments.
- Divide this amount by the length of stay to calculate the per diem outlier amount.
- For days **one** through **nine**, multiply this per diem outlier amount by 0.80.
- For day **ten** and thereafter, multiply the per diem outlier amount by 0.60.
- The sum of these two amounts is the total outlier payment.

**Additional Clarifications**

- The effective date of the system is for discharges (or “through” dates for interim bills) occurring during cost reporting periods beginning on or after January 1, 2005.
- Although the IPF PPS new payment system is effective January 1, 2005, transition is based on a providers’ cost reporting year. IPF providers will begin the new IPF PPS system at the beginning of their new cost reporting period.

If an IPF provider has their cost reporting period starting on October 1, 2005, then October 1, 2005 will be:

- ♦ The beginning date of their first transition year to the IPF PPS, and
- ♦ The date that they begin billing under the new IPF PPS system.

If an IPF provider has their cost reporting period starting on January 1, 2005, then January 1, 2005 will be:

- ♦ The beginning date they will begin billing under the new IPF PPS, and
- ♦ The beginning date of their first transition year.
- CMS has received a number of questions concerning what is considered a “new IPF,” and will be issuing additional guidance shortly regarding what constitutes a new IPF.

*Further Information Related to Inpatient Psychiatric Facility Prospective Payment System (continued)*

- Providers should notify their FI 30 days prior to the start of the provider’s fiscal year, if they believe they are entitled to the emergency department (ED) adjustment, to determine if their FI requires additional information or documentation. **However, providers whose cost reporting periods begin January 1, 2005 through March 1, 2005 should have contacted their FI on this issue prior to March 7, 2005.**
- **Psychiatric units of critical access hospitals (CAHs) are reimbursed under the IPF PPS.** In CR 3541, dated December 1, 2004, under the heading, “Affected Medicare Providers,” the second bulleted paragraph contained an error. The paragraph should read as follows:
 

“Veterans Administration hospitals, hospitals that are reimbursed under state cost control system 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), and nonparticipating hospitals furnishing emergency services to Medicare beneficiaries are not included in the IPF PPS. 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).”
- CMS will be providing guidance on the national cost to charge ratios which will be established using the most current IPF data available. The provider specific file required to calculate the national cost to charge ratios is under development.
- Age adjustment is determined as of admission date.
- Code First Chart (page 6 of CR 3541). The last row containing code 320.7 should be deleted. CMS is including a table (See Attachment 1 of CR 3678, the official instruction issued to your intermediary), that shows what adjustment factors apply. The Code First example provided on page 7 of CR 3541 was in error and a corrected example may be found on pages 3 and 4 of CR 3678.
- The ICD-9-CM procedure codes for oncology treatments are 92.21 through 92.29 and 99.25.
- Comorbidity chart (page 7 of CR 3541) should have reflected the following:
  - ♦ Oncology Treatment, 1400 through 2399 with a radiation therapy or chemotherapy code 92.2 – 92.29 or 99.25, instead of V58. or V58.1.
  - ♦ Chronic obstructive pulmonary disease, delete code V461 and add codes V4611 and V4612.
- For IPFs that are distinct part psychiatric units, total Medicare inpatient routine charges will be obtained from the PS&R report associated with the latest settled cost report. If PS&R data is not available,
  - ♦ Estimate Medicare routine charges estimated by dividing Medicare routine costs on Worksheet D- 1, Part II, line 41, by the result of Worksheet C, Part I, line 31, column 3 divided by line 31, column 6.
  - ♦ Add this amount to Medicare ancillary charges on Worksheet D-4, column 2, line 103 to arrive at total Medicare charges.
  - ♦ To calculate the total Medicare costs for distinct part units, data will be obtained from Worksheet D-1, Part II, line 49 minus (Worksheet D, part III, column 8, line 31 plus Worksheet D, Part IV, column 7, line 101). All references to worksheet and specific line numbers should correspond with the subprovider identified as the IPF unit that is the letter “S” or “M” in the third position of the Medicare provider number.
  - ♦ Divide the total Medicare costs by the total Medicare charges to compute the cost-to-charge ratio.

More information is available at:  
<http://www.cms.hhs.gov/providers/ipfpps/>.

**Payment to Hospitals and Units excluded from the acute Inpatient Prospective Payment System for Direct Medical Education (DGME) and Nursing & Allied Health (N&AH) Education for Medicare Advantage Beneficiaries**

Current IPFs are already following the requirements in CR 2476, Transmittal A-03-007, published on February 3, 2003, at: [http://www.cms.hhs.gov/manuals/pm\\_trans/A03007.pdf](http://www.cms.hhs.gov/manuals/pm_trans/A03007.pdf).

New IPFs and IPF distinct part units located in a critical access hospital should familiarize themselves with these instructions. **There is no authority for IPFs to bill for the indirect medical education as is done under the IPPS.**

**Stays Prior to and Discharge After IPF PPS Implementation Date**

**Cost Report Period begins Prior to April 1, 2005:**

Until the IPF PPS system changes are in place, IPF providers should continue to follow current billing instructions when patients are in the facility over the fiscal year begin date, i.e., split the bill. Once the changes are implemented, the IPF providers should follow the billing instructions as outlined in CR 3541. These instructions include the criteria for canceling and rebilling if the stay crosses the provider’s PPS effective date. For IPF providers, the claims submitted prior to their PPS effective date should only be canceled if the stay contains at least one benefit day applied on or after the PPS effective period. Stays that are benefits exhausted or noncovered prior to the provider’s PPS effective date should not be canceled and rebilled as one stay. For patients admitted into the IPF after the PPS effective date, our system will automatically adjust those bills for the IPF.



**Further Information Related to Inpatient Psychiatric Facility Prospective Payment System (continued)****Related Instructions**

CR 3541 - an overview of all of the policy and billing requirements related to IPF PPS (Transmittal 384, dated December 1, 2004), may be found at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R384CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R384CP.pdf).

The Medlearn Matters article related to CR 3541 may be found at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3541.pdf>.

In addition, the November 15, 2004 final rule in the *Federal Register* (Volume 69, Number 219, page 66922) may be found at: <http://www.cms.hhs.gov/providerupdate/regs/cms1213f.pdf>.

**Additional Information**

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

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From that Web page, look for CR 3678 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: 3678

Related CR Release Date: January 21, 2005

Related CR Transmittal Number: 444

Effective Date: Cost reporting periods beginning on or after January 1, 2005

Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 444, CR 3678

**Fiscal Year 2005 Inpatient Prospective Payment System Update**

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

**Note:** CMS revised this article on April 28, 2005, to show that information in Change Request (CR) 3459 was updated by CR 3672 (Transmittal 422, dated December 30, 2004), and Attachment 2 of CR 3672 includes changes to hospitals that require a special wage index (file position 155-160). Attachment 2 in CR 3672 also includes: 1) blended wage indexes, hold harmless wage indexes, and other special wage index exceptions that have changed since CR 3459 was released; and 2) providers who are located in core-based statistical areas (CBSAs) listed in Attachment 1 (where the changes to the wage data have caused their wage index values to change). To see CR 3672, go to the following CMS website: [http://www.cms.hhs.gov/manuals/pm\\_trans/R422CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R422CP.pdf).

The Medlearn Matters article related to CR 3672 may be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3672.pdf>.

The article related to CR 3459 was published in the *First Quarter 2005 Medicare A Bulletin* (pages 31-35).

The article related to CR 3672 was published in the *Second Quarter 2005 Medicare A Bulletin* (page 37).

**Provider Types Affected**

Hospitals (inpatient prospective payment system [IPPS]) and long term care hospitals [LTCH]

**Provider Action Needed**

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

**Background**

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

This instruction also addresses new GROUPER and DRG changes that are effective October 1, 2004 for hospitals paid under the LTCH prospective payment system (PPS)

as well as information on the HwH provision. LTCH PPS rate changes occurred on July 1, 2004. For other LTCH policy changes, please also refer to:

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

Fiscal Year 2005 Inpatient Prospective Payment System Update (continued)

Key changes are as follows:

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

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

<http://www.cms.hhs.gov/providerupdate/regs/cms1428f.pdf>

**Furnished Software Changes**

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

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

**IPPS PRICER 05.0**

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

**1. Rates:**

Standardized Amount Update Factor	1.033
Hospital Specific Update Factor	1.033
Common Fixed Loss Cost Outlier Threshold	\$25,800.00
Federal Capital Rate	\$416.53
Puerto Rico Capital Rate	\$199.01
Outlier Offset-Operating National	0.948978
Outlier Offset-Operating Puerto Rico	0.973183
Outlier Offset-Operating National PR blend	0.955029
IME Formula	1.42*
	[1 + resident-to-bed ratio** .405-1]
MDH/SCH Budget Neutrality Factor *	0.999876

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

**Quality = 1 / Wage Index > 1 Full Update and .711 Labor Share**

	Labor Share	Non-Labor Share
National	3238.07	1316.18
PR National	3238.07	1316.18
PR Specific	1554.79	625.84

**Quality <> 1 / Wage Index > 1 Lower Update and .711 Labor Share**

	Labor Share	Non-Labor Share
National	3225.53	1311.08
PR National	3225.53	1311.08
PR Specific	1548.77	623.42

**Quality = 1 / Wage Index <= 1 Full Update and .62 Labor Share**

	Labor Share	Non-Labor Share
National	2823.64	1730.62
PR National	2823.64	1730.62
PR Specific	1351.99	828.64

**Quality <> 1 / Wage Index <= 1 Lower Update and .62 Labor Share**

	Labor Share	Non-Labor Share
National	2812.70	1723.91
PR National	2812.70	1723.91
PR Specific	1346.76	825.43

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

The revised hospital wage indices and geographic adjustment factors are contained in Tables 4a2 (urban areas), 4b2 (rural areas), and 4c2 (redesignated hospitals) of the August 11, 2004 *Federal Register*. These tables may be found at the following CMS website:

<http://www.cms.hhs.gov/providers/hipps/ippswage.asp>

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

**2. Postacute Care Transfer Policy**

On October 1, 1998, CMS established a postacute care transfer policy that paid as transfers all cases assigned to one of ten DRGs if the patient is discharged to:

- a psychiatric hospital or unit,
- an inpatient rehabilitation hospital or unit,
- an LTCH,
- a children's hospital,
- a cancer hospital,
- a skilled nursing facility, or
- a home health agency.

On October 1, 2003, that list was expanded to 29 DRGs.

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

**3. New Technology Add-On Payment**

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

- The maximum add-on payment for InFUSE™ is \$1,955.00 (ICD-9-CM procedures of 84.51 and 84.52 must both be present AND codes 81.05, 81.08, 81.35, and 81.38 **must not** be present).
- The maximum add-on payment for OP-1 is also \$1,955.00 (ICD-9-CM code of 84.52 **must** be present and at least one of 81.05, 81.08, 81.35, or 81.38 must also be present).

For both of these add-ons, the DRG must also be 497 or 498.

**Fiscal Year 2005 Inpatient Prospective Payment System Update (continued)**

- The maximum add-on payment for CRT-D is \$16,262.50 (ICD-9-CM code of 00.51 or 00.54 **must** be present).
- The maximum add-on payment for Kinetra® is \$8,285.00 (ICD-9-CM codes 02.93 AND 86.95 **must** be present).

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

**Low Volume Hospitals**

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

**Hospital Quality Initiative**

The hospitals that will receive the quality initiative bonus are listed at the following website:

<http://www.qnetexchange.org/public/>.

Please select ‘HDC’, then ‘List of Providers’ under the heading ‘Reporting Hospital Quality Data for Annual Payment Update’ or ‘What’s New’. The actual CR contains a list of the providers (by provider number) that are not receiving the quality initiative bonus.

**Core-Based Statistical Area (CBSA)**

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

**Disproportionate Share (DSH) Adjustment for Urban to Rural Providers**

42 CFR 412.102 provides for a transition to a rural payment amount from an urban payment amount under the operating PPS over two years. There are a few hospitals with a DSH adjustment near or greater than 12 (the cap on the operating DSH adjustment for certain groups of providers) that were considered urban under the MSA definition, but are now considered rural under the CBSA definition. These providers will receive an adjustment to their operating DSH payment over the next two years and have been coded into the PRICER in an attempt to most closely approximate the DSH payment they will receive upon cost report settlement. The adjustment gives these hospitals ? of the difference between the urban and rural operating DSH for fiscal year (FY) 2005 and ? of the difference between the urban and rural operating DSH for FY 2006. Based on the best available data, CMS has identified the following providers:

**Medicare Provider Identification Numbers**

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

**Capital PPS Payments to Hospitals Located in Puerto Rico**

Currently, section 412.374 of the regulations provide that capital PPS payments to hospitals located in Puerto Rico are based on a blend of 50 percent of the capital federal rate (derived from the costs of all acute care hospitals participating in the IPPS, including those located in Puerto Rico) and 50 percent of the Puerto Rico capital rate (derived from the costs of Puerto Rico acute care hospitals only).

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

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

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

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

In the August 11, 2004 IPPS final rule, CMS explained that because of the changes to the operating PPS described above, rural and other urban hospitals that were previously eligible to receive the large urban add-on and DSH payments under the capital PPS because they reclassified to a large urban area for the purpose of the standardized amount under the operating PPS, are no longer able to reclassify, and therefore, will not be eligible to receive those additional capital PPS payment adjustments beginning in FY 2005.

For discharges occurring on or after October 1, 2004, only hospitals geographically located in a large urban area (as defined in section 412.63[c][6]) are eligible for large

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urban add-on payments provided for under section 412.312(b)(2)(ii) and section 412.316(b). Similarly, for discharges occurring on or after October 1, 2004, only hospitals serving low-income patients that are geographically located in an urban area (as defined in section 412.64) and that meet all other requirements of section 412.320 will be eligible for capital PPS DSH payments provided for under section 412.320.

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

Currently, under the capital PPS the large urban location adjustment provided for under section 412.316(b) and the DSH payment adjustment for certain urban hospitals provided for under section 412.320 are based on the existing geographic classifications set forth at section 412.63. Beginning in FY 2005 and thereafter, a hospital's geographic classification (MSA) will be based on OMB's new CBSA designations, as set forth under new section 412.64.

Because of this change in the MSA definitions (under new section 412.64), CMS has revised section 412.316(b) and section 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the large urban location adjustment (412.316(b)) and the DSH payment adjustment (section 412.320) will be based on the geographic classifications at section 412.64.

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

**Long-Term Care Hospital Changes  
LTCH PPS Cost-To-Charge Ratios**

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

**LTCH PRICER, DRGs, and Relative Weights**

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

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

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

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

**LTC Hospital Within Hospital (HwH) Provision**

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

- The policies will also be applicable if the host hospital is a hospital other than an acute care hospital but only applicable if the HwH is an LTCH.
- For existing LTCH HwHs, the three performance of basic hospital functions qualifications for HwHs at 412.22(e)(5) (i), (ii), and (iii) are eliminated for cost reporting periods beginning on or after October 1, 2004. (Note provisions of "hold harmless year October 1, 2004 – October 1, 2005 below.)
- If an LTC HwH meets existing separateness and control of administrative and medical governance provisions at 412.22(e)(1) through (e)(4), payment will be made under the LTCH PPS as specified in 412.534.

**Basic Payment Formula**

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

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

*Fiscal Year 2005 Inpatient Prospective Payment System Update (continued)***Specific Circumstances**

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

**Transition Period**

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

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

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

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

- For discharges in excess of that threshold, the payments will be determined under “the basic payment formula” specified above.
- **Year 3** – (cost reporting periods beginning on or after October 1, 2006 through September 30, 2007)
  - LTC HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the lesser of the percentage of those patients for their 2004 cost reporting period or 50 percent.
  - For discharges in excess of that threshold, the payments will be determined under “the basic payment formula” specified above.
- **Year 4** – (cost reporting periods beginning on or after October 1, 2007 (full phase-in)
  - LTC HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the 25 percent of the applicable percentage described for “specific circumstances above.”
  - For discharges in excess of that threshold, the payments will be determined under “the basic payment formula” specified above.

**Implementation**

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

**Additional Information**

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

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

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

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

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

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

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# LOCAL COVERAGE DETERMINATIONS

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

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

## Effective and Notice Dates

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

## Electronic Notification

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

## More Information

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

Medical Policy – 19T  
 First Coast Service Options, Inc.  
 P.O. Box 2078  
 Jacksonville, FL 32231-0048  
 or call 1-904-791-8465

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

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## ADDITIONS/REVISIONS TO LMRPs/LCDs

### A11000: Debridement Services—Revision to Policy

The local coverage determination (LCD) for debridement services – A11000 was effective on January 1, 2005. Since that time, CPT codes 11004, 11005, and 11006 (debridement of skin, subcutaneous tissue, muscle, and fascia for necrotizing soft tissue infection), as well as, CPT code 11008 (removal of prosthetic material or mesh, abdominal wall for necrotizing soft tissue infection) were determined to be inpatient services only. Therefore, these codes were moved to the “Coding Guidelines” section for information only.

#### Effective Date

This revision is effective for services provided **on or after January 1, 2005**. The full-text for this LCD will be available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

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### A22899: Kyphoplasty—Revision to Policy

The local medical review policy (LMRP) for kyphoplasty was effective on September 23, 2002. Based upon CMS Change Request 3649, dated January 14, 2005, procedure codes C9718 (Kyphoplasty, one vertebral body, unilateral or bilateral injection) and C9719 (Kyphoplasty, one vertebral body, unilateral or bilateral injection; each additional vertebral body [list separately in addition to code for primary procedure]) have been added to the policy.

This revision is effective for services provided **on or after January 1, 2005**.

In addition, a decision was made to retire this policy based on data analysis and local standards of medical practice. The effective date for the retirement of this policy is based on dates of service **on or after February 1, 2005**.

The full-text for this LMRP may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

### A76090: Diagnostic Mammography—Revision to Policy

The local medical review policy (LMRP) for diagnostic mammography – 76090 was last updated on January 1, 2004. Since that time, type of bill 14x has been removed from the policy per Change Request 3469.

#### Effective Date

This revision is effective for services provided **on or after April 1, 2005**. The full-text of this LMRP may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

### A76092: Screening Mammograms—Revision to Policy

The local medical review policy (LMRP) for screening mammograms – 76092 was last updated on January 1, 2004. Since that time, type of bill 13x has been added to the policy and type of bill 14x has been removed from the policy per Change Request 3469.

#### Effective Date

This revision is effective for services provided **on or after April 1, 2005**. The full-text of this LMRP may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

### ABotulinum Toxins: Botulinum Toxins—Revision to Policy

The local coverage determination (LCD) for botulinum toxins was previously revised on October 1, 2004. This LCD has been revised to add ICD-9-CM code 705.21 – Primary focal hyperhidrosis to the “ICD-9 Codes that Support Medical Necessity” section of the policy. The “Indications and Limitations of Coverage” and/or “Medical Necessity” sections have been revised accordingly.

#### Effective Date

This revision is effective for services provided **on or after April 4, 2005**. The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

## AEPO: Epoetin alfa—Revision to Policy

The local coverage determination (LCD) for epoetin alfa was last revised June 1, 2004. A revision to this LCD was made to add the following additional diagnosis codes under the “ICD-9 Codes that Support Medical Necessity” section for the following category:

- Under Non-Renal Diagnosis (Q0136) added diagnosis code:  
285.22 Anemia in neoplastic disease

### Effective Date

This revision is effective for claims processed **April 8, 2005**, for services provided **on or after January 5, 2004**. The revised full-text for this LCD is available on the provider education website <http://www.floridamedicare.com> on or after these effective dates. ❖

## AJ0207: Amifostine (Ethyol®)—Revision to Policy

The local coverage determination (LCD) for amifostine was last updated on June 1, 2004. A revision to this LCD was made to add the following additional off-label indication under the “Indications and Limitations of Coverage and/or Medical Necessity” for the treatment of:

- Mucositis, radiation therapy or radiation combined with chemotherapy induced – to reduce the incidence of mucositis in patients receiving radiation therapy or radiation combined with chemotherapy.

Additionally, ICD-9-CM codes were removed from the policy.

### Effective Date

This revision is effective for services processed **on or after March 11, 2005**. The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

## AJ1563: Intravenous Immune Globulin—Revision to Policy

The local coverage determination (LCD) for intravenous immune globulin (IVIG) was last revised January 1, 2005. Change request 3745, dated March 18, 2005 discontinued HCPCS J1563 (Injection, immune globulin, intravenous, 1g) and J1564 (Injection, immune globulin, intravenous, 10 mg) with HCPCS, which appropriately distinguish lyophilized and non-lyophilized forms of IVIG.

- HCPCS code J1563 has been deleted and replaced with HCPCS Q9941 (Injection, immune globulin, intravenous, lyophilized, 1 gm) and Q9942 (injection, immune globulin, intravenous, lyophilized, 10 mg).
- HCPCS code J1564 has been deleted and replaced with Q9943 (Injection, immune globulin, intravenous non-lyophilized, 1 gm) and HCPCS Q9944 (Injection, immune globulin, intravenous non-lyophilized, 10 mg).

In addition, the LCD number has been changed from AJ1563 to AQ9941.

### Effective Date

This revision is effective for services provided **on or after April 1, 2005**. The revised full-text for this LCD is available on the provider education website [www.floridamedicare.com](http://www.floridamedicare.com) on or after this effective date. ❖

## AJ9000: Antineoplastic Drugs—Addition to Policy

The local coverage determination (LCD) for antineoplastic drugs was last updated on January 1, 2005. A revision to this LCD was made to add the additional FDA-approved indications under the “Indications and Limitations of Coverage and/or Medical Necessity” for the following drugs:

- J9600 (Porfimer sodium) – Ablation of high-grade dysplasia (HGD) in Barrett esophagus (BE) patients who do not undergo esophagectomy.
- J9263 (Oxaliplatin) – For injection in combination with infusional 5-fluorouracil/leucovorin (5-FU/LV) for the adjunctive treatment of stage III colon cancer patients who have undergone resection of the primary tumor. The indication is based on an improvement in disease-free survival, with no demonstrated benefit in overall survival after median follow up of four years.

In addition, ICD-9-CM code 530.85 – Barrett’s esophagus (for ablation of high-grade dysplasia in BE patients who do not undergo esophagectomy) was added to the list of diagnoses for J9600.

### Effective Date

These additions are effective for services processed **on or after March 23, 2005** for services provided **on or after August 1, 2003**, for HCPCS code J9600, and services provided **on or after November 4, 2004**, for HCPCS code J9263. The revised full-text for this LCD is available on the provider education website <http://www.floridamedicare.com> on or after these effective dates. ❖



**APULMDIAGSVCS: Pulmonary Diagnostic Services—Addition to Policy**

The local coverage determination (LCD) for pulmonary diagnostic services was last revised on January 1, 2005. Since that time, type of bill code 14x has been added to the policy.

**Effective Date**

This addition is effective for services provided **on or after February 3, 2005**. The revised full-text for this LCD is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**ASKINSUB: Skin Substitutes—Revision to Policy**

The local coverage determination (LCD) for skin substitutes was previously revised on January 1, 2005. Since that time, HCPCS descriptors have been updated and each skin substitute has been referenced to the appropriate HCPCS code(s). In addition, the global periods have been removed from the coding guidelines. Please refer to the most current Medicare physician fee schedule for this information.

**Effective Date**

This revision is effective for services provided **on or after January 1, 2005**. The revised full-text for this LCD is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**AVISCO: Viscosupplementation Therapy for Knee—Addition to Policy**

The local coverage determination (LCD) for viscosupplementation therapy for knee was last updated on January 1, 2005. Based upon CMS Change Request 3649, dated January 14, 2005, HCPCS code C9220 (Sodium hyaluronate per 30 mg dose, for intra-articular injection) has been added to the policy.

**Effective Date**

This addition is effective for services provided **on or after January 1, 2005**. The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**RETIREMENT OF EXISTING LMRPs/LCDs****Ambulance Services—Retirement of Policies**

Florida Medicare has determined that information in the following local medical review policies (LMRP) did not meet criteria mandated by the Centers for Medicare & Medicaid Services (CMS) for a local coverage determination (LCD). The coverage guidelines in these policies are provided under the CMS national regulations. Therefore, the following LMRPs will be retired.

**Policy Number Policy Name**

AA0425	Ground Ambulance Services
AA0430	Air ambulance Services
AA0434	Specialty Care Transport

Coverage guidelines for these services may be found in the Medicare Benefit Policy Manual, Pub. 100-2, Chapter 10 on the CMS website at [http://www.cms.hhs.gov/manuals/102\\_policy/bp102c10.pdf](http://www.cms.hhs.gov/manuals/102_policy/bp102c10.pdf).

**Effective Date**

The retirement of these policies are effective for services provided **on or after April 1, 2005**. ❖

## ADDITIONAL MEDICAL INFORMATION

### Clarification of Psychotherapy Documentation Requirements

Effective February 22, 2005 the Medicare requirements for submitting psychotherapy notes have changed. Change request 3457 states that providers can **no** longer be required to submit psychotherapy notes when the notes in question are protected by the Final Privacy Rule, 45 CFR, Section 164.501. Psychotherapy notes are defined as notes recorded by a mental health professional that 1) document or analyze the contents of a counseling session, and 2) are separated from the rest of the medical record. The definition of psychotherapy notes **does not** include the following information:

- Prescription medication and monitoring
- Counseling sessions start and stop times
- Modalities and frequencies of treatment rendered
- Results of clinical tests, and any summary of: diagnosis, functional status, treatment plan, symptoms, prognosis, progress in treatment

At various times providers will continue to receive documentation requests from Medicare. When documentation is requested, the provider will be required to respond by submitting medical record information. The provider *has the option to:*

- Submit original psychotherapy notes. This requires the patient to authorize release of the record. **OR**
- In responding to these requests the provider can extract information from the psychotherapy note and submit documentation in the form of a summary. This summary must include documentation outlining the patient's need for the services provided (i.e., that the services provided were reasonable and medically necessary).

The summary document **must** include all of the following information to support the medical necessity of the psychotherapy session:

- Description of emotional or behavioral symptoms that demonstrate inappropriate or maladaptive functioning that is a significant change in the patient's baseline level of functioning.
- Progress towards treatment goals since last session.
- Time spent in psychotherapy encounter/session.
- Description of treatment, including therapeutic interventions such as behavior modification, supportive interaction, and discussion of reality provided to the patient during the psychotherapy session.
- Degree of patient participation in the psychotherapy session.
- Patient reaction to the psychotherapy session.

If the provider does not submit information when requested, that clearly demonstrates that the service rendered was reasonable and medically necessary, the claim will be denied.

**Please note:** In addition to the psychotherapy notes, the additional development request (ADR) letter requires the submission of: any and all referring physicians' orders, initial evaluation and/or diagnostic interview, test results/reports and treatment plan/treatment plan updates. ❖

Source: CMS Medlearn Matters article:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3457.pdf>

# CRITICAL ACCESS HOSPITAL SERVICES

## April 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 billing Medicare fiscal intermediaries (FIs) for outpatient services not paid under the outpatient prospective payment system (OPPS)

### Provider Action Needed

#### STOP – Impact to You

This article informs hospitals that are not paid under the OPPS of new additions, changes, and deletions of HCPCS codes, diagnosis codes, and procedure codes.

#### CAUTION – What You Need to Know

The effective dates of these changes vary as discussed in this instruction and in CR 3750. Unless otherwise noted, the effective date corresponds to the date of service.

#### GO – What You Need to Do

Ensure that billing staff are aware of these changes which will be implemented by Medicare on April 4, 2005

#### Background

This instruction is based on information contained in Change Request (CR) 3750 which informs FIs that the non-OPPS OCE has been updated with new additions, changes, and deletions to Healthcare Common Procedure Coding System/Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4) codes. This OCE is used to process bills from hospitals not paid under the OPPS. The Centers for Medicare & Medicaid Services (CMS) sent detailed information about these changes in separate communications.

The following are changes made to version 20.2 of the non-OPPS OCE:

- **Changes retroactive to August 1, 2000, (OCE v15.2)**

The following codes have been **removed** from the **nonreportable** list, **effective August 1, 2000:**

Code	Description of Code
93042	Rhythm ECG, report
93233	ECG monitor/review, 24 hrs
93237	ECG monitor/review, 24 hrs
93722	Plethysmography report

- **Changes retroactive to January 1, 2004, (OCE v19.1)**

The following code has been **deleted** from the list of **valid HCPCS, effective January 1, 2004:**

Code	Description of Code
C9408	FDG, per dose, brand

The following code has been **added** to the **noncovered** list, **effective January 1, 2004:**

Code	Description of Code
E0637	Sit-stand w seatlift

The following codes have been **removed** from the **nonreportable** list, **effective January 1, 2004:**

Code	Description of Code
E1019	HD feature power seat
E1021	Ex hd feature power seat
E0637	Sit-stand w seatlift

- **Changes retroactive to October 1, 2004, (OCE v20.0)**

The following codes have been **added** to the list of **valid HCPCS, effective October 1, 2004:**

Code	Description of Code
S0109	Methadone oral 5mg
S0166	Inj olanzapine 2.5mg
S0167	Inj apomorphine HCl 1mg
S0168	Inj azacitidine 100mg
S0515	Scleral lens liquid bandage
S2215	UGI endoscopy inj implant
S8093	CT angiography coronary
S9097	Home visit wound care

The following codes have been **deleted** from the list of **valid HCPCS, effective October 1, 2004:**

Code	Description of Code
G0330	PET image initial dxs cervcal
G0331	PET image restage ovarian ca
S2370	Intradiscal electrothermal
S2371	Each additional interspace

The following codes have been **added** to the **nonreportable** list, **effective October 1, 2004:**

Code	Description of Code
S0109	Methadone oral 5mg
S0166	Inj olanzapine 2.5mg
S0167	Inj apomorphine HCl 1mg
S0168	Inj azacitidine 100mg
S0515	Scleral lens liquid bandage
S2215	UGI endoscopy inj implant
S8093	CT angiography coronary
S9097	Home visit wound care

- **Changes retroactive to January 1, 2005, (OCE v20.1)**

The following codes have been **added** to the list of **valid HCPCS, effective January 1, 2005:**

Code	Description of Code
C9127	Paclitaxel protein pr
C9128	Inj pegaptamib sodium
C9440	Vinorelbine tar,brand
G0235	PET not otherwise specified
G0369	Pharm fee 1st month transpla
G0370	Pharmacy fee oral cancer etc
G0371	Pharm dispense inhalation 30
G0374	Pharm dispense inhalation 90

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

G9021 Chemo assess nausea vomit L1  
 G9022 Chemo assess nausea vomit L2  
 G9023 Chemo assess nausea vomit L3  
 G9024 Chemo assess nausea vomit L4  
 G9025 Chemo assessment pain level1  
 G9026 Chemo assessment pain level2  
 G9027 Chemo assessment pain level3  
 G9028 Chemo assessment pain level4  
 G9029 Chemo assess for fatigue L1  
 G9030 Chemo assess for fatigue L2  
 G9031 Chemo assess for fatigue L3  
 G9032 Chemo assess for fatigue L4  
 K0670 Stance phase only  
 K0671 Portable oxygen concentrator  
 S0142 Colistimethate inh sol mg  
 S0143 Aztreonam inh sol gram  
 S0197 Prenatal vitamins 30 day  
 S0595 New lenses in pts old frame  
 S0625 Digital screening retinal  
 S3005 Eval self-assess depression  
 S8434 Interim splint upper extreme  
 S8940 Hippotherapy per session

The following codes have been **deleted** from the list of valid HCPCS, **effective January 1, 2005:**

<b>Code</b>	<b>Description of Code</b>
A4534	Youth size brief each
C2666	Unassigned #71
C2667	Unassigned #72
C2668	Unassigned #73
C2669	Unassigned #74
C2670	Unassigned #75

The following codes have been **added** to the **noncovered** list, **effective January 1, 2005:**

<b>Code</b>	<b>Description of Code</b>
E0203	Therapeutic lightbox tabletp
G0235	PET not otherwise specified

The following codes have been removed from the Non-Covered list, effective January 1, 2005:

<b>Code</b>	<b>Description of Code</b>
0020T	Extracorp shock wave tx, ft
78608	Brain imaging (PET)
78609	Brain imaging (PET)
78811	Tumor imaging (pet), limited
78812	Tumor image (pet)/skul-thigh
78813	Tumor image (pet) full body
78814	Tumor image pet/ct, limited
78815	Tumor image pet/ct skul-thigh
78816	Tumor image pet/ct full body

The following codes have been **added** to the **nonreportable** list, **effective January 1, 2005:**

<b>Code</b>	<b>Description of Code</b>
C9127	Paclitaxel protein pr
C9128	Inj pegaptamib sodium
C9440	Vinorelbine tar,brand
G0345	IV infuse hydration, initial
G0346	Each additional infuse hour
G0347	IV infusion therapy/diagnost
G0348	Each additional hr up to 8hr

G0349 Additional sequential infuse  
 G0350 Concurrent infusion  
 G0351 Therapeutic/diagnostic injec  
 G0353 IV push, single orinital dru  
 G0354 Each addition sequential IV  
 G0355 Chemo administrate subcut/IM  
 G0356 Hormonal anti-neoplastic  
 G0357 IV push single/initial subst  
 G0358 IV push each additional drug  
 G0359 Chemotherapy IV one hr initi  
 G0360 Each additional hr 1-8 hrs  
 G0361 Prolong chemo infuse>8hrs pu  
 G0362 Each add sequential infusion  
 G0363 Irrigate implanted venous de  
 G0368 EKG interpret & report preve  
 G0369 Pharm fee 1st month transpla  
 G0370 Pharmacy fee oral cancer etc  
 G0371 Pharm dispense inhalation 30  
 G0374 Pharm dispense inhalation 90  
 G9021 Chemo assess nausea vomit L1  
 G9022 Chemo assess nausea vomit L2  
 G9023 Chemo assess nausea vomit L3  
 G9024 Chemo assess nausea vomit L4  
 G9025 Chemo assessment pain level1  
 G9026 Chemo assessment pain level2  
 G9027 Chemo assessment pain level3  
 G9028 Chemo assessment pain level4  
 G9029 Chemo assess for fatigue L1  
 G9030 Chemo assess for fatigue L2  
 G9031 Chemo assess for fatigue L3  
 G9032 Chemo assess for fatigue L4  
 K0671 Portable oxygen concentrator  
 S0142 Colistimethate inh sol mg  
 S0143 Aztreonam inh sol gram  
 S0197 Prenatal vitamins 30 day  
 S0595 New lenses in pts old frame  
 S0625 Digital screening retinal  
 S3005 Eval self-assess depression  
 S8434 Interim splint upper extrem  
 S8940 Hippotherapy per session

The following codes have been **removed** from the **nonreportable** list, **effective January 1, 2005:**

<b>Code</b>	<b>Description of Code</b>
36416	Capillary blood draw
78491	Heart image (pet), single
78492	Heart image (pet), multiple
Q0081	Infusion ther other than che
Q0083	Chemo by other than infusion
Q0084	Chemotherapy by infusion

• **Changes effective April 1, 2005, (OCE v.20.2)**

The following codes have been **added** to the list of **valid HCPCS, effective April 1, 2005:**

<b>Code</b>	<b>Description of Code</b>
C9223	Inj adenosine, tx dx
C9723	Dyn IR Perf Img
C9724	EPS gast cardia plic
G9041	Low vision serv occupational
G9042	Low vision orient/mobility
G9043	Low vision rehab therapist
G9044	Low vision rehab teacher

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

Q4079 Injection, natalizumab  
 Q9941 IVIG lyophil 1 G  
 Q9942 IVIG lyophil 10 MG  
 Q9943 IVIG non-lyophil 1 G  
 Q9944 IVIG non-lyophil 10 MG  
 Q9945 LOCM <= 149 mg/ml iodine, 1 ml  
 Q9946 LOCM 150-199 mg/ml iodine, 1 ml  
 Q9947 LOCM 200-249 mg/ml iodine, 1 ml  
 Q9948 LOCM 250-299 mg/ml iodine, 1 ml  
 Q9949 LOCM 300-349 mg/ml iodine, 1 ml  
 Q9950 LOCM 350-399 mg/ml iodine, 1 ml  
 Q9951 LOCM >=400 mg/ml iodine, 1 ml  
 Q9952 Inj Gad-base MR contrast, ml  
 Q9953 Inj Fe-based MR contrast, ml  
 Q9954 Oral MR contrast, 100 ml  
 Q9955 Inj perflexane lip micros, ml  
 Q9956 Inj octafluoropropane mic, ml  
 Q9957 Inj perflugren lip micros, ml

The following codes have been **deleted** from the list of **valid HCPCS, effective April 1, 2005:**

<b>Code</b>	<b>Description of Code</b>
G0030	PET imaging prev PET single
G0031	PET imaging prev PET multiple
G0032	PET follow SPECT 78464 singl
G0033	PET follow SPECT 78464 mult
G0034	PET follow SPECT 76865 singl
G0035	PET follow SPECT 78465 mult
G0036	PET follow cornry angio sing
G0037	PET follow cornry angio mult
G0038	PET follow myocard perf sing
G0039	PET follow myocard perf mult
G0040	PET follow stress echo singl
G0041	PET follow stress echo mult
G0042	PET follow ventriculogm sing
G0043	PET follow ventriculogm mult
G0044	PET following rest ECG singl
G0045	PET following rest ECG mult
G0046	PET follow stress ECG singl
G0047	PET follow stress ECG mult
G0125	PET image pulmonary nodule
G0210	PET img wholebody dxlung
G0211	PET img wholebody init lung
G0212	PET img wholebod restag lung
G0213	PET img wholebody dx
G0214	PET img wholebod init
G0215	PETimg wholebod restag
G0216	PET img wholebod dx melanoma
G0217	PET img wholebod init melan
G0218	PET img wholebod restag mela
G0220	PET img wholebod dx lymphoma
G0221	PET imag wholebod init lympho

G0222 PET imag wholbod resta lymph  
 G0223 PET imag wholbod reg dx head  
 G0224 PET imag wholbod reg ini hea  
 G0225 PET whol restag headneckonly  
 G0226 PET img wholebody dx esophagl  
 G0227 PET img wholebod ini esophage  
 G0228 PET img wholebod restg esopha  
 G0229 PET img metaboloc brain pres  
 G0230 PET myocard viability post  
 G0231 PET WhBD colorec; gamma cam  
 G0232 PET whbd lymphoma; gamma cam  
 G0233 PET whbd melanoma; gamma cam  
 G0234 PET WhBD pulm nod; gamma cam  
 G0253 PET image brst dection recur  
 G0254 PET image brst eval to tx  
 G0296 PET imge restag thyrod cance  
 G0336 PET imaging brain Alzheimers

The following code has been **removed** from the **noncovered list, effective April 1, 2005:**

<b>Code</b>	<b>Description of Code</b>
J8501	Oral aprepitant

The following codes have been **added** to the **nonreportable list, effective April 1, 2005:**

<b>Code</b>	<b>Description of Code</b>
C9223	Inj adenosine, tx dx
C9723	Dyn IR Perf Img
C9724	EPS gast cardia plic
J1563	IV immune globulin
J1564	Immune globulin 10 mg

**Implementation**

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

**Additional Information**

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

That instruction is available at:  
[http://www.cms.hhs.gov/manuals/pm\\_trans/R503CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R503CP.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: 3750  
 Related CR Release Date: March 11, 2005  
 Related CR Transmittal Number: 503  
 Effective Date: Various dates as reflected in CR 3750  
 Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 503, CR 3750

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## Implementation of the Physician Scarcity Area Bonus and Revision to the Health Professional Shortage Area Payment to a Critical Access Hospital

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

### Provider Types Affected

Critical access hospitals (CAHs) located in a physician scarcity area (PSA)/health professional shortage area (HPSA) area and billing for Medicare fiscal intermediaries (FIs) for physician services

### Provider Action Needed

#### STOP – Impact to You

This article includes information from change request (CR) 3790, which states that Medicare will pay an additional five percent bonus payment to physicians who render service in a CAH that is located in a designated PSA. Some of this information was previously supplied to CAHs is a special edition Medlearn Matters article, SE0453, which is available at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0453.pdf>.

#### CAUTION – What You Need to Know

The MMA also extended the HPSA provision to include a ten percent bonus for mental health physicians (psychiatrists) services rendered in a CAH that is located in a HPSA. Additional clarifications/additions in CR 3790 include: 1) reassignment of billing rights from 855I to 855R, 2) a new modifier for nonparticipating physicians, and 3) the use of appropriate modifiers for nonphysician practitioners.

#### GO – What You Need to Do

Please refer to the Background and Additional Information sections of this article for details regarding these changes.

### Background

The Social Security Act (SSA) provides for two methods of payment for outpatient CAH services. A CAH will be paid under 1) a reasonable cost method unless it elects payment under 2) an optional method, also known as method II. Under the method II option, the CAH submits bills for both facility and professional services to the FI. Medicare makes payment for the facility services at the same level that would apply under the reasonable cost method (increasing to 101 percent for cost reporting periods beginning on or after January 1, 2004), but services of professionals to outpatients are paid at 115 percent of the amount that would have otherwise been paid under the physician fee schedule. The Medicare Modernization Act of 2003 (MMA, Section 405) amended the SSA by specifying that the Centers for Medicare & Medicaid Services (CMS) may not require, as a condition for a CAH to make an election of the optional method of payment (method II), that each physician or other practitioner providing professional services in the CAH assign billing rights to the CAH with respect to the services. However, the optional payment method does not apply to those physicians and practitioners who have not assigned such billing rights.

**Change request 3790 (and this article) address procedures relating to CAHs (TOB 85x) that have elected the optional payment methodology (method II).**

These changes have been established with the passage of the MMA (Sections 413a and 413b) that creates additional incentive payments for certain physician scarcity areas and mental health areas. The MMA (Section 413a) requires that an additional five percent bonus payment be made to physicians in designated physician scarcity areas. **This bonus is in addition to the amount of payment that would be made for services rendered by physicians.**

Physician scarcity designations will be based on the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in every county. In addition, physician scarcity areas will be identified based on the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in each identified rural census tract.

**Based on the amount actually paid (not the Medicare approved payment amount for each service) Medicare will pay a 5 percent physician scarcity bonus on a quarterly basis.** A single service may be eligible for both the new physician scarcity bonus as well as the current (HPSA) bonus payment. Payment will be based on the ZIP code of where the service was performed, and the physician scarcity bonus designations will be updated every 3 years.

#### For ZIP codes that:

- **Completely fall into full counties designated as HPSAs**, the MMA (Section 413b) requires that the HPSA bonus payment be automatically paid for services rendered in locations with those ZIP codes. CMS will also automatically pay a bonus for those ZIP codes that are considered to fully fall in the county based on a determination of dominance made by the United States Postal Service (USPS) and for those ZIP codes that fully fall within partial county HPSAs. The CAHs will no longer need to include modifier QB or QU on claims from these locations in order to receive the bonus payment for physician services.
- **Do not fall within a full county HPSA or fully within a non-full county HPSA**, the CAHs must continue to place either HCPCS modifier, QB or QU, on the claim in order to receive the bonus. In addition, the CAHs will need to submit the modifier for new designations made by the Health Resources and Services Administration (HRSA) throughout the year and for any designated areas not included in the automated file because of the cut off date of the data used. This will only be necessary if the ZIP code of where they provide their service is not already on the list of ZIP codes that will automatically receive the bonus payment. Designations can be identified by accessing the HPSA designations through the CMS website. The bonus will be effective for services rendered on or after the date of designation by HRSA.

Psychiatrist's services rendered in a CAH located in a primary medical care HPSA are eligible to receive bonus payments. In addition, psychiatrists rendering service in a CAH located in a mental care HPSA are eligible to receive bonus payments.

**Implementation of the Physician Scarcity Area Bonus and Revision to the HPSA Payment to a CAH (continued)**

Please refer to the Medicare Claims Processing Manual (Pub. 100-04), Chapter 12 (Physician/Nonphysician Practitioners), Sections 90.4 (Billing and Payment in Health Professional Shortage Areas (HPSAs), and 90.4.9 (HPSA Incentive Payments for Physician Services Rendered in a Critical Access Hospital [CAH]), for further billing instructions on mental care HPSAs at the following CMS website: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c12.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c12.pdf).

**Implementation**

The implementation date for this instruction is July 15, 2005.

**Additional Information**

Other important information conveyed in CR3790 is as follows:

- For a nonparticipating physician service, a CAH must place modifier AK on the claim. The intermediary should pay 95 percent of the payment amount for nonparticipating physician services. Calculating 95 percent of 115 percent of an amount is equivalent to multiplying the amount by a factor of 1.0925.
- Payment for nonphysician practitioners will be 115 percent of the allowable amount under the Medicare physician fee schedule (MPFS).
- For nonphysician services, one of the following modifiers must be on the applicable line:

**GF** – Services rendered in a CAH by a nurse practitioner (NP), clinical nurse specialist (CNS), certified registered nurse (CRN) or physician assistant (PA). (Payment at 95 percent of the MPFS)

**SB** – Services rendered in a CAH by a nurse midwife. (Payment at 65 percent of the MPFS)

**AH** – Services rendered in a CAH by a clinical psychologist. (Payment at 100 percent of the MPFS)

**AE** – Services rendered in a CAH by a nutrition professional/registered dietitian. (Payment at 85 percent of the MPFS)

For service rendered in ZIP code areas that cannot automatically receive the bonus, it will be necessary to know the census tract of the area to determine if a bonus should be paid and a modifier submitted. Visit the U.S. Census Bureau website at: <http://www.Census.gov> to retrieve census tract data.

CMS will supply files to its FIs with ZIP codes that cover the PSAs. If a CAH realizes that it is in a new PSA that was not so designated at the time CMS creates its annual PSA file, the CAH can designate the PSA by using the modifier AR on such claims.

Also, CAHs that have elected method II should supply their FI with a list of their physicians, by specialty, that have reassigned their payment to the CAH. Your FI will determine which physicians are eligible for the primary care bonus and which should receive the specialty bonus. A HCPCS accompanying the modifier AG denotes a primary physician, and one with modifier AF denotes a specialty physician.

Remember that FIs will only pay the bonus for primary care designations of general practice, family practice, internal medicine, and obstetrics/gynecology, for the ZIP codes designated as primary care scarcity areas. The FIs will only pay the bonuses for physician provider specialties, other than oral surgery (dentists only), chiropractic, optometry, and podiatry, for the ZIP codes designated as specialty physician scarcity areas.

Quarterly payments should be made to CAHs, where applicable, one month after the close of a quarter.

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

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

From that Web page, look for CR 3790 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: CR 3790  
 Related CR Release Date: April 15, 2003  
 Related CR Transmittal Number: 523  
 Effective Date: January 1, 2005  
 Implementation Date: July 15, 2005

Source: CMS Pub. 100-4, Transmittal 523, CR 3790

## Clarification to the Health Professional Shortage Area Provision

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

### Provider Types Affected

Psychiatrists and critical access hospitals (CAHs) billing Medicare carriers or fiscal intermediaries (FIs) in a health professional shortage area (HPSA)

### Provider Action Needed

#### STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is directing Medicare carriers and FIs to return any bonus payment to psychiatrists in mental care HPSAs that were incorrectly recovered in any overpayment actions taken since implementation of the HPSA mental care bonus payment on July 1, 2004, and to make bonus payment for those services that were initially withheld.

#### CAUTION – What You Need to Know

A Medicare bonus payment is payable for all professional services provided as authorized by license by psychiatrists in a mental health HPSA.

#### GO – What You Need to Do

Affected psychiatrists and CAHs should be aware of this action to be sure they receive correct payments for furnishing services to Medicare patients in mental care HPSAs.

### Background

Federal law for Medicare bonus payments recognizes geographic-based, primary medical care and mental care HPSAs as eligible areas for receiving bonus payments. Consequently, physicians, including psychiatrists, furnishing services in primary medical care HPSAs are eligible to receive bonus payments.

Psychiatrists furnishing services in mental care HPSAs are eligible to receive bonus payments for all professional services they provide in mental care HPSAs.

Effective July 1, 2004, carriers and FIs began making HPSA bonus payments to psychiatrists furnishing services in mental care HPSAs. Some carriers and FIs may have interpreted Medicare's instructions in such a way that they limited bonus payments in the mental care HPSAs to services they determined were mental health services and may have initiated overpayment recovery actions for

bonuses they determined to be paid incorrectly. CMS has determined that these actions are incorrect.

CR 3736 clarifies the language in the Medicare Claims Processing Manual (Pub. 100-04), Chapter 12, Section 90.4.5c to indicate that the bonus is payable for all professional services provided by psychiatrists in a mental care HPSA that they are licensed to provide. It also instructs carriers and FIs to review any overpayment actions taken on mental care HPSAs, cancel any overpayment recovery actions that have been initiated and are in process, and return any overpayments already collected.

### Additional Information

These bonus payments were also addressed in Medlearn Matters articles MM3108 and MM3336. To view the details on the payments, you may retrieve these articles, respectively, at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3108.pdf>.

and

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3336.pdf>.

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

From that Web page, look for CR 3736 in the CR NUM column on the right, and then click on the file for that CR. If you have questions regarding this issue, contact your carrier/intermediary on their toll free number, which is available at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3736

Related CR Release Date: April 15, 2005

Related CR Transmittal Number: 524

Effective Date: May 16, 2005

Implementation Date: May 16, 2005

Source: CMS Pub. 100-4, Transmittal 524, CR 3736

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## Payment of Ambulance Services to Indian Health Service/Tribal Hospitals

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

**Note:** CMS revised this article on January 14, 2005, to show that the related Change Request (CR) 3521 was reissued on January 11, 2005. The CR was revised to show that type of bill (TOB) 12x is a valid type for use by critical access hospitals (CAHs) billing for ambulance services. The original CR inadvertently stated that TOB 13x was to be used. This article has also been revised to show CAHs may use TOB 12x for this purpose.

### Provider Types Affected

Indian health service (IHS) and tribal hospitals, including critical access hospitals, which manage and operate hospital-based ambulance services

### Provider Action Needed

This article advises affected hospitals that Section 630 of the Medicare Modernization Act (MMA) allows reimbursement for ambulance services provided by IHS/tribal hospitals, including CAHs that manage and operate hospital-based ambulances.

### Background

Effective January 1, 2005, Section 630 of the Medicare Modernization Act (MMA) allows for reimbursement of ambulance services provided by IHS/tribal hospitals, including CAHs that manage and operate hospital-based ambulances.

This instruction advises Medicare fiscal intermediaries (FIs) that claims for ambulance services from IHS/tribal hospitals, including CAH based ambulance services, submitted by IHS and tribal organizations will be processed by the IHS/tribal selected FI.

Ambulance services originating from IHS/tribal hospitals, including CAHs that are hospital-based ambulance services, will be paid according to the appropriate payment methodology. For IHS/tribal hospital-based ambulance services, the appropriate payment is 100 percent of the federal rate of the ambulance fee schedule.

For IHS/tribal CAH based ambulance services, the appropriate payment methodology is cost-based and payment is at 100 percent of the reasonable cost for CAH based ambulance services so long as the CAH meets the 35-mile requirement for reasonable costs. In such instances where the 35-mile rule is not met, payment will be based on a blend of 20 percent cost and 80 percent ambulance fee schedule in 2005 and 100 percent of that fee schedule beginning in 2006.

IHS/tribal hospitals should bill their hospital based ambulance services on a TOB 13x with a revenue code of 054x and without revenue code 051x, while IHS/tribal CAH

facilities with a hospital based ambulance service should bill using TOB 85x or 12x, revenue code 054x, without revenue code 051x, and condition code B2. Medicare FIs will also apply appropriate deductible and coinsurance amounts when processing these claims.

Also, when an outpatient visit occurs in conjunction with the ambulance service, Medicare will accept claims with revenue codes 051x and 054x and will pay the inclusive rate to the IHS/tribal hospital or CAH.

### Implementation

The implementation date for this instruction is April 4, 2005. Because of the April implementation date for Medicare system changes, your intermediary will hold any claims received for these services before April 4 until the system changes are made and the claims may be correctly processed.

### Additional Information

The Medicare Claims Processing Manual (Pub. 100-04), Chapter 15, has been revised to reflect these changes. The updated manual instructions are attached to the official instruction released to your intermediary. You may view that instruction at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR3521 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: 3521  
 Related CR Release Date: Re-issued January 11, 2005  
 Related CR Transmittal Number: 425  
 Effective Date: January 1, 2005  
 Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 425, CR 3521

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## **Indian Health Service or Tribal Hospital Payment Methodology for Inpatient Social Admissions and Outpatient Services at a Separate Facility**

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

### **Provider Types Affected**

Indian health services (IHS) or tribal hospitals, including critical access hospitals (CAHs)

### **Provider Action Needed**

This instruction clarifies the IHS or tribal hospitals, including CAHs, payment methodology for social admissions and outpatient services rendered at separate facilities.

### **Background**

IHS or tribal hospitals (including CAHs) often submit a type of bill (TOB) 12x for social admissions. This TOB is denied by the designated fiscal intermediary (FI) if a separate facility subsequently bills TOB 13x for outpatient services or TOB 72x for dialysis services rendered during a social admission at an IHS/Tribal/CAH.

It should be noted that:

- There may be situations when a beneficiary is admitted to an IHS/Tribal facility for social reasons. If these social admissions are for patient and family convenience, they are not billable to Medicare.
- Social admission stays do not qualify for any payment on either a TOB 11x or 12x.
- For admissions before surgery, only the scheduled surgery and related services may be:
  - ♦ Billed on a TOB 83x, if the surgery is performed on an outpatient basis; and
  - ♦ Billed on a TOB 11x, if the surgery is performed on an inpatient basis.
- Social admissions occurring after an inpatient discharge may not be billed to Medicare.
- For patients in a social admission status requiring outpatient services at another facility, Medicare FIs will reject the TOB 12x if submitted.
- A duplicate payment would be created if a TOB 12x from the admitting facility occurred with 1) a TOB 13x from another hospital, or 2) a TOB 72x from a renal dialysis facility. This is inappropriate.

Because there is a significant number of social admissions in IHS/Tribal facilities, Medicare has decided to disallow payment for inpatient Part B services during a

social admission stay when there is another bill from a different facility for an outpatient service.

The following represents the Centers for Medicare & Medicaid Services (CMS) policy:

- When a TOB 12x from an IHS/Tribal facility (including CAHs) covers the same time period as 1) a TOB 13x received from another hospital, or 2) a TOB 72x received from a renal dialysis facility:
  - ♦ TOB 12x is presumed to represent a social admission and is disallowed; and
  - ♦ TOBs 13x and 72x will be paid.
- A social admission stay does not qualify for any payment for the TOBs 11x or 12x.
- A social admission cannot be used to satisfy the three-day prior stay for skilled nursing facilities.

### **Implementation**

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

### **Related Instructions**

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

From that Web page, look for CR 3452 in the CR NUM column on the right, and click on the file for that CR.

### **Additional Information**

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

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

Related Change Request (CR) #: 3452  
 Related CR Release Date: October 29, 2004  
 Related CR Transmittal #: 336  
 Effective Date: April 1, 2005  
 Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 336, CR 3452

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## Billing for Durable Medical Equipment, Orthotics, Prosthetics, Drugs, and Surgical Dressings Claims

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

### Provider Types Affected

All Indian health services (IHS) and tribally owned and operated hospitals or hospital-based facilities including critical access hospitals (CAHs) billing Medicare durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs)

### Provider Action Needed

#### STOP – Impact to You

Effective July 1, 2005, IHS hospitals and tribally owned and operated hospitals and hospital-based facilities, including CAHs, may begin billing for DME, prosthetics and orthotics, surgical dressings, drugs and therapeutic shoes, as further discussed in this article.

#### CAUTION – What You Need to Know

Affected providers may need to enroll with the National Supplier Clearinghouse (NSC) as some of these services must be billed to a Medicare DMERC. Other services will be billable to the Medicare FI.

#### GO – What You Need to Do

Please be aware of the changes addressed in this instruction and ensure that billing staffs submit claims accordingly.

### Background

This article advises affected providers and suppliers that beginning July 1, 2005, IHS and tribally owned and operated hospitals and hospital-based facilities including CAHs may begin billing for:

- DME used in the patient's home
- Orthotics and Prosthetics
- Drugs paid by DMERCs
- Surgical Dressings
- Therapeutic shoes furnished in accordance with the requirements of Section 1861 (s)(12).

**Note:** For the remainder of this article, the term IHS/tribal facilities will be used and will refer to facilities owned by the Indian health services (IHS) and to tribally owned and operated hospitals and hospital-based facilities, including CAHs.

The **appropriate DMERC** should be **billed for DME, therapeutic shoes, and drugs** and the **designated FI billed for prosthetics, orthotics, and surgical dressings**. All **suppliers** should have a **supplier number** from the National Supplier Clearinghouse (NSC) to bill the DMERC.

For information on the process for enrolling as a supplier with the NSC, visit: <http://www.cms.hhs.gov/providers/enrollment/forms/>.

**Note:** To bill drugs to the Medicare DMERC, IHS/tribal facilities must be registered with the NSC as a pharmacy and have a pharmacy license number on file with the NSC.

Prior to the enactment of section 630 of the Medicare Modernization Act (MMA) in 2003, IHS facilities were not permitted to bill for Part B services unless covered under section 1848 of the Social Security Act. The new MMA legislation expands the scope of the items and services paid to IHS hospital-based facilities to include all Part B covered items and services that are not paid under the Medicare physician fee schedule and are not included in the Medicare IHS all-inclusive rate for a five-year period beginning January 1, 2005.

### Additional Information

Some key billing information for IHS/tribal facilities is as follows:

- Beginning with services provided on or after July 1, 2005, IHS/tribal facilities may send claims to their Medicare DMERC for DME, therapeutic shoes, and drugs showing a specialty code of A9 (IHS/tribal facility) and a place of service code of 12 to indicate patient's home on the claim. If a claim is received with **a date of service prior to July 1, 2005, the DMERC will deny the claim with reason code 26.**

Also, coinsurance and deductibles are waived for these claims.

- Payment for DME will be based on the DME fee schedule and payment for drugs will be based on the average sales price (ASP) drug file.
- Beginning for services provided on or after July 1, 2005, IHS/tribal facilities may begin billing their Medicare FI for orthotics, prosthetics, and surgical dressings.
- When billing orthotics, prosthetics, and surgical dressings to the FI, IHS/tribal facilities should use the following revenue codes:
  - ♦ 0274 for orthotics with the appropriate HCPCS code
  - ♦ 0274 for prosthetics with the appropriate HCPCS code
  - ♦ 0623 for surgical dressings and the appropriate HCPCS code
- When billing for prosthetics, orthotics, and surgical dressings to the FI, IHS/tribal facilities should show only those items on the type of bill TOB13x that are payable under the DME fee schedule.

### Clarification of Rules for Drug Administration

In addition to the changes described above, IHS/tribal facilities need to note that related CR 3674 also clarifies the all-inclusive rate (AIR) billing rules for drug administration (injections) occurring without a medically indicated outpatient encounter. In an effort to ensure that the AIR is paid appropriately, any injection (e.g., B-12) that requires only a licensed professional's administration must not be billed as a visit payable at the AIR. A visit cannot be billed if the injection is the only service the facility provides.

**Billing for Durable Medical Equipment, Orthotics, Prosthetics, Drugs, and Surgical Dressings Claims (continued)**

If the patient receives an injection and no qualifying visit takes place, the charges/expenses for the injection should be combined with the expenses/charges for the next qualifying visit. The qualifying visit should be for the condition being treated with the injection or drug.

For complete details, including the revised sections of the Medicare Claims Processing Manual, please see the official instruction issued to your FI/DMERC regarding this change. This instruction may be viewed at: [http://www.cms.hhs.gov/manuals/transmittals/cr\\_num\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/cr_num_dsc.asp).

Once at that site, scroll down the CR NUM column on the right looking for CR 3674 and click on the file for that CR. For details regarding enrollment as a supplier for the purpose of billing a DMERC, please visit: <http://www.cms.hhs.gov/providers/enrollment/forms/>.

See sections 100 through 140 of Chapter 15 of the Medicare Benefit Policy Manual for a detailed description of DME, prosthetics, and orthotics. This manual may be accessed at: [http://www.cms.hhs.gov/manuals/102\\_policy/bp102index.asp](http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp).

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IHS/tribal facilities should note that they may not bill for items or services that fall outside the scope of the benefits described in these sections. If you have any questions please contact your FI 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: 3674

Related CR Release Date: February 4, 2005

Related CR Transmittal Number: 461

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 461, CR 3674

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## Billing Requirements for Physician Services Rendered in Method II Critical Access Hospitals

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

### Provider Types Affected

Critical access hospitals (CAHs) billing Medicare fiscal intermediaries (FIs) for physician services

### Provider Action Needed

#### STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is adding/changing billing requirements for CAHs that bill Medicare FIs for physician services that are rendered in a method II CAH facility.

#### CAUTION – What You Need to Know

Physician services rendered in method II CAHs are to be paid using the appropriate facility fee schedule amount from the Medicare physician fee schedule (MPFS) and such services may be eligible for additional bonus payments depending on where the services are performed.

#### GO – What You Need to Do

To assure accurate payments, be aware of the changes discussed in this instruction.

### Background

Physician services that are rendered in a CAH facility and billed under method II should be paid using the appropriate facility fee schedule amount from the Medicare physician fee schedule. To assure accurate payments, CMS will modify the billing requirements as follows:

- The first change under CR 3800 is to correct the type of bill (TOB) to be used in billing for these services. CR 3262, Transmittal 262, dated July 30, 2004, stated incorrectly, 72x as the TOB for CAH outpatient. The correct TOB for a CAH for outpatient services is 85x.

- Some physician services submitted by CAHs using method II billing have been paid incorrectly, because Medicare FIs make payments based on the supplemental Medicare physicians fee schedule file, which contained only nonfacility fee schedule amounts. Under method II, physician services are paid to the CAH at 115 percent of the applicable MPFS payment amount. CMS will assure that the FIs make payments based on the MPFS facility rate for the applicable Health Care Common Procedure Codes System (HCPCS) codes.
- Section 413 of the Medicare Modernization Act (MMA) established an additional 5 percent payment for services rendered in a physician scarcity area (PSA) and required the automation of the health professional shortage area (HPSA) incentive payment. CAHs can have outpatient departments that are off-site (not physically located in the hospital).

Presently, there is no way to differentiate the offsite outpatient department bill from the CAH bill. Therefore, bonus payments are not being made for services rendered in the off-site outpatient department if its location differs from that of the CAH itself. To correct this, CMS has established that the address and ZIP code will be used to identify off-site outpatient departments of CAHs. To remedy this situation, when billing for reassigned benefits from physicians/professionals for services rendered, the CAH must place the address and ZIP code of the actual place of service on the claim in the 2310E loop of the 8371 for electronic claims and in the “Remarks” field for hard copy UB-92 claims and on DDE claims. However, the

**Billing Requirements for Physician Services Rendered in Method II Critical Access Hospitals (continued)**

ZIP code placement will be determined by the FIs for hardcopy and DDE claims.

- CMS is clarifying, in its Medicare Claims Processing Manual (Section 30.1.1), that CAHs are exempt from the payment window provisions that bundle outpatient services into inpatient payments when the outpatient services occur within the 1 and 3 day window prior to an inpatient stay. Because CAHs are exempt from the 1- and three-day window provisions, services rendered by a CAH to a beneficiary who is an outpatient prior to that beneficiary's admission to the CAH as an inpatient are not bundled on the inpatient bill. Outpatient CAH services must be billed as such, and on a separate bill (85x TOB) from inpatient services. Outpatient services rendered on the date of admission to an inpatient setting are still billed and paid separately as outpatient services in a CAH.

**Implementation Date**

The implementation date for this instruction is July 5, 2005

**Additional Information**

See the following Medlearn Matters special editions and articles for a detailed review of revisions to the health professional shortage area and implementation of the physician scarcity area bonus payments:

SE0453 titled, Proposed Implementation of the Physician Scarcity Bonus and Revision to the Health Professional Shortage Area (HPSA). This article may be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0453.pdf>.

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SE0449 titled, Physician Education for the Revisions to the Health Professional Shortage (HPSA) Bonus Payment Processes and Implementation of the Physician Scarcity Area (PSA) Bonus Payments. This article may be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0449.pdf>.

MM3336 titled, Bonus Payments for Services in Health Professional Shortage Areas (HPSAs). This article may be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3336.pdf>.

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

From that Web page, look for CR 3800 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3800

Related CR Release Date: April 22, 2005

Related CR Transmittal Number: 530

Effective Date: January 5, 2004 – HPSA Bonus  
January 3, 2005 – Physician Scarcity  
July 1, 2001 – Physicians Services

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 530, CR 3800

# ESRD SERVICES

## New Case-Mix Adjusted ESRD Composite Payment Rates and New Composite Rate Exceptions Window for Pediatric ESRD Facilities.

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

**Note:** CMS has issued a full replacement of Change Request 3572. CR 3572 has been rescinded. Guidelines and instructions related to CR 3572 were published in the [Second Quarter 2005 Medicare A Bulletin \(pages 46-47\)](#).

### Provider Types Affected

Medicare fiscal intermediaries (FIs) for end-stage renal disease (ESRD) services

### Provider Action Needed

This article contains information provided in Change Request (CR) 3720, which relates that the Centers for Medicare & Medicaid Services (CMS) is using a limited number of characteristics that explain variation in reported costs for composite rate services consistent with the legislative requirement. The current composite payment rates will be adjusted for individual patient characteristics and budget neutrality for services furnished on or after April 1, 2005.

### Background

In accordance with the Social Security Act (Section 1881(b)(12)(A)), as added by the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, Section 623(d)(1)),

“The Secretary shall establish a basic case-mix adjusted prospective payment system for dialysis services furnished (by providers of services and renal dialysis facilities in a year) to individuals in a facility and to individuals at home. The case-mix under the system would be for a limited number of patient characteristics.”

The use of a case-mix measure permits the targeting of greater payments to facilities that treat more costly and resource-intensive patients. The methodology for applying patient characteristic adjusters (applicable to each treatment) will determine the case-mix adjustment (that will vary for each patient). Thus, an ESRD facility’s average composite payment rate per treatment will depend on its unique (patients) case-mix.

The patient characteristic variables that are utilized in determining an individual patient’s case-mix adjusted composite payment rate include the following:

- Five age groups,
- Low Body Mass Index (BMI),
- Body surface area (BSA), and
- Patients under age 18.

**Note:** Pediatric ESRD patients (defined as those under the age of 18) receive a specific case-mix adjustment factor. As a result, none of the other case-mix adjusters (i.e., the five age groups, low BMI and BSA) is applicable to pediatric ESRD patients.

Each month, the ESRD PRICER program uses each patient’s height and weight (as reported on billing Form CMS – 1450) to automatically calculate the low BMI and BSA case-mix adjustments to an ESRD facility’s composite payment rate.

Budget neutrality is designed to ensure that the total aggregate payments each year from the Medicare trust fund do not increase or decrease as a result of changes in the payment methodology. Therefore, **the case-mix adjusted composite rate payments for 2004 must result in the same aggregate expenditures for 2005 (as if the adjustments are not made)**.

While the magnitude of some of the patient specific case-mix adjustment factors appears to be significant, facility variation in the case-mix is limited. Regardless of the type of provider, the average case-mix adjustments for patient characteristics do not vary significantly. This is because of the overall similarity of the distribution of patients among the eight case-mix classification categories across facility classification groups.

Because ESRD facilities can maintain their current exception rates, they should compare their exception rate to the basic case-mix adjusted composite rate to determine the best payment rate for their facility.

**Each dialysis facility has the option of being paid at:**

- Its current exception rate, or
- The basic case-mix adjusted composite rate (including all of the MMA 623 payment adjustments).

**If the facility retains its exception rate, it is not subject to any of the adjustments specified in Section 623 of the MMA.**

**Also, determinations as to whether an ESRD facility’s exception rate per treatment will exceed its average case-mix adjusted composite rate per treatment are best left to the entities affected.**

Each ESRD facility is required to notify its FI in writing at any time if it wishes to:

- Give up or withdraw its exception rate, and
- Be subject to the basic case-mix adjusted composite payment rate methodology.

The case-mix adjusted composite payment rates will begin 30 days after the FI’s receipt of the facility’s notification letter. ESRD facilities that elect to retain their exceptions do not need to notify their FIs.

**Note:** CMS is opening a new pediatric facility exception request window for pediatric facilities that did not have an approved exception rate as of October 1, 2002 (MMA, Section 623[b][1][D]).

*New Case-Mix Adjusted ESRD Disease Composite Payment Rates ... (continued)*

The statute defines the term “**pediatric facility**” as a **renal facility with at least 50 percent of patients under 18**. If a pediatric ESRD facility projects (on the basis of prior years’ cost and utilization trends) that it will have an allowable cost per treatment higher than its prospective rate, the facility may request that CMS:

- Approve an exception to that rate, and
- Set a higher prospective payment rate.

CMS will adjudicate these exception requests in accordance with the exception criteria contained in:

- The *Code of Federal Regulation* (CFR), Title 42, Chapter IV, Part 413, Section 180. See 42 CFR 413.180, which may be found at the following Government Printing Office (GPO) website: [http://www.access.gpo.gov/nara/cfr/waisidx\\_04/42cfr413\\_04.html](http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr413_04.html).
- Publication 15, Medicare Provider Reimbursement Manual (PRM), Part I, Chapter 27, which may be found at the following CMS website: [http://www.cms.hhs.gov/manuals/pub151/PUB\\_15\\_1.asp](http://www.cms.hhs.gov/manuals/pub151/PUB_15_1.asp).

If the facility fails to adequately justify its pediatric exception request (in accordance with regulations or program instructions), its exception request will be denied.

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**Implementation**

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

**Additional Information**

For complete details, please see the official instruction issued to your FI regarding this change. That instruction may be viewed by going to: [http://www.cms.hhs.gov/manuals/pm\\_trans/R477CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R477CP.pdf).

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

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

Related Change Request (CR) Number: 3720

Related CR Release Date: February 18, 2005

Related CR Transmittal Number: 477

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 477, CR 3720

## Billing for Syringes Used in the Treatment of End-Stage Renal Disease Patients

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

**Provider Types Affected**

Physicians, providers, and suppliers billing carriers and intermediaries for end-stage renal disease (ESRD) services and supplies

**Provider Action Needed**

Providers billing HCPCS code A4657 for ESRD patients need to be aware of the proper use of this code when billing for syringes, especially when a pre-filled syringe is used in the administration of the drug contained in the syringe and no other syringe is used. In such instances, the supply charge associated with A4657 **cannot** be billed to Medicare.

**Background**

In some previous Change Requests (CRs) relating to ESRD, there was mention that Healthcare Common Procedure Coding System (HCPCS) code A4657 (syringe – with or without needle) was allowed for epoetin (EPO). However, physicians, providers, and suppliers should note that pre-filled syringes with medications used to administer the drug to an ESRD patient should not be billed with HCPCS code A4657 to Medicare. Also note that HCPCS code A4657 (syringe – with or without needle) should be billed only when an actual syringe is taken from the

provider’s supplies and used to administer the drug. Syringes that are pre-filled with medications should not require the use of another syringe to administer the medication.

When a drug is supplied in a pre-filled syringe (and no other syringe is used in the administration of the drug contained in the syringe) then the supply charge associated with HCPCS code A4657 **cannot** be billed to Medicare.

Only when a new syringe is used in the administration of the drug should HCPCS code A4657 be used. Note that this special edition article relates to billing for syringes used in the treatment of ESRD patients.

**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 Article SE0527

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## End-Stage Renal Disease Composite Payment Rate System Changes

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

### Provider Types Affected

Renal dialysis facilities billing Medicare fiscal intermediaries for dialysis services

### Provider Action Needed

Renal dialysis facilities should note that this special edition article provides the latest information regarding changes to the end-stage renal disease (ESRD) composite payment rate system.

### Background

The ESRD Medicare payment for dialysis services has been made based on an established amount, known as the composite rate. The composite rate was a single payment amount that is not varied according to the characteristics of the beneficiary treated. This rate includes the cost of some drugs, laboratory tests, and other items and services provided to Medicare beneficiaries receiving dialysis. Some drugs and biologicals, laboratory test and other services are paid separately from the composite rate.

Drugs that were separately billable were paid based on the average wholesale price (AWP). EPOGEN® (epoetin [EPO] alfa), a separately payable drug, was not paid at the AWP; rather, it was paid at \$10.00 per 1,000 units. The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), Section 623, includes major provisions that affect the development of revised ESRD composite payment rates effective for outpatient dialysis services furnished on or after January 1, 2005.

The MMA statute mandates the following:

- The current composite payment rates have been increased by 1.6 percent for dialysis treatments furnished on or after January 1, 2005.
- The composite payment rates as increased by the 1.6 percent must also include a drug add-on adjustment in the amount 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’s reports to the Department of Health & Human Services.

Therefore, effective January 1, 2005, the Centers for Medicare & Medicaid Services (CMS) has changed the way ESRD facilities are paid for dialysis treatments and separately billable drugs as follows:

- Increase the composite rate payments by 1.6 percent
- Pay for separately billable drugs based on acquisition costs or average sales price plus 6 percent.
- Include an 8.7 percent drug add-on adjustment.

### Base Composite Rate 1.6 Percent Increase

Effective January 1, 2005, independent facility rates have increased 1.6 percent from \$126.33 per treatment to \$128.35 per treatment, and hospital-based facility rates will increase from \$130.32 per treatment to \$132.41 per treatment.

### Payment for Separately Billable ESRD Drugs

Effective January 1, 2005:

- The top 10 most frequently used ESRD drugs are paid at the 2005 average acquisition price (AAP) (see Table 1).

- Other ESRD drugs are paid at the average sales price (ASP) plus six percent.
- Facilities are paid separately for syringes used for administering EPO.
- Hospital-based facilities will continue to be paid cost for separately billable drugs except EPO, which will be paid AAP.

**Table 1: Calculated 2005 AAP Amount**

Drug	2005 Average Acquisition Payment Amount
EPOGEN® (EPO)	\$9.76
Calcitriol	\$0.96
Doxercalciferol	\$2.60
Iron dextran	\$10.94
Iron sucrose	\$0.37
Levocarnitine	\$13.63
Paricalcitol	\$4.00
Sodium ferric gluconate	\$4.95
Alteplase, Recombinant	\$31.74
Vancomycin	\$2.98

### Drug Add-on Adjustment

The drug add-on adjustment is 8.7 percent, which increases the composite rate by \$11.17 for independent facilities and \$11.52 for hospital-based facilities. See Table 2 below:

**Table 2: Composite Rate Adjustment for Drug Spread Single Add-on Adjustment**

	Base Composite Rate with 1.6% Increase	Base Composite Rate with 8.7% Drug Add-on (2005)
Add-on percent	1.6%	8.7%
Independent	\$128.35	\$139.52
Hospital-Based	\$132.41	\$143.93

Providers are also encouraged to report and code comorbidities on ESRD claims.

See Change Request (CR) 3554, Transmittal 27, dated November 23, 2004, Subject: New ESRD Composite Payment Rates Effective January 1, 2005 at the following website:  
[http://www.cms.hhs.gov/manuals/pm\\_trans/R27BP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R27BP.pdf).

### Limited Case-Mix Variables Effective April 1, 2005

In accordance with the Social Security Act, Section 1881(b)(12)(A), as added by the MMA, Section 623(d)(1), “The Secretary shall establish a basic case-mix adjusted prospective payment system for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to individuals at home. The case-mix system would be for a limited number of patient characteristics.” Use of a case-mix measure permits targeting of greater payments to facilities that treat more costly resource-intensive patients.

CMS is using a limited number of characteristics that explain variation in reported costs for composite rate services consistent with the legislative requirement. The



**End-Stage Renal Disease Composite Payment Rate System Changes (continued)**

current composite payment rates will be adjusted for individual patient characteristics and budget neutrality for services furnished on or after April 1, 2005.

An ESRD facility's average composite payment rate per treatment will depend on its unique (patients) case mix.

The patient characteristic variables that are utilized in determining an individual patient's case-mix adjusted composite payment rate include:

Five age groups as follows:

Age	Multiplier
18-44	1.223
45-59	1.055
60-69	1.000
70-79	1.094
80+	1.174

- A low Body Mass Index (BMI):
  - ♦ There will be a case-mix adjustment of 1.112 for patients with a BMI less than 18.5 kg/m<sup>2</sup>;
- A Body Surface Area (BSA, meters<sup>2</sup>); and
- A separate case-mix adjustment for pediatric patients:
  - ♦ A case-mix adjustment factor of 1.62 will be added for ESRD patients under age 18,
  - ♦ BSA and BMI adjustments do not apply to pediatric patients, and
  - ♦ Pediatric ESRD facilities may request an exception to the composite rate.

**Note:** This adjustment is for the basic case-mix adjusted payment. Section 623 of the MMA requires the Secretary to submit a report to Congress and to establish a demonstration project that will be used to develop a more fully-bundled case-mix adjustment payment system for ESRD services.

See Change Request (CR) 3720, Transmittal 477, Dated February 18, 2005, Subject: New Case-Mix Adjusted End Stage Renal Disease (ESRD) Composite Payment Rates and New Composite Rate Exceptions Window for Pediatric ESRD Facilities at the following CMS website: [http://www.cms.hhs.gov/manuals/pm\\_trans/R477CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R477CP.pdf).

**Budget Neutrality**

Budget neutrality is designed to ensure that total aggregate payments from the Medicare trust fund do not increase or decrease as a result of changes in the payment methodology.

Therefore, a budget neutrality adjustment will be applied to the case-mix adjusted composite rate payments beginning April 1, 2005. The case-mix budget neutrality adjustment to the composite rate is 0.9116.

Effective March 7, 2005, ESRD facilities should begin to report the following two new value codes:

- Value code A8 – Patient weight in kilograms
- Value code A9 – Patient height in centimeters

Effective April 1, 2005, ESRD facilities must report value codes A8 and A9. Claims will be returned to the dialysis facilities prior to payment if values codes A8 and A9 are not completed.

**Timeline for Future Changes**

The following provides an overview of the planned timeline and future changes:

**January 1, 2005**

- 1.6 percent composite rate adjustment
- Drug payment calculation changes

**February 4, 2005**

- Publish revised conditions of coverage

**March 7, 2005**

- Report new value codes

**April 1, 2005**

- Value Codes A8 and A9 must be reported on claims.
- New exception window for pediatric facilities that did not have an approved exception rate as of October 1, 2002.
- Case-mix adjustment will take effect.

**Mid-2005**

- Proposed rule will be published for 2006 updates

**January 1, 2006**

- Demonstration to test revised system will begin

**Calculation of Case-Mix Adjusted Payment**

**Example 1**

Adjusted Composite Rate System

The following example presents a patient dialyzing at Neighbor Dialysis, an independent ESRD facility located in Baltimore, MD.

**Calculation of Basic Composite Rate for Neighbor Dialysis**

Wage adjusted composite rate for independent facilities in Baltimore, MD: \$134.93 wage adjusted composite rate increased by drug add-on adjustment \$134.93 x 1.087 = \$146.67.

Adjusted facility composite rate after budget neutrality adjustment (\$146.67 X 0.9116) = \$133.70.

John Smith attains age 18 on April 10, 2005 and undergoes hemodialysis. John weighs 75.5 kg and is 181.5 cm in height. Because John Smith attains age 18 on April 10, he is considered age 18 for the entire month of April and would not be classified as a pediatric patient.

**Calculation of Case-Mix Adjusted Payment**

The BSA and BMI for John Smith will be calculated by the PRICER program used to compute the composite payment for each patient based on the height and weight reported on the UB-92 (the weight that is recorded at the latest clinic visit for this hemodialysis patient). The computations of the BSA and BMI for John Smith are shown below:

$$BSA = 0.007184 \times (\text{height}) 0.725 \times (\text{weight}) 0.425$$

$$BSA = 0.007184 \times 181.5 \times 0.725 \times 75.50.425$$

$$BSA = 0.007184 \times 43.4196 \times 6.2824 = 1.9596$$

$$BMI = \text{weight/height (m)}^2$$

John Smith is 181.5 cm in height, which converts to 1.815 meters.

## End-Stage Renal Disease Composite Payment Rate System Changes (continued)

$$\text{BMI} = 75.5 / 1.815^2 = 22.9191$$

The case-mix adjustment factor for John Smith, an 18 year old whose BMI exceeds 18.5 kg/m<sup>2</sup> and has a BSA of 1.9596 is calculated as follows:

Age adjustment factor (age 18–44) 1.223

BMI adjustment factor (BMI = 18.5 kg/ m<sup>2</sup>) = 1.000

BSA adjustment factor (1.0371.9596 - 1.84/0.1) =

BSA adjustment factor (1.0371.196) = 1.0444

Case-mix adjustment factor (1.223 X 1.000 X 1.0444) = 1.2773

Basic case-mix adjusted composite payment (\$133.70 X 1.2773) = \$170.77

### Example 2

Linda Jones is age 16 and undergoes peritoneal dialysis at Community Hospital, a hospital-based facility in New York City. Linda weighs 35 kg and is 160.0 cm in height. The basic composite rate for Linda Jones is calculated as follows:

Wage adjusted composite rate for hospital-based facilities in New York, New York: \$146.35

Wage adjusted composite rate increased by drug adjustment factor (\$146.35 X 1.087) = \$159.08

Adjusted facility composite rate after budget neutrality adjustment (\$159.08 X 0.9116) = \$145.02

Because Linda is a pediatric ESRD patient, the automatic pediatric adjustment factor of 1.62 applies.

Neither the age, BMI, nor BSA adjustments are applicable because Linda is less than age 18. Pediatric adjusted composite rate (\$145.02 X 1.62) = \$234.93

If Community Hospital were entitled to a composite rate exception, then the provider could elect to retain its exception rate in lieu of receiving the otherwise applicable pediatric payment rate of \$234.93.

### Questions (Q) & Answers (A)

The following Qs and As are offered to address some of the key questions you may have regarding these changes:

**Q.** How do we code height and weight for value codes A8, and A9 on billing forms?

**A.** Weight is coded in kilograms. Weight is to be recorded post dialysis (i.e., dry weight) and is the weight that is recorded at the last clinic visit. Height is to be coded in centimeters. Height is to be entered as the patient presents. Patients with bilateral lower extremity amputations will be coded as they actually present. Both height and weight are to be entered for the last dialysis session for the billing period.

**Q.** How often should height be measured?

**A.** Height is entered for the last dialysis session for that billing period. Height should be measured for the initial or first billing period and may be assessed periodically, as reasonable or if the facility notes any changes in the patient.

**Q.** When are height and weight coding to begin being entered on the bill?

**A.** Due to systems difficulties in accepting values codes A8 and A9, all facilities should begin coding both height and weight on the bills effective March 7, 2005. Beginning for dates of services on or after April 1, 2005, the bills will be returned to the dialysis facilities prior to payment if values codes A8 and A9 are not completed.

**Q.** How many comorbid conditions should be entered, and should such conditions as bi-lateral lower extremity amputations be coded?

**A.** There is space for up to ten comorbid conditions. CMS recommends that facilities enter as many comorbid conditions as the patient has. These conditions will be used to do additional research for both refining the basic case mix system and in support of the development of the fully bundled payment system.

In addition we will be developing a system to monitor both the basic and fully bundled payment system. For the purposes of this monitoring system, we are recommending that if a patient is an amputee that this code be entered as a comorbid condition. CMS is specifically interested in monitoring bilateral amputations of the lower extremities and will be very interest in monitoring the following ICD-9 CM codes: 879.6 (bilateral), 897.7 (complicated) and 897.5 (NS, complicated). In addition, CMS is planning to monitor selected V codes for amputation, i.e., V49.75 (below the knee) and V49.76 (above the knee).

### Additional Information

To review official instructions issued to your fiscal intermediary regarding the ESRD composite payment rate system go to:

Change Request 3539, Transmittal 348, Dated October 29, 2004, Subject: January 2005 Quarterly Average Sales Price (ASP) Medicare Part B Pricing File, Effective January 1, 2005:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R348CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R348CP.pdf).

Change Request 3554, Transmittal 27, Dated November 23, 2004, Subject: New ESRD Composite Payment Rates Effective January 1, 2005:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R27BP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R27BP.pdf).

Change Request 3554, Transmittal 373, Dated November 19, 2004, Subject: New ESRD Composite Payment Rates Effective January 1, 2005:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R373CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R373CP.pdf).

Change Request 3720, Transmittal 477, Dated February 18, 2005, Subject: New Case-Mix Adjusted End Stage Renal Disease (ESRD) Composite Payment Rates and New Composite Rate Exceptions Window for Pediatric ESRD Facilities:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R477CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R477CP.pdf).

To review the ESRD Composite Payment Rate System fact sheet, go to: <http://www.cms.hhs.gov/medlearn/ESRDCompRatePaymentSys.pdf>.

To review the Medlearn Matters article related to CR 3554, go to: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3554.pdf>.

**End-Stage Renal Disease Composite Payment Rate System Changes (continued)**

To review the Medlearn Matters article related to CR 3539, go to: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3539.pdf>.

To review the Medlearn Matters article related to CR 3720, go to: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3720.pdf>.

The following websites are provided as a resource to obtain additional relevant information:

- MMA Legislative Summary including MMA Section 623: <http://www.cms.hhs.gov/mmu/HR1/PL108-173summary.asp#sec623>.
- ESRD Information Resource for Medicare Page, which includes the ESRD Calculator in the "Resources" Section: <http://www.cms.hhs.gov/providers/esrd.asp>.

- *Federal Register*, Vol. 69, No. 219, November 15, 2004: [http://www.afehct.org/pdfs/HHSRF111\\_15.pdf](http://www.afehct.org/pdfs/HHSRF111_15.pdf).

If you have further questions, please contact your Medicare fiscal intermediary at their toll-free number, which may be found at:

<http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: NA

Related CR Release Date: NA

Source: CMS Special Edition Medlearn Article SE0511

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## End-Stage Renal Disease Composite Payment Rate System Changes— Provider Question and Answer Conference Call

The Provider Communications Group from the Centers for Medicare & Medicaid Services (CMS) will be holding a series of provider question and answer conference call on the revisions to the end-stage renal disease (ESRD) composite payment rate system, as directed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Policy and billing subject matter experts from the Division of Chronic Care Management and the Division of Institutional Claim Processing will be available to answer providers' questions regarding these revisions.

These calls are open to providers, Medicare contractors, and CMS staff and will consist of a question and answer session.

The next call will be held on:

**Thursday, May 19, 2005, from 1:00 – 3:00 p.m. ET.**

The toll-free call telephone number is:

**1-888-455-0787.**

In order to join the call, participants will be required to give the following information to the conference operator:

Passcode: **ESRD**

Leader's name: **Ann Palmer**

Providers may review the following resources prior to the conference call:

- **End Stage Renal Disease Composite Payment Rate System Fact Sheet** <http://www.cms.hhs.gov/medlearn/ESRDCompRatePaymentSys.pdf>
- **Medlearn Matters Articles**  
<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3539.pdf>  
<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3554.pdf>  
<http://www.cms.hhs.gov/medlearn/mattersmmarticles/2005/MM3720.pdf>  
<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0511.pdf>
- **Change Request 3539/Transmittal 348** [http://www.cms.hhs.gov/manuals/pm\\_trans/R348CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R348CP.pdf)
- **Change Request 3554/Transmittal 27** [http://www.cms.hhs.gov/manuals/pm\\_trans/R27BP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R27BP.pdf)
- **Change Request 3554/Transmittal 373** [http://www.cms.hhs.gov/manuals/pm\\_trans/R373CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R373CP.pdf)
- **Change Request 3720/Transmittal 477** [http://www.cms.hhs.gov/manuals/pm\\_trans/R477CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R477CP.pdf)
- **Pricing File and NDC-HCPCS Crosswalk (background files)** <http://www.cms.hhs.gov/providers/drugs/asp.asp>
- **End-Stage Renal Disease Information Resource for Medicare** <http://www.cms.hhs.gov/providers/esrd.asp>

Source: CMS Joint Signature Memorandum 05297, April 7, 2005

# CORF SERVICES

## Update to the Therapy Code Lists

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

### Provider Types Affected

Providers billing intermediaries and carriers for Part A inpatient and Part B outpatient services

### Provider Action Needed

Providers should note that this article provides details from Change Request (CR) 3647, which updates the list of Healthcare Common Procedure Coding System (HCPCS) codes describing therapy services including physical therapy, occupational therapy, and speech-language pathology. It also clarifies the term “always therapy” codes. The term “therapy” as used in this article refers only to physical therapy, occupational therapy, and speech-language pathology. The term “therapists” refers to physical therapists, occupational therapists, speech-language pathologists, and, in some cases, to physicians, clinical nurse specialists, nurse practitioners, and physician assistants who may provide therapy services.

### Background

Change Request (CR) 3647 updates the list of HCPCS codes that describe therapy services for physical therapy, occupational therapy, and speech-language pathology. Some of these changes are required to prevent conflicts with OPPS codes, which were effective January 1, 2005, and others are updates to the current list.

Financial limitations on therapy services were mandated by the Balanced Budget Act (BBA), and in order to limit the services, a list of the services to which limits would apply was developed and published as AB-03-018 in February 7, 2003. The original list may be viewed at: [http://www.cms.hhs.gov/manuals/pm\\_trans/AB03018.pdf](http://www.cms.hhs.gov/manuals/pm_trans/AB03018.pdf).

Specialty codes 73 and 74 were incorrectly noted in transmittal AB-03-018 and have since been reassigned to specialties that are not therapy services.

This list is being updated due to new codes and new information about the codes listed. The limitations are not in effect in the year 2005, but are mandated to be implemented on January 1, 2006 unless new legislation is passed. Regardless of whether financial limitations are in effect, CMS uses this list to identify therapy services for policy purposes.

### Applicable Outpatient Rehabilitation HCPCS Codes

CMS identifies the following codes as therapy services. See the notes below the table for details about each code.

The financial limits (when in effect) apply to services represented by the following codes, except as noted below.

**Note:** Listing of the following codes does not imply that services are covered.

#### HCPCS Codes Identified as Therapy Services

64550+	90901+	<u>92506</u>	<u>92507</u>	<u>92508</u>	<u>92526</u>	<u>92597</u>	<u>92605****</u>
<u>92606****</u>	<u>92607</u>	<u>92608</u>	<u>92609</u>	92610+	92611+	92612+	92614+
92616+	95831+	95832+	95833+	95834+	95851+	95852+	96105+
96110+♦✓	96111+✓	96115+✓	<u>97001</u>	<u>97002</u>	<u>97003</u>	<u>97004</u>	<u>97010****</u>
<u>97012</u>	<u>97016</u>	<u>97018</u>	<u>97020</u>	<u>97022</u>	<u>97024</u>	<u>97026</u>	<u>97028 97032</u>
<u>97033</u>	<u>97034</u>	<u>97035</u>	<u>97036</u>	<u>97039</u>	<u>97110</u>	<u>97112</u>	<u>97113 97116</u>
<u>97124</u>	<u>97139</u>	<u>97140</u>	<u>97150</u>	<u>97504**</u>	<u>97520</u>	<u>97530</u>	<u>97532+</u>
<u>97533</u>	<u>97535</u>	<u>97537</u>	<u>97542</u>	97597+	97598+	<u>97602****</u>	<u>97605****</u>
<u>97606****</u>	<u>97703</u>	<u>97750</u>	<u>97755</u>	<u>97799*</u>	G0279+***	G0280+***	<u>G0281</u>
<u>G0283</u>	<u>G0329</u>	0029T+***					

\* The physician fee schedule abstract file does not contain a price for codes 96110, or 97799, since the carrier prices them. Therefore, the fiscal intermediary (FI) must contact the carrier to obtain the appropriate fee schedule amount in order to make proper payment for these codes.

♦ Effective January 1, 2004, 96110 will be an active code on the physician fee schedule. Carriers shall no longer price this code.

\*\* Code 97504 should not be reported with code 97116. However, if code 97504 was performed on an upper extremity and code 97116 (gait training) was also performed; both codes may be billed with modifier 59 to denote a separate anatomic site.

\*\*\* The physician fee schedule abstract file does not contain a price for codes G0279, G0280, 0020T, or 0029T since they are priced by the carrier. In addition, the carrier determines coverage for these codes. Therefore, the FI contacts the carrier to obtain the appropriate fee schedule amount.

\*\*\*\* Codes are bundled. They are bundled with any therapy codes. Regardless of whether they are billed alone or in conjunction with another therapy code, Medicare does not pay separately for these codes. If billed alone, either code will be denied using group code CO on the remittance advice notice with claim adjustment reason code 97 that says:

*Update to the Therapy Code Lists (continued)*

“Payment is included in the allowance for another service/procedure.”

Medicare will use reason code 97 to deny a procedure code that should have been bundled.

Alternatively, reason code B15, which has the same intent, may also be used.

✓ *If billed by an outpatient hospital department, these are paid using the outpatient prospective payment system (OPPS).*

**Underlined codes are always therapy services, regardless of the circumstances or who performs them. These codes always require therapy modifiers whenever they are billed.**

+ Codes sometimes represent therapy services. These codes and all codes on the above list always represent therapy services when performed by therapists.

There are some circumstances when these codes will not be considered representative of therapy services and therapy limits (when they are in effect) will not apply. Codes marked + are not therapy services when:

- It is not appropriate to bill the service under a therapy plan of care, and
- They are billed by providers of services who are not therapists, i.e., physicians, clinical nurse specialists, nurse practitioners and psychologists.

The codes marked + on the above list may not be used by therapists, or by physicians, or by nonphysician practitioners who are not therapists without a therapy modifier in situations where the service provided is integral to an outpatient rehabilitation therapy service. It is not the code marked + itself, but the circumstance under which a code marked + is billed that determines whether a modifier is required. Physicians and nonphysician practitioners who can appropriately provide the services represented by the codes marked ‘+’ on the above list should only use therapy modifiers (GP, GN, GO) with the above codes when the services are outpatient rehabilitation therapy services provided under a therapy plan of care. **Do not use the modifier when it is not needed.**

Therapy services, whether represented by “always therapy” codes, or “sometimes therapy codes in the above list performed as outpatient rehabilitation therapy services, must follow all the policies for therapy services (see the Medicare Claims Processing Manual (Pub. 100-04), Chapter 5, and the Medicare Benefit Policy Manual (Pub. 100-02), Chapter 15).

**Additional HCPCS Codes**

Codes that are not on the list of therapy services should not be billed with a modifier. There are thousands of such codes; but, for example, the following outpatient non-rehabilitation HCPCS codes should be billed without modifiers:

**Outpatient Non-Rehabilitation HCPCS Codes**

95860 95861 95863 95864 95867 95869 95870 95900 95903 95904 95934 G0237 G0238 G0239

**Note:** The above list of codes is intended to facilitate the contractor’s ability to pay claims under the Medicare physician fee schedule (MPFS). It is not intended to be a list of all covered OPT services and does not assure coverage of these services.

**Implementation**

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

**Additional Information**

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

From that Web page, look for CR 3647 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3647

Related CR Release Date: April 1, 2005

Related CR Transmittal Number: 515

Effective Date: January 3, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 515, CR 3647

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# SKILLED NURSING FACILITY SERVICES

## Prosthetics and Orthotics Ordered in a Hospital or Home Prior to a Skilled Nursing Facility Admission

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

### Provider Types Affected

Skilled nursing facilities (SNFs), physicians, suppliers, and providers

### Provider Action Needed

This article is informational only and describes who is responsible for billing when a customized device is ordered for beneficiary while in the hospital or home but delivered to the beneficiary at a skilled nursing facility (SNF).

### Background

When a customized device is ordered while a beneficiary is an inpatient at a hospital, and the device is not delivered until after the beneficiary has moved to an SNF, the issue arises as to who is responsible for the billing of the item.

When a beneficiary is going from a hospital stay to an SNF Part A stay and needs an orthotic or prosthetic device, the facility where the medical need occurred is responsible for billing (rather than the supplier or provider of the device, which would bill for instances when need is established while the beneficiary is at home or in the community). Thus, if a prosthetic or orthotic device is medically necessary at the time the beneficiary is in the hospital, in the rare case when the prosthetic or orthotic is not delivered until the beneficiary has arrived at the SNF, the hospital remains responsible for billing for the item.

However, when the medical necessity for the prosthetic or orthotic device occurs after the time the Part A resident enters the SNF; the SNF is responsible for the billing of the prosthesis or orthosis. Given that most prosthetics (and all orthotic devices) are subject to SNF consolidated billing, the cost would be covered in the SNF’s global per diem payment unless the item is specifically excluded from SNF consolidated billing. Certain specified customized prosthetics are excluded and if the need for these devices was established in the SNF, the supplier is to bill the durable medical equipment regional carrier (DMERC).

When a beneficiary requires a prosthesis or orthosis while in the home and then enters an SNF for a covered Part A stay, the DMERC would be billed by the party which supplied the device (not the SNF).

Medical necessity must have been established while the beneficiary was in the home.

If the beneficiary enters an SNF for a noncovered stay and thereafter develops a medical need for a customized device which the SNF orders, the SNF would bill the DMERC for the item, since SNF consolidated billing rules do not apply.

### Additional Information

See the Medicare Claims Processing Manual, Pub. 100-4, Chapter 20, section 110.3, “Pre-Discharge Delivery of DMEPOS for Fitting and Training,” which covers instances in which a beneficiary may take delivery of DME, a prosthetic, or an orthotic for use at home during his or her last two days in an inpatient facility before returning home. This publication can be found at: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp).

Also, see Medlearn Matters Special Edition SE0437 for an article that provides specifics on how SNF consolidated billing applies to prosthetics and orthotics. This article may be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0437.pdf>.

In addition, the CMS Medlearn consolidated billing website may be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>.

It includes the following relevant information:

- General SNF consolidated billing information.
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing).
- Therapy codes that must be consolidated in a non-covered stay.
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS consolidated billing website may be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and Federal Register notices).

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

Source: CMS Special Edition Medlearn Article SE0507

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## Modification to the Fiscal Intermediary Standard System Regarding Ambulance Services Billed on Types of Bill 18x and 21x

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

### Provider Types Affected

Skilled nursing facilities (SNFs) and swing bed facilities billing Medicare fiscal intermediaries (FIs) for ambulance services

### Provider Action Needed

#### STOP – Impact to You

Swing beds and SNFs should discontinue billing ambulance services on types of bill (TOBs) 18x and 21x.

#### CAUTION – What You Need to Know

This information in related CR 3564 supersedes Transmittal A-02-085, published September 11, 2002, effective January 1, 2003, and removes the ability of revenue code 054x to be accepted on (TOBs) 18x and 21x.

#### GO – What You Need to Do

Be aware of this correction and note that previously processed claims with revenue code 054x on TOBs 18x or 21x do not have to be reprocessed since no error in claim payment was made.

### Background

CMS Transmittal A-02-085, a program memorandum published September 11, 2002 with an effective date of January 1, 2003, stated that ambulance services could be billed on TOBs 18x and 21x, though no separate payment could be made for such services, since TOBs 18x and 21x receive bundled payments under prospective payment systems.

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Ambulance services billed on applicable institutional claims on line items using revenue code 054x are always funded through the Medicare Part B trust fund. It was discovered that ambulance services billed on TOBs 18x and 21x caused charges to be posted to the Provider Statistical and Reimbursement (PS&R) report incorrectly.

### Implementation Date

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

### Additional Information

The official instruction issued to your intermediary (CR 3564) regarding this change may be found at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R439CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R439CP.pdf).

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

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

Related Change Request (CR) Number: 3564

Related CR Release Date: January 21, 2005

Related CR Transmittal Number: 439

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 439, CR 3564

## Reporting Revenue Code for Ambulance Services

The Medlearn Matters article MM3564 title "Modification to the Fiscal Intermediary Standard System Regarding Ambulance Services Billed on Types of Bill 18x and 21x" indicates reporting revenue code 054x on line items when billing for ambulance services on applicable institutional claims.

First Coast Service Options, Inc. reminds our providers that billing ambulance services to this fiscal intermediary **must be reported using revenue code 540**, based on the established guidelines for method II payment methodology. ❖

## Skilled Nursing Facility Consolidated Billing as It Relates to Therapy Services

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

### Provider Types Affected

Skilled nursing facilities (SNFs), physicians, practitioners, physical and occupational therapists, speech language pathologists, rehabilitation agencies, hospitals, home health agencies

### Provider Action Needed

This article is informational only and describes SNF consolidated billing (CB) as it applies to physical and occupational therapies and speech-language pathology services furnished to SNF residents during a Part A covered stay, residents of a Medicare-certified SNF who are not eligible for Part A care, and beneficiaries who reside in the non-certified portion of a nursing home.

**Note:** The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These "excluded" services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would

*Skilled Nursing Facility Consolidated Billing as It Relates to Therapy Services (continued)*

generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier.

**Background**

When the SNF prospective payment system (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. Consolidated billing assigns to the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. A covered Part A stay occurs when a beneficiary meets all of the requirements for coverage under Part A's extended care benefit, and resides in an institution or part thereof that is Medicare-certified as an SNF. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are services specifically excluded from this consolidated billing provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service.

(See Medlearn Matters Special Edition article SE0431 for a detailed overview of SNF consolidated billing, including a section on services excluded from SNF consolidated billing.) This article can be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

The law specifically provides that physical therapy (PT), occupational therapy (OT), and speech language pathology (SLP) services are not excluded from consolidated billing (Section 1888(e)(2)(A)(ii) of the Social Security Act and regulations at 42 CFR 411.15(p)(1)(i)). (References in this article to therapy cover only PT, OT, and SLP services.)

The consolidated billing legislation is very emphatic that PT, OT, and SLP services furnished to SNF residents are always subject to consolidated billing. This applies even when a resident receives the therapy during a noncovered stay in which a beneficiary who is not eligible for Part A extended care benefits still resides in an institution (or part thereof) that is Medicare-certified as an SNF. The legislation also applies regardless of whether or not the services are performed by, or under the supervision of, a practitioner (such as a physician) whose services would otherwise be excluded from consolidated billing.

Therapy services that are furnished to residents of a Medicare-certified SNF are subject to the SNF consolidated billing provision. Payment for therapy services furnished during a covered Part A stay is included in the SNF's global per diem PPS rate.

In a noncovered SNF stay, the beneficiary may be eligible for coverage of individual medical and other health services under Part B. Since the beneficiary still resides in a Medicare-certified institution (or part thereof) the therapy

services are subject to the SNF consolidated billing provision. Under this provision, the claims for therapy services furnished during a noncovered SNF stay must be submitted to Medicare by the SNF itself. The SNF is responsible for reimbursing the provider. The SNF would bill its fiscal intermediary and be reimbursed under the Medicare fee schedule.

When a beneficiary resides in a nursing home (or part thereof) that is not certified as an SNF by Medicare, the Part A extended care benefit cannot cover the beneficiary's stay. However, the beneficiary may still be eligible for Part B coverage of certain individual services, including therapy. In this case, the beneficiary is not considered an SNF resident for Medicare billing purposes, and the therapy services are not subject to consolidated billing. Either the therapy provider or the facility may bill the Medicare carrier for Part B directly.

**Additional Information**

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

The Centers for Medicare and Medicaid Services (CMS) Medlearn consolidated billing website may be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>.

It includes the following relevant information:

- General SNF consolidated billing information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing)
- Therapy codes that must be consolidated in a non-covered stay
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS consolidated billing website can be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and Federal Register notices).

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

Source: CMS Special Edition Medlearn Article SE0518

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



## April Update to 2005 HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement

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

**Note:** CMS revised this article on February 8, 2005 to correct punctuation in the first bullet point under Major Category V. No other changes were made. This article was published in the [Second Quarter 2005 Medicare A Bulletin \(pages 53-55\)](#).

### Provider Types Affected

Institutional providers billing claims to Medicare fiscal intermediaries (FIs) and physicians, practitioners, and suppliers billing Medicare carriers for services

### Provider Action Needed

#### STOP – Impact to You

HCPCS codes are being added to or removed from the skilled nursing facility (SNF) consolidated billing (CB) enforcement list.

#### CAUTION – What You Need to Know

Services included on the SNF consolidated billing enforcement list will be paid to SNF Medicare providers only. Services excluded from the SNF consolidated billing enforcement list may be paid to Medicare providers other than SNFs. See *Background* and *Additional Information* sections for further explanation.

#### GO – What You Need to Do

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

### Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the SNF prospective payment system (PPS).

#### Quarterly updates now apply to both FIs and carriers/durable medical equipment regional carriers (DMERCs)

This is the first joint FI/carrier/DMERCs quarterly update published subsequent to the 2005 annual updates. These updates affect claims with dates of service on or after the effective date of the instructions printed below unless otherwise indicated. **Services appearing on this HCPCS list** (that are submitted on claims to both Medicare FIs and carriers, including DMERCs), **will not be paid by Medicare to providers, other than an SNF, when included in SNF CB.**

For the annual notice on SNF CB each January, separate instructions are published for FI and carriers/DMERCs. The 2005 annual update for FIs can be found on the CMS website at:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R360CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R360CP.pdf).

Information on the 2005 annual update for carriers can be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>.

Please take note of the following important points:

- For non-therapy services, SNF CB applies only when the services are furnished to an SNF resident during a covered Part A stay.
- For physical, occupational or speech-language therapy services, SNF CB applies whenever they are furnished to an SNF resident, regardless of whether Part A covers the stay.

- Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in an SNF stay.
- Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB to assure proper payment in all settings.

**This notification provides a list of the exclusions, and some inclusions, to SNF CB, and the codes below are being added or removed from the annual update. Note the following:**

**Major Category I** additions noted below means these codes:

- May only be billed by hospitals and critical access hospitals (CAHs) for beneficiaries in SNF Part A stays, and
- Will only be paid when billed by these providers.

**Major Category III** additions noted below means these services:

- May be provided by any Medicare provider licensed to provide them, except an SNF, and
- Are excluded from SNF PPS and CB.

**Major Category IV** additions noted below means these services:

- Are covered as Part B benefits and not included in SNF PPS, however
- Must be billed by the SNF for beneficiaries in a Part A stay with Part B eligibility on type of bill (TOB) 22x.

**Major Category V** additions to therapy inclusions noted below means:

- SNFs alone can bill and be paid for these services when delivered to beneficiaries in an SNF, whereas codes being removed from this therapy inclusion list now can be billed and potentially paid to other types of providers for beneficiaries **NOT** in a Part A stay or in an SNF bed receiving ancillary services billed on TOB 22x.

#### Computerized Axial Tomography (CT) Scans (Major Category I, FI annual update, EXCLUSION)

- **Remove G0131** – computerized tomography, bone mineral density study, one or more sites; axial skeleton
- **Remove G0132** – computerized tomography, bone mineral density study, one or more sites; appendicular skeleton
- **Add 76070\*** – computed tomography, bone mineral density study, one or more sites; axial skeleton
- **Add 76071\*** – computed tomography, bone mineral density study, one or more sites; appendicular skeleton

*April Update to 2005 HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement (continued)*

Note on previous codes:

\* Codes replaced HCPCS codes G0131 and G0132. The professional components of these codes were already added with the 2005 annual update as separately payable by the carrier for claims with dates of service on or after January 1, 2005.

**Radiation Therapy**

(Major Category I, FI annual update, **EXCLUSION**)

- **Remove C9714^** – Placement of balloon catheter into the breast for interstitial radiation therapy following a partial mastectomy; concurrent/immediate
- **Remove C9715^** – Placement of balloon catheter into the breast for interstitial radiation therapy following a partial mastectomy; delayed
- **Remove G0256+** – prostate brachytherapy
- **Add 19296^^** – placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance
- **Add 19297^^** – placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent
- **Add C1715** – brachytherapy needle
- **Add C1717** – brachytx seed, HDR Ir-192
- **Add C1728** – Cath, brachytx seed adm
- **Add C2633** – brachytx source, Cesium-131
- **Add C2634** – Brachytx source, HA, I-125
- **Add C2635** – Brachytx source, HA, P-103
- **Add C2636** – Brachytx linear source, P-103
- **Add C9722** – KV imaging w/IR tracking

Note on codes above:

^ These codes were discontinued December 31, 2004.  
+ HCPCS code G0256 was discontinued December 31, 2003

^^ These codes are effective January 1, 2005 and replaced codes C9714 and C9715 and these codes were already added with the 2005 annual update as separately payable by the carrier for claims with dates of service on or after January 1, 2005.

**Dialysis Supplies**

(Major Category II, FI annual update, **EXCLUSION**)

- **Remove A4712** – water, sterile, for injection

**Note:** HCPCS code A4712 was discontinued December 31, 2003.

**Chemotherapy Administration**

(Major Category III, FI annual update, **EXCLUSION**)

- **Add G0357+** – Intravenous, push technique, single or initial substance/drug
- **Add G0358+** – Intravenous, push technique, each additional substance/drug

- **Add G0359+** – chemotherapy administration, intravenous infusion technique, up to one hour, single or initial substance/drug
- **Add G0360+** – Each additional hour, 1 to 8 hours
- **Add G0361+** – initiation of prolonged chemotherapy infusion (more than 8 hours)
- **Add G0362+** – Each additional sequential infusion (different substance/drug), up to 1 hour
- **Add G0363+** – Irrigation of implanted venous access device for drug delivery systems

Note on codes above:

+ These codes were effective January 1, 2005. These codes were already added with the 2005 annual update as separately payable by the Medicare carrier for claims with dates of service on or after January 1, 2005.

**Mammography**

(Major Category IV, FI annual update, **EXCLUSIONS**)

- **Remove G0203** – screening mammography

**Note:** HCPCS code G0203 was discontinued December 31, 2001.

**Diabetic Screening**

(Major Category IV, FI annual update, **EXCLUSIONS**)

- **Add 82950** – Glucose; post glucose dose

**Note:** This is not a physician service and will not be added as separately payable by the Medicare carrier.

**New Preventive Benefit (Per section 611 of the Medicare Modernization Act (MMA—Initial Preventive Physical Exam**

(Major Category IV, FI annual update, **EXCLUSIONS**)

- **Add G0344** – Initial prev exam
- **Add G0367•** – EKG tracing for initial prev

Note on code above:

• HCPCS code G0367 was effective January 1, 2005. Only the corresponding professional component of this code, G0368, will be separately payable by the carrier. It was already added with the 2005 annual update. G0367 is the technical component only and will be subject to consolidated billing.

**Therapies**

(Major Category V, FI annual update, **INCLUSIONS**)

- **Update for HCPCS 92605 and 92606 already included in the 2005 annual update.** Payment for these codes is bundled with other rehabilitation services. They may be bundled with any therapy code.
- No payment can be made for these codes.
- **Remove 92601** – Cochlear implant w/ programming
- **Remove 92602** – Cochlear implant, subsequent programming
- **Remove 92603** – Diagnostic analysis, cochlear implant w/ programming
- **Remove 92604** – Diagnostic analysis, cochlear implant, subsequent programming

*April Update to 2005 HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement (continued)*

- **Remove 92525** – Evaluation of swallowing
- **Remove 97014** – E stim unattended (not payable by Medicare)(this was replaced by G0283)
- **Remove 97545** – Work hardening, initial 2 hrs
- **Remove 97546** – Work hardening, each add'l hr
- **Add 96110** – Development testing, limited
- **Add 96111** – Developmental testing, extended
- **Add 96115** - Neurobehavioral status exam

HCPCS code 92525 was discontinued December 31, 2002.

**Note:** Section 1888 of the Social Security Act codifies SNF PPS and CB. The new coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services will be added by these routine updates; that is, 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.

### Implementation

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

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### Additional Information

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

From that Web page, look for CR 3683 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3683

Related CR Release Date: January 21, 2005

Related CR Transmittal Number: 449

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 449, CR 3683

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## Services Furnished Under an “Arrangement” with an Outside Entity

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

**Note:** CMS revised this article on February 8, 2005, to provide some clarification language but no substantive changes were made to the article. This article was published in the [Second Quarter 2005 Medicare A Bulletin \(pages 49-51\)](#).

### Provider Types Affected

Any physician, provider or supplier who renders a Medicare-covered service subject to consolidated billing to a skilled nursing facility (SNF) resident

### Provider Action Needed

No provider action is necessary. This article is informational only and clarifies the instruction contained in CR 3248, issued on May 21, 2004. It explains that an “arrangement” between a Medicare SNF and its supplier is validated not by the presence of specific supporting written documentation but rather by their actual compliance with the requirements governing such “arrangements.” However, supporting written documentation that provides details regarding the services to be provided “under arrangement” and the manner in which the SNF will pay the supplier for those services can help both parties arrive at a mutual understanding on these points.

### Background

Under the SNF consolidated billing provisions of the Social Security Act (the Act) the Medicare billing responsibility is placed with the SNF itself for most of its residents’ services. (See sections 1862[a][18], 1866[a][1][H][ii], and 1888[e][2][A]). The SNF must include on its Part A claim submitted to its Medicare intermediary almost all of the services a resident receives during a covered stay. The SNF

should not include on the claims those services that are excluded from the SNF’s prospective payment system (PPS) per diem payment for the particular stay.

These excluded services continue to be separately billable under Part B by those outside suppliers that actually furnish the service. In this context, the term “supplier” can also refer to:

- A provider of services (such as a hospital), which would submit the bill for Part B services to its Medicare intermediary; and
- Practitioners who, in addition to performing their separately billable professional services, essentially act as a supplier by also furnishing other services that are subject to the consolidated billing requirement.

Outside entities (other than a provider of services) would generally submit their Part B bills to a Medicare carrier, but Part B bills for certain types of items or equipment are submitted to the Medicare durable medical equipment regional carrier (DMERC).

In addition, Part B consolidated billing makes the SNF itself responsible for the submission of Part B bills for any *physical, occupational or speech-language therapy services* received by a resident during a *noncovered* stay.

*Services Furnished Under an “Arrangement” with an Outside Entity (continued)*

Further, the SNF must provide any Part A or Part B service that is subject to SNF consolidated billing either directly with its own resources, or through an outside entity (e.g., a supplier) under an “arrangement,” as set forth in Section 1861(w) of the Act. If an outside entity provides a service that is subject to SNF consolidated billing to a SNF resident during a covered stay, the outside entity must look to the SNF for payment (rather than billing under Part B). In these situations, Medicare’s payment to the SNF represents payment in full for the arranged-for service, and the SNF in turn is responsible for making payment to an outside entity that furnishes a service which is included in the SNF’s prospective payment system (PPS) per diem payment.

**Problem Situations**

Since the start of the SNF PPS, problematic situations have arisen when the SNF resident receives services that are subject to consolidated billing from an outside entity, such as a supplier. These problems are usually connected with either of two scenarios, namely:

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

**Documenting Arrangements**

SNFs should document, in writing, arrangements with suppliers that render services on an ongoing basis (e.g., pharmacies, laboratories and X-ray suppliers) to the SNF’s patients. Documentation of a valid arrangement, including mutually agreeable terms, should help to avoid confusion and friction between SNFs and their suppliers.

Suppliers need to know which services fall under the consolidated billing provisions so they do not improperly bill Medicare carriers under Part B or other payers (like Medicaid and beneficiaries) directly for services.

It is also important that when ordering or providing services “under arrangement,” the parties reach a mutual understanding of all the payment terms, e.g., how to submit an invoice, how payment rates are determined, and how long it will take for payment after the supplier presents an invoice to the SNF.

**SNF’s Responsibility**

However, the absence of a valid arrangement with its supplier (written or not) does not relieve the SNF of its responsibility to pay suppliers for services “bundled” in the SNF PPS payment from Medicare. The SNF must be considered the responsible party (even in cases where it did not specifically order the service) when beneficiaries in Medicare Part A stays receive medically necessary supplier services, because the SNF has already been paid under the SNF PPS. Examples of this obligation occur when:

- The physician performs additional diagnostic tests during a scheduled visit that had not been ordered by the SNF; or

- A family member arranges a physician visit without the knowledge of SNF staff and the physician bills the SNF for “incident to” services.

Establishing a valid arrangement prior to ordering services from a supplier minimizes the likelihood of a payment dispute between the parties. However, occasional disagreements between the parties that result in nonpayment by the SNF of a supplier claim may occur. When patterns of such nonpayments are identified, there are potentially adverse consequences to SNFs with regard to Medicare agreement. All SNFs, under the terms of their Medicare provider agreement, must comply with program regulations. **These regulations require a valid arrangement to be in place between the SNF and any outside entity providing resident services subject to consolidated billing. Moreover, in receiving a bundled per-diem payment under the SNF PPS that includes such services, the SNF is accepting Medicare payment and financial responsibility for the service.**

Under Section 1862(a)(18) of the Act, there is no valid “arrangement” if an SNF obtains services subject to consolidated billing from an outside supplier but refuses to pay the supplier for those services. This situation could result in the following consequences:

- The SNF is found in violation of the terms of its provider agreement; and/or
- Medicare does not cover the particular services at issue.

The SNF provider agreement includes a section requiring a specific commitment to comply with the requirements of the consolidated billing provision. See Section 1866(a)(1)(H)(ii) of the Act and the regulations at 42 CFR 489.20(s). Also Section 1866(g) of the Act imposes a civil money penalty on any person who knowingly and willfully presents (or causes to be presented) a bill or request for payment inconsistent with an arrangement or in violation of the requirement for such an arrangement.

**Additional Guidance**

In the absence of a valid “arrangement” between an SNF and its supplier, the problems which arise tend to fall into one of the following problem scenarios.

**Problem Scenario 1**

An SNF elects to utilize an outside supplier to furnish a type of service that would be subject to Part A consolidated billing, but then fails to inform the supplier that the resident receiving the service is in a covered Part A stay. This causes the supplier to conclude mistakenly that the service it furnishes to that resident is not subject to consolidated billing.

Based on the inaccurate impression that the resident’s SNF stay is noncovered, the supplier inappropriately submits a separate Part B claim for the service and may also improperly bill other insurers and the resident. Then the supplier only learns of the actual status of the resident’s Medicare-covered SNF stay when that Part B claim is denied by Medicare.

**Services Furnished Under an “Arrangement” with an Outside Entity (continued)**

In this scenario, even though the supplier made reasonable efforts to ascertain from the SNF both the beneficiary’s status as an SNF resident and the specific nature of the beneficiary’s SNF stay, the information from the SNF (on which the supplier relied) proved to be inaccurate.

The Centers for Medicare & Medicaid Services (CMS) realizes that unintentional mistakes occasionally may occur when furnishing such information. However, the SNF is responsible for making a good faith effort to provide accurate information to its supplier and to pay the supplier once the error is pointed out.

In Scenario 1, if the SNF refuses to pay the supplier even after the supplier brings the situation to the attention of the SNF, the SNF would risk being in violation of its provider agreement by not complying with the consolidated billing requirements. As stated previously, supporting written documentation for services provided “under arrangement” would provide a basis for resolving the dispute and ensuring compliance with the consolidated billing requirements.

By making sure that it sends accurate and timely information to its supplier regarding a resident’s covered stay, the SNF can often prevent disputes such as those described in Scenario 1 from arising. The communication of accurate and timely resident information by the SNF to the supplier is especially important when a portion of an otherwise “bundled” service remains separately billable to Part B (e.g., the professional component representing a physician’s interpretation of an otherwise “bundled” diagnostic test).

**Problem Scenario 2**

A resident temporarily departs from the SNF on a brief leave of absence, typically accompanied by a relative or friend. While briefly offsite, the resident (or the relative or friend, acting on the resident’s behalf) obtains services that are subject to the consolidated billing requirement, but fails to notify the SNF. The SNF refuses to pay for the offsite services, and the supplier bills the beneficiary/family member directly.

As in the previous scenario, the SNF remains responsible for any services included in the SNF “bundle” of services subject to consolidated billing that are furnished to the resident by an outside entity, *even in the absence of a valid arrangement with the SNF*.

The SNF can take steps to prevent problems like this from occurring by making sure that the resident or his/her representative fully understands the applicable requirements.

For example, under Section 1802 of the Act, Medicare law guarantees to a beneficiary the right to choose any qualified entity willing to provide services to him/her. By selecting a particular SNF, the beneficiary has in effect exercised this right of choice regarding the entire array of services for which the SNF is responsible under the consolidated billing requirement and agrees to use only those outside suppliers that the CNF selects or approves to provide services.

The staff of the SNF should explain these rights and requirements to the beneficiary and his/her family members or representative(s) during the admission process. In addition, the SNF should periodically remind the beneficiary or his/her representative of this rights/requirements throughout the resident’s stay, and especially upon the resident’s temporarily leaving the facility.

The supplier in this scenario also retains responsibility for preventing problems from arising by understanding and complying with the consolidated billing requirements. Therefore, before providing beneficiary services, the supplier should determine whether that beneficiary currently receives any comprehensive Medicare benefits (e.g., SNF or home health), which could include the supplier’s services. If the beneficiary is a resident of an SNF with which the supplier does not have a valid “arrangement,” the supplier should consult with the SNF before actually furnishing any services that may be subject to the consolidated billing provision. Further, the supplier should know that the beneficiary cannot be charged for the bundled service in accordance with the regulations at 42 CFR 489.21(h).

**Additional Information**

The Medicare Claims Processing Manual has been revised to include language reflecting this clarification. That revision is attached to the official instruction issued to your intermediary/carrier regarding this change. The official instruction may be found at:

[http://www.cms.hhs.gov/manuals/pm\\_trans/R412CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R412CP.pdf).

Also 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: 3592

Related CR Release Date: December 23, 2004

Related CR Transmittal Number: 412

Effective Date: May 21, 2004

Implementation Date: January 24, 2005

Source: CMS Pub. 100-4, Transmittal 412, CR 3592

## Skilled Nursing Facility Consolidated Billing

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

**Note:** CMS revised this article on February 18, 2005. Specifically, in the second paragraph of the “Clarification” statement below was modified to say “These “excluded” services....” instead of “These included services...” CMS regrets this error. This article was republished in the [Second Quarter 2005 Medicare A Bulletin \(pages 56-59\)](#).

### Provider Types Affected

All Medicare providers, suppliers, physicians, skilled nursing facilities (SNF), and rural swing bed hospitals

### Provider Action Needed

This article is informational only and is intended to remind affected providers that SNFs must submit all Medicare claims for the services its residents receive, except for a short list of specifically excluded services as mentioned in the “Excluded Services” section below. This requirement was established initially as specified in the Balanced Budget Act of 1997 (BBA, P.L. 105-33) and is known as SNF consolidated billing (CB).

**Clarification:** The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These “excluded” services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier.)

### Background

Prior to the Balanced Budget Act of 1997 (BBA), an SNF could elect to furnish services to a resident in a covered Part A stay, either:

- Directly, using its own resources;
- Through the SNF’s transfer agreement hospital; or
- Under arrangements with an independent therapist (for physical, occupational, and speech therapy services).

In each of these circumstances, the SNF billed Medicare Part A for the services.

However, the SNF also had the further option of “unbundling” a service altogether; that is, the SNF could permit an outside supplier to furnish the service directly to the resident, and the outside supplier would submit a bill to Medicare Part B, without any involvement of the SNF itself. This practice created several problems, including the following:

- A potential for duplicate (Parts A/B) billing if both the SNF and outside supplier billed.
- An increased out-of-pocket liability incurred by the beneficiary for the Part B deductible and coinsurance even if only the supplier billed; and A dispersal of responsibility for resident care among various outside suppliers, which adversely affected quality

(coordination of care) and program integrity, as documented in several reports by the Office of the Inspector General (OIG) and the Government Accountability Office (GAO).

Based on the above-mentioned problems, Congress enacted the Balanced Budget Act of 1997 (BBA), Public Law 105-33, Section 4432(b). This section of the law contains the SNF CB requirements. Under the CB requirement, **an SNF itself must submit all Medicare claims for the services that its residents receive** (except for specifically excluded services listed below).

Conceptually, SNF CB resembles the bundling requirement for inpatient hospital services that’s been in effect since the early 1980s—assigning to the facility itself the Medicare billing responsibility for virtually the entire package of services that a facility resident receives, except for certain services that are specifically excluded.

CB eliminates the potential for duplicative billings for the same service to the Part A fiscal intermediary (FI) by the SNF and the Part B carrier by an outside supplier. It also enhances the SNF’s capacity to meet its existing responsibility to oversee and coordinate the total package of care that each of its residents receives.

### Effective Dates

CB took effect as each SNF transitioned to the prospective payment system (PPS) at the start of the SNF’s first cost reporting period that began on or after July 1, 1998.

The original CB legislation in the BBA applied this provision for services furnished to every resident of an SNF, regardless of whether Part A covered the resident’s stay. However, due to systems modification delays that arose in connection with achieving Year 2000 (Y2K) compliance, the Centers for Medicare & Medicaid Services (CMS) initially postponed implementing the Part B aspect of CB, i.e., its application to services furnished during noncovered SNF stays.

The aspect of CB related to services furnished during noncovered SNF stays has now essentially been repealed altogether by Section 313 of the Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554, Appendix F). Thus, with the exception of physical therapy, occupational therapy, and speech language pathology services (which remain subject to CB regardless of whether the resident who receives them is in a covered Part A stay), this provision now applies only to those services that an SNF resident receives during the course of a covered Part A stay.

### Excluded Services

There are a number of services that are excluded from SNF CB. These services are outside the PPS bundle, and they remain separately billable to Part B when furnished to an SNF resident by an outside supplier. However, Section 4432(b)(4) of the BBA (as amended by Section 313(b)(2) of the BIPA) requires that bills for these excluded services, when furnished to SNF residents, must contain the SNF’s Medicare provider number.

**Skilled Nursing Facility Consolidated Billing (continued)**

Services that are categorically excluded from SNF CB are the following:

- Physicians' services furnished to SNF residents. These services are not subject to CB and, thus, are still billed separately to the Part B carrier.
- Certain diagnostic tests include both a professional component (representing the physician's interpretation of the test) and a technical component (representing the test itself), and the technical component is subject to CB. **The technical component of these services must be billed to and reimbursed by the SNF.** (See Medlearn Matters Special Edition Article SE0440 for a more detailed discussion of billing for these diagnostic tests.)
- Section 1888(e)(2)(A)(ii) of the Social Security Act specifies that **physical therapy, occupational therapy, and speech-language pathology services are subject to CB**, even when they are furnished by (or under the supervision of) a physician.
- Physician assistants working under a physician's supervision
- Nurse practitioners and clinical nurse specialists working in collaboration with a physician
- Certified nurse-midwives
- Qualified psychologists
- Certified registered nurse anesthetists
- Services described in Section 1861(s)(2)(F) of the Social Security Act (i.e., Part B coverage of home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies).
- Services described in Section 1861(s)(2)(O) of the Social Security Act (i.e., Part B coverage of epoetin alfa (EPO, trade name Epogen®) for certain dialysis patients. Note: darbepoetin alfa (DPA, trade name Aranesp®) is now excluded on the same basis as EPO).
- Hospice care related to a resident's terminal condition.
- An ambulance trip that conveys a beneficiary to the SNF for the initial admission, or from the SNF following a final discharge.

**Physician "Incident To" Services**

While CB excludes the types of services described above and applies to the professional services that the practitioner performs personally, **the exclusion does not apply to physician "incident to" services** furnished by someone else as an "incident to" the practitioner's professional service. These "incident to" services furnished by others to SNF residents are subject to CB and, accordingly, must be billed to Medicare by the SNF itself.

**Outpatient Hospital Services**

In Program Memorandum (PM) Transmittal A-98-37 (November 1998, reissued as PM transmittal A-00-01, January 2000), CMS identified specific types of outpatient hospital services that are so exceptionally intensive or costly that they fall well outside the typical scope of SNF care

plans. CMS has excluded these services from SNF CB as well (along with those medically necessary ambulance services that are furnished in conjunction with them). These excluded service categories are:

- Cardiac catheterization; computerized axial tomography (CT) scans
- Magnetic resonance imaging services (MRIs)
- Ambulatory surgery that involves the use of an operating room
- Emergency services
- Radiation therapy services
- Angiography
- Certain lymphatic and venous procedures.

Effective with services furnished on or after April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113, Appendix F) has identified certain additional exclusions from CB. The additional exclusions enacted in the BBRA apply only to certain specified, individual services *within* a number of broader service categories that otherwise remain subject to CB. Within the affected service categories the exclusion applies only to those individual services that are specifically identified by HCPCS code in the legislation itself, while all other services within those categories remain subject to CB. These service categories are:

- Chemotherapy items and their administration
- Radioisotope services
- Customized prosthetic devices.

In addition, effective April 1, 2000, this section of the BBRA has unbundled those ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services.

Finally, effective January 1, 2004, as provided in the August 4, 2003 final rule (68 *Federal Register* 46060), two radiopharmaceuticals, Zevalin™ and Bexxar®, were added to the list of chemotherapy drugs that are excluded from CB (and, thus, are separately billable to Part B when furnished to an SNF resident during a covered Part A stay).

**Effects of CB**

SNFs can no longer "unbundle" services that are subject to CB in order for an outside supplier to submit a separate bill directly to the Part B carrier. Instead, the SNF itself must furnish the services, either directly, or under an "arrangement" with an outside supplier in which the SNF itself (rather than the supplier) bills Medicare. The outside supplier must look to the SNF (rather than to Medicare Part B) for payment.

In addition, SNF CB:

- Provides an essential foundation for the SNF PPS, by bundling into a single facility package all of the services that the PPS payment is intended to capture.
- Spares beneficiaries who are in covered Part A stays from incurring out-of-pocket financial liability for Part B deductibles and coinsurance.

**Skilled Nursing Facility Consolidated Billing (continued)**

- Eliminates potential for duplicative billings for the same service to the Part A (FI) by the SNF and to the Part B carrier by an outside supplier.
- Enhances the SNF’s capacity to meet its existing responsibility to oversee and coordinate each resident’s overall package of care.

**Additional Information**

While this article presents an overview of the SNF CB process, CMS also has a number of articles that provide more specifics on how SNF CB applies to certain services and/or providers. These articles are as follows:

- Skilled Nursing Facility Consolidated Billing as It Relates to Certain Types of Exceptionally Intensive Outpatient Hospital Services <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0432.pdf>.
- Skilled Nursing Facility Consolidated Billing as It Relates to Ambulance Service <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0433.pdf>.
- Skilled Nursing Facility Consolidated Billing and Erythropoietin (EPO, Epoetin Alfa) and Darbepoetin Alfa (Aranesp) <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0434.pdf>.
- Skilled Nursing Facility Consolidated Billing as It Relates to Dialysis Coverage <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0435.pdf>.
- Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0436.pdf>.
- Skilled Nursing Facility Consolidated Billing as It Relates to Prosthetics and Orthotics <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0437.pdf>.
- Medicare Prescription Drug, Improvement, and Modernization Act – Skilled Nursing Facility Consolidated Billing and Services of Rural Health Clinics and Federally Qualified Health Centers <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0438.pdf>.

- Skilled Nursing Facility Consolidated Billing as It Relates to Clinical Social Workers <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0439.pdf>.
- Skilled Nursing Facility Consolidated Billing as It Relates to Certain Diagnostic Tests <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0440.pdf>.
- Skilled Nursing Facility Consolidated Billing and “Incident To” Services (Services That Are Furnished as an Incident to the Professional Services of a Physician or Other Practitioner) (coming soon). In addition, the CMS Medlearn consolidated billing website may be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>.

It includes the following relevant information:

- General SNF consolidated billing information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing)
- Therapy codes that must be consolidated in a non-covered stay
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS consolidated billing website may be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

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

Source: CMS Special Edition Medlearn Matters SE0431

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## Skilled Nursing Facility Consolidated Billing as It Relates to Certain Types of Exceptionally Intensive Outpatient Hospital Services

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

**Note:** CMS revised this article on February 18, 2005, to include a clarification statement but no substantive changes were made to the article. This article was published in the [First Quarter 2005 Medicare A Bulletin \(pages 72-73\)](#).

**Provider Types Affected**

Skilled nursing facilities (SNFs), physicians, suppliers, providers, and imaging centers

**Clarification:** The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These “excluded” services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These



*SNFCB as It Relates to Certain Types of Exceptionally Intensive Outpatient Hospital Services (continued)*

sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare Intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier).

**Provider Action Needed**

This special edition describes SNF consolidated billing (CB) as it relates to certain types of exceptionally intensive outpatient hospital services, such as magnetic resonance imaging (MRI) services, computerized axial tomography (CT) scans, and radiation therapy.

**Background**

When the SNF prospective payment system (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. For a detailed overview of SNF CB, including a section on services excluded from SNF CB, see *Medlearn Matters Special Edition* article SE0431 at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

The original CB legislation (Section 4432(b) of the Balanced Budget Act of 1997, P. L. 105-33 (BBA 1997)) specified a list of services at Section 1888(e)(2)(A)(ii) of the Social Security Act that were excluded from this provision. As with the inpatient hospital bundling requirement (Section 1862(a)(14) of the Social Security Act) on which it was modeled, the SNF CB provision excluded primarily the services of physicians and certain other practitioners.

Moreover, these services were excluded categorically, without regard to the specific setting in which they were furnished. This legislation did not authorize the Department of Health and Human Services (DHHS) to create additional categorical exclusions from CB administratively, thereby reserving this authority for the Congress itself. In fact, Congress subsequently did enact a number of additional CB exclusions that applied uniformly to services furnished in both hospital and non-hospital settings, in Section 103 of the Balanced Budget Refinement Act of 1999 (BBRA 1999, P.L.106-113, Appendix F).

While the original CB legislation did not authorize DHHS to simply carve out entire categories of services from CB without regard to setting, it did define the SNF CB provision in terms of services furnished to a resident of an SNF, and provided a degree of administrative discretion in defining when a beneficiary is considered to be an SNF "resident" for this purpose.

Using this authority, the Centers for Medicare & Medicaid Services (CMS) identified several types of exceptionally intensive outpatient hospital services that were

well beyond the general scope of SNF care plans. These services include:

- Emergency services
- Cardiac catheterizations
- Computerized axial tomography (CT) scans
- Magnetic resonance imaging (MRI) services
- Ambulatory surgery
- Radiation therapy
- Angiography
- Lymphatic and venous procedures.

CMS established that a beneficiary's receipt of such services in the outpatient hospital setting had the effect of temporarily suspending his/her status as an SNF resident for CB purposes, thus enabling the hospital to bill Part B separately for the services. (See Title 42 of the *Code of Federal Regulations* (42 CFR), Section 411.15(p)(3)(iii).) The underlying rationale for this exclusion was that these services were so far beyond the normal scope of SNF care as to require the intensity of the hospital setting in order to be furnished safely and effectively.

In the legislative history that accompanied the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), Congress explicitly recognized that this administrative exclusion is specifically limited to "...certain outpatient services from a Medicare participating hospital or critical access hospital..." (emphasis added). [See the House Ways and Means Committee Report (H. Rep. No. 108-178, Part 2 at 209), and the Conference Report (H. Conf. Rep. No. 108-391 at 641)]. This means that the exclusion does not encompass services that are furnished in other, non-hospital settings (such as freestanding clinics).

As noted previously, in addition to the existing exclusion of certain types of intensive outpatient hospital services under the regulations at 42 CFR 411.15(p)(3)(iii), Congress has elected to exclude several categories of services from CB in the statute itself, at Sections 1888(e)(2)(A)(ii)-(iii) of the Social Security Act. Unlike the administrative exclusion discussed above, which applies solely to services furnished in the outpatient hospital setting, the statutorily excluded services are separately billable to Part B regardless of the setting (hospital versus freestanding) in which they are furnished.

For example, as amended by Section 103 of BBRA 1999, Section 1888(e)(2)(A)(iii)(II) of the Social Security Act excludes certain types of intensive chemotherapy services, regardless of whether they are furnished in a hospital or freestanding setting. Additional legislation would be required to expand the exemption of CT scans, MRI services, and radiation therapy to apply to services furnished in non-hospital settings.

Chemotherapy and its administration and radioisotopes and their administration are identified in the statute by HCPCS codes. These services are separately billable in all care settings, but the exclusion applies only to the codes specified in the Social Security Act and subsequent regulations. Therefore, other services given in conjunction with an

*SNFCB as It Relates to Certain Types of Exceptionally Intensive Outpatient Hospital Services (continued)*

excluded code (e.g., other pharmaceuticals, medical supplies, etc.) remain bundled and should be reimbursed by the SNF to the supplier.

Please note that the professional charge for the physician who performs/interprets the radiological procedure is NOT subject to CB. Since the physician service exclusion applies to the professional component of the diagnostic radiology service, the physician bills his/her service directly to the Medicare Part B carrier for reimbursement.

**Additional Information**

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and may be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

The Centers for Medicare and Medicaid Services (CMS) Medlearn Consolidated Billing website may be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>.

It includes the following relevant information:

- General SNF CB information.

- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB).
- Therapy codes that must be consolidated in a noncovered stay.
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS consolidated billing website may be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

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

Source: CMS Special Edition Medlearn Matters SE0432

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**SNF Consolidated Billing as It Relates to Ambulance Services**

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

**Note:** CMS revised this article to include a clarification statement, but no substantive changes were made. The original article was published in the [First Quarter 2005 Medicare A Bulletin \(pages 74\)](#).

**Provider Types Affected**

Skilled nursing facilities (SNFs), physicians, ambulance suppliers, and providers

**Provider Action Needed**

This special edition article describes SNF consolidated billing (CB) as it applies to ambulance services for SNF residents.

**Clarification:** The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These “excluded” services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier).

**Background**

When the SNF prospective payment system (PPS) was introduced in 1998, it changed not only the way SNFs are paid but also the way SNFs must work with suppliers,

physicians, and other practitioners. CB assigns the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF’s residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article may be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

Ambulance services have not been identified as a type of service that is categorically excluded from the CB provisions. However, certain types of ambulance transportation have been identified as being separately billable in specific situations, i.e., based on the reason the ambulance service is needed.

This policy is comparable to the one governing ambulance services furnished in the inpatient hospital setting, which has been subject to a similar comprehensive Medicare billing or “bundling” requirement since 1983.

Since the law describes CB in terms of services that are furnished to a “resident” of an SNF, the initial ambulance trip that brings a beneficiary to an SNF is not subject to CB, as the beneficiary has not yet been admitted to the SNF as a resident at that point.

*SNF Consolidated Billing as It Relates to Ambulance Services (continued)*

Similarly, an ambulance trip that conveys a beneficiary from the SNF at the end of a stay is not subject to CB when it occurs in connection with one of the events specified in regulations at 42 CFR 411.15(p)(3)(i)-(iv) as ending the beneficiary's SNF "resident" status. The events are:

- A trip for an inpatient admission to a Medicare-participating hospital or critical access hospital (CAH). (See discussion below regarding an ambulance trip made for the purpose of transferring a beneficiary from the discharging SNF to an inpatient admission at another SNF.)
- A trip to the beneficiary's home to receive services from a Medicare-participating home health agency under a plan of care.
- A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that are not included in the SNF's comprehensive care plan (see further explanation below).
- A formal discharge (or other departure) from the SNF that is not followed by readmission to that or another SNF by midnight of that same day.

**Ambulance Trips to Receive Excluded Outpatient Hospital Services**

The regulations specify the receipt of certain exceptionally intensive or emergency services furnished during an outpatient visit to a hospital as one circumstance that ends a beneficiary's status as an SNF resident for CB purposes. Such outpatient hospital services are, themselves, excluded from the CB requirement, on the basis that they are well beyond the typical scope of the SNF care plan.

Currently, only those categories of outpatient hospital services that are specifically identified in Program Memorandum (PM) No. A-98-37, November 1998 (reissued as PM No. A-00-01, January 2000) are excluded from CB on this basis. These services are the following:

- Cardiac catheterization
- Computerized axial tomography imaging (CT) scans
- Magnetic resonance imaging (MRI) services
- Ambulatory surgery involving the use of an operating room (the ambulatory surgical exclusion includes the insertion of percutaneous esophageal gastrostomy (PEG) tubes in a gastrointestinal or endoscopy suite)
- Emergency room services
- Radiation therapy
- Angiography
- Lymphatic and venous procedures.

Since the receipt of one of these excluded types of outpatient hospital services is considered to end a beneficiary's status as an SNF resident for CB purposes, any associated ambulance trips are, themselves, excluded from CB as well; thus, an ambulance trip furnished in connection with the receipt of such services should be billed separately to Part B by the outside supplier.

**Other Ambulance Trips**

By contrast, when a beneficiary leaves the SNF to receive offsite services **other than** the excluded types of outpatient hospital services described above and then returns to the SNF, he or she retains the status of a SNF resident with respect to the services furnished during the absence from the SNF. Accordingly, ambulance services furnished in connection with such an outpatient visit would remain subject to CB, even if the purpose of the trip is to receive a particular type of service (such as a physician service) that is, itself, categorically excluded from the CB requirement. However, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section 103) excluded from SNF CB those ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

**Transfers Between Two SNFs**

A beneficiary's departure from an SNF is not considered to be a "final" departure for CB purposes if he or she is readmitted to that or another SNF by midnight of the same day (see 42 CFR 411.15(p)(3)(iv)).

Thus, when a beneficiary travels directly from SNF 1 and is admitted to SNF 2 by midnight of the same day, that day is a covered Part A day for the beneficiary, to which CB applies. Accordingly, the ambulance trip that conveys the beneficiary would be bundled back to SNF 1 since, under section 411.15(p)(3), the beneficiary would continue to be considered a resident of SNF 1 (for CB purposes) up until the actual point of admission to SNF 2.

However, when an individual leaves an SNF via ambulance and does not return to that or another SNF by midnight, the day is not a covered Part A day and, accordingly, CB would not apply.

**Roundtrip to a Physician's Office**

If an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance (i.e., using any other means of transport would be medically contraindicated) (see 42 CFR 409.27(c)), then the ambulance roundtrip is the responsibility of the SNF and is included in the PPS rate.

The preamble to the July 30, 1999 final rule (64 *Federal Register* 41674-75) clarifies that the scope of the required service bundle furnished to Part A SNF residents under the PPS specifically encompasses coverage of transportation via ambulance under the conditions described above, rather than more general coverage of other forms of transportation.

**Additional Information**

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and may be found at:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

The Centers for Medicare & Medicaid Services (CMS) Medlearn consolidated billing website is at:

<http://www.cms.hhs.gov/medlearn/snfcode.asp>.

*SNF Consolidated Billing as It Relates to Ambulance Services (continued)*

It includes the following relevant information:

- General SNF CB information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB)
- Therapy codes that must be consolidated in a non-covered stay
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS consolidated billing website may be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>.

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It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

Related Change Request (CR) Number: N/A

Effective Date: N/A

Implementation Date: N/A

Source: CMS Special Edition Medlearn Matters SE0433

## Skilled Nursing Facility Consolidated Billing and Erythropoietin (EPO, Epoetin Alfa) and Darbepoetin Alfa (Aranesp)

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

**Note:** CMS revised this article to include a clarification statement and to remove the reference to Chapter 17 of the Medicare Benefit Policy Manual in the Additional Information section of this article. This article was republished in the [Second Quarter 2005 Medicare A Bulletin \(pages 52-53\)](#).

### Provider Types Affected

Skilled nursing facilities (SNFs), physicians, suppliers, end-stage renal disease (ESRD) facilities, and hospitals

### Provider Action Needed

This special edition is informational only and describes SNF consolidated billing (CB) as it applies to erythropoietin (EPO) alfa (Epoetin®) and darbepoetin alfa (Aranesp®) and related services.

**Clarification:** The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare covered stay, except for a small number of services that are specifically excluded from this provision. These excluded services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of services (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier).

### Background

The original Balanced Budget Act of 1997 list of exclusions from the prospective payment system (PPS) and consolidated billing (CB) for SNF Part A residents specified the services described in section 1861(s)(2)(O) of the Social Security Act—the Part B erythropoietin (EPO) benefit. This benefit covers EPO and items related to its administration for those dialysis patients who can self-administer the drug, subject to methods and standards established by the Secre-

tary for its safe and effective use (see 42 CFR 405.2163(g) and (h)). For an overview of SNF CB and a list of excluded services, see Medlearn Matters article SE0431 at:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

Regulations at 42 CFR 414.335 describe payment for EPO and require that EPO be furnished by either a Medicare-approved ESRD facility or a supplier of home dialysis equipment and supplies. The amount that Medicare pays is established by law. Thus, the law and implementing regulations permit an SNF to unbundle the cost of the Epogen drug when it is furnished by an ESRD facility or an outside supplier, which can then bill for it under Part B.

An SNF that elects to furnish EPO to a Part A resident itself cannot be separately reimbursed over and above the Part A SNF PPS per diem payment amount for the Epogen drug. As explained above, the exclusion of EPO from CB and the SNF PPS applies only to those services that meet the requirements for coverage under the separate Part B EPO benefit, i.e., those services that are furnished and billed by an approved ESRD facility or an outside dialysis supplier.

By contrast, if the SNF itself elects to furnish EPO services (including furnishing the Epogen drug) to a resident during a covered Part A stay (either directly with its own resources, or under an “arrangement” with an outside supplier in which the SNF itself does the billing), the services are no longer considered Part B EPO services, but rather, become Part A SNF services. Accordingly, they would no longer qualify for the exclusion of Part B EPO services from CB, and would instead be bundled into the PPS per diem payment that the SNF receives for its Part A services.

**Note:** The Part B coverage rules that apply to EPO are applied in the same manner to Aranesp. (See Medicare Claims Processing Manual, Pub. 100-04,

**SNF Consolidated Billing and Erythropoietin (EPO, Epoetin Alfa) and Darbepoetin Alfa (Aranesp) (continued)**

Chapter 8 – Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, Section 60.7.2; see also Medicare Benefit Policy Manual, Pub. 100-02, Chapter 11 – End Stage Renal Disease [ESRD], Section 90). Accordingly, Aranesp is now excluded on the same basis as EPO.

**Note:** EPO (epoetin alfa, trade name Epogen) and DPA (darbepoetin alfa, trade name Aranesp) are not separately billable when provided as treatment for any illness other than ESRD. In this case, the SNF is responsible for reimbursing the supplier. The SNF should include the charges on the Part A bill filed for that beneficiary.

**Additional Information**

Medlearn Matters SE0431, containing the list of services excluded from SNF CB, may be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

The Medicare Renal Dialysis Facility Manual, Chapter II, Coverage of Services may be found at the following CMS website: [http://www.cms.hhs.gov/manuals/29\\_rdf/rd200.asp?#\\_1\\_17](http://www.cms.hhs.gov/manuals/29_rdf/rd200.asp?#_1_17).

Also, the Medicare Benefit Policy Manual Chapter 11 regarding billing and payment details for EPO and DPA may be found at the following CMS website: [http://www.cms.gov/manuals/102\\_policy/bp102c11.pdf](http://www.cms.gov/manuals/102_policy/bp102c11.pdf).

You may find the Medicare Claims Processing Manual, Pub. 100-04, Chapter 8, Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, at the

following CMS website: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c08.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c08.pdf).

The CMS consolidated billing website may be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>.

It includes the following relevant information:

- General SNF consolidated billing information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing)
- Therapy codes that must be consolidated in a non-covered stay
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS consolidated billing website may be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

Related Change Request (CR) Number: N/A

Effective Date: N/A

Implementation Date: N/A

Source: CMS Special Edition Medlearn Matters SE0434

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**Skilled Nursing Facility Consolidated Billing as It Relates to Dialysis Coverage**

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

**Note:** CMS revised this article to include a clarification statement, but no substantive changes were made. The original article was published in the [First Quarter 2005 Medicare A Bulletin \(pages 77\)](#).

**Provider Types Affected**

Skilled nursing facilities (SNFs), physicians, end-stage renal disease (ESRD) facilities, and hospitals

**Provider Action Needed**

This special edition is an informational article that describes SNF consolidated billing (CB) as it applies to dialysis coverage for SNF residents. See Medlearn Matters article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article can be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

**Clarification:** The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These excluded services can be separately

furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier).

**Background**

Dialysis furnished to an SNF resident during a covered Part A stay falls within the scope of the SNF benefit under the Social Security Act, Section 1861(h)(7), as long as the SNF elects to provide the dialysis itself, either directly or under an “arrangement” with a qualified outside supplier in which the SNF itself assumes the Medicare billing responsibility. When covered in this manner, the dialysis would be included in the global Medicare Part A per diem payment that the SNF receives under the prospective payment system.

*Skilled Nursing Facility Consolidated Billing as It Relates to Dialysis Coverage (continued)*

However, the SNF PPS legislation also gives SNFs the option of “unbundling” the dialysis and, thereby, allowing an outside supplier to furnish the dialysis services and submit a bill directly to its Medicare Part B carrier.

If the SNF elects this option, dialysis services that meet the requirements for separate coverage under the Part B dialysis benefit (as described in the Social Security Act, Section 1861(s)(2)(F)) are excluded from SNF CB. As such, these services can be furnished and billed directly to the Medicare Part B carrier by the outside dialysis supplier itself. In addition, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section 103) excluded from SNF CB those ambulance services that are necessary to transport an SNF resident offsite to receive the Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

As noted previously, if the SNF elects to provide the dialysis services under Part A, either directly or under an arrangement with an outside supplier, these services would be included in the SNF’s PPS per diem payment (since dialysis services that SNFs furnished in this manner during the PPS base period would have been included on their cost reports and reflected in the PPS base).

Further, since the Social Security Act (Section 1833(d)) expressly prohibits payment under Part B for any service that is covered under Part A, such services would not be excluded from SNF CB, since they would no longer meet the statutory criteria (Section 1888(e)(2)(A)(ii)) of being items and services that meet the requirements for coverage under the separate Part B dialysis benefit of the Social Security Act (Section 1861(s)(2)(F)).

**Additional Information**

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and may be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

The Centers for Medicare & Medicaid Services (CMS) Medlearn consolidated billing website can be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>.

It includes the following relevant information:

- General SNF CB information.
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB).
- Therapy codes that must be consolidated in a noncovered stay.
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS consolidated billing website may be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

Related Change Request (CR) Number: N/A

Effective Date: N/A

Implementation Date: N/A

Source: CMS Special Edition Medlearn Matters SE0435

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**Skilled Nursing Facility Consolidated Billing as It Relates to Prosthetic and Orthotic Devices**

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

**Note:** CMS revised this article to include a clarification statement but no substantive changes were made to the article. This article was published in the [First Quarter 2005 Medicare A Bulletin \(pages 79-80\)](#).

**Provider Types Affected**

Skilled nursing facilities (SNFs), physicians, suppliers, and providers

**Provider Action Needed**

This special edition is an informational article that describes SNF consolidated billing (CB) as it applies to prosthetics and orthotics for SNF residents.

**Clarification:** The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These “excluded” services can be separately furnished to the resident and billed under Medicare Part

B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier).

**Background**

The SNF CB provision of the Balanced Budget Act of 1997 (BBA, P.L. 105-33, Section 4432[b]) is a comprehensive billing requirement under which the SNF itself is responsible for billing Medicare for virtually all of the services that its residents receive. This billing requirement is similar to the billing requirement that has been in effect for inpatient hospital services since 1983.

*Skilled Nursing Facility Consolidated Billing as It Relates to Prosthetic and Orthotic Devices (continued)*

The BBA identified a list of services that are excluded from SNF CB. These services are primarily those provided by physicians and certain other types of medical practitioners, and they can be separately billed to Medicare Part B carriers directly by the outside entity that furnishes them to the SNF's residents (Social Security Act, Section 1888[e][2][A][ii]). Since the BBA did not list prosthetic devices among the services identified for exclusion, such items initially were categorically included within the scope of the CB provision.

However, effective with services furnished on or after April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113, Appendix F, Section 103) provided for the exclusion of certain additional types of services from SNF CB. These services are listed in a separate Medlearn Matters article, SE0431, which also provides an overview of SNF CB. This article may be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

The original statutory exclusions enacted by the BBA consist of a number of broad service categories and encompass all of the individual services that fall within those categories. By contrast, the additional exclusions enacted in the BBRA are more narrowly targeted, and apply only to certain specified, individual services **within** a number of broader service categories that otherwise remain subject to CB.

For customized prosthetic devices, the exclusion applies only to those individual items that the legislation itself specifically identifies by Healthcare Common Procedure Coding System (HCPCS) code, while all other items within this category remain subject to CB. The individual HCPCS codes by which the excluded services are identified appear in annual and quarterly CB updates. These CB updates may be found at: [http://www.cms.hhs.gov/providers/snfpps/snfpps\\_pubs.asp](http://www.cms.hhs.gov/providers/snfpps/snfpps_pubs.asp).

The BBRA Conference Committee report (H. Rep. 106-479) characterized the individual services that this legislation targeted for exclusion as "...high-cost, low-probability events that could have devastating financial impacts because their costs far exceed the payment [SNFs] receive under the prospective payment system...."

The BBRA also gives the Centers for Medicare & Medicaid Services (CMS) limited authority to identify additional prosthetic codes for exclusion, in response to developments such as major advances over time in the state of medical technology, or reconfigurations of the HCPCS codes themselves. When new HCPCS codes are established for excluded services, the new codes are communicated through the annual and quarterly CB updates.

Moreover, while Congress elected to exclude from CB certain specific customized prosthetic devices that meet the criteria discussed above regarding high cost and low probability, it declined to exclude other types of prosthetic devices, and also declined to exclude orthotics as a class.

In contrast to prosthetics, those items in the orthotics category tend to be more standardized and lower in cost. Further, even those customized items that fall at the high end

of the orthotics category generally are still significantly less expensive and more commonly furnished in SNFs than customized items that fall at the high end of the prosthetics category.

Accordingly, orthotics would not appear to meet the criteria of exceptionally high cost and low probability that served as the basis for the BBRA exclusions. Further, even if certain individual orthotic devices were to be identified as meeting these criteria, excluding them from the CB requirement could not be accomplished administratively, but would require further legislation by Congress to add this service category to the statutory exclusion list.

In addition, CMS notes that in contrast to prosthetics (where the needs of a patient with a missing limb can often be addressed only through the use of a single, particular type of customized device), it is often medically feasible to use a relatively inexpensive orthotic device in place of a more expensive one. Thus, CMS believes that the SNF PPS appropriately places the financial responsibility for such devices (along with the decision-making authority for selecting among them) with the SNF itself, because it may be possible to address a particular SNF resident's condition with equal efficacy by selecting among a broader range of orthotic devices.

### Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and may be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

CMS Medlearn consolidated billing website may be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>.

It includes the following relevant information:

- General SNF consolidated billing information.
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing).
- Therapy codes that must be consolidated in a noncovered stay.
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS consolidated billing website may be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

Related Change Request (CR) Number: N/A

Effective Date: N/A

Implementation Date: N/A

Source: CMS Special Edition Medlearn Matters SE0437

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## Skilled Nursing Facility Consolidated Billing and Services of Rural Health Clinics and Federally Qualified Health Centers

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

**Note:** CMS revised this article to include a clarification statement, but no substantive changes were made. The original article was published in the [First Quarter 2005 Medicare A Bulletin \(pages 80\)](#).

### Provider Types Affected

Skilled nursing facilities (SNFs), physicians, rural health clinics (RHCs), and federally qualified health centers (FQHCs)

### Provider Action Needed

This special edition is an informational article that describes SNF consolidated billing (CB) as it applies to services provided by RHCs and FQHCs.

**Clarification:** The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These "excluded" services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier).

### Background

When the SNF prospective payment system (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. CB places with the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay.

Payment for this full range of services is included in the SNF PPS global per diem rate. The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. For a detailed overview of SNF CB and a list of the services excluded from SNF CB, see Medlearn Matters Special Edition SE0431 at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

RHC and FQHC services currently do not appear on the list of services that are excluded from the SNF CB requirement. Consequently, when a SNF resident receives RHC or FQHC services during a covered Part A stay, the services are bundled into the SNF's comprehensive per diem payment for the covered stay itself, and are not separately billable as RHC or FQHC services to the Fiscal Intermediary (FI). This means that rather than submitting a separate bill to the FI for these services, the RHC or FQHC looks to the SNF for its payment.

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However, Section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) has amended the law to specify that when a SNF's Part A resident receives the services of a physician (or another type of practitioner that the law identifies as being excluded from SNF consolidated billing) from an RHC or FQHC, those services would not become subject to CB merely by virtue of being furnished under the auspices of the RHC or FQHC.

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

### Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and may be found at:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

Also, the Centers for Medicare & Medicaid Services (CMS) Medlearn consolidated billing website may be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>.

It includes the following relevant information:

- General SNF consolidated billing information.
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing).
- Therapy codes that must be consolidated in a non-covered stay.
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS consolidated billing website may be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

Related Change Request (CR) Number: N/A

Effective Date: January 1, 2005

Implementation Date: N/A

Source: CMS Special Edition Medlearn Matters SE0438



## Skilled Nursing Facility Consolidated Billing as It Relates to Clinical Social Workers

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

**Note:** CMS revised this article to include a clarification statement, but no substantive changes were made. The original article was published in the [First Quarter 2005 Medicare A Bulletin \(pages 81\)](#).

### Provider Types Affected

Skilled nursing facilities (SNFs), physicians, practitioners, and clinical social workers (CSW)

### Provider Action Needed

This special edition is an informational article that describes SNF consolidated billing (CB) as it applies to CSW services furnished to SNF residents during a Part A covered stay.

**Clarification:** The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These "excluded" services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier).

### Background

When the SNF prospective payment system (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns SNFs the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay.

Payment for this full range of services is included in the SNF PPS global per diem rate. The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. For a detailed overview of SNF

CB and a list of the services excluded from SNF CB, see Medlearn Matters Special Edition SE0431 at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

Since CSW services do not currently appear on this excluded list, they are included within the overall package of services that is subject to the SNF CB requirement. Al-

though the inclusion of CSW services under the SNF CB requirement does not preclude Medicare coverage for these services, it makes the SNF responsible for including them in its Part A bill for the resident's covered stay.

In fact, bundling CSW services in the Part A payment rate is not a new concept. The corresponding Medicare comprehensive billing requirement for inpatient hospital services, which similarly includes CSW services while excluding the services of certain other types of mental health professionals, has been in effect since 1983, and served as a model for SNF CB.

### Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and may be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

Also, the Centers for Medicare & Medicaid Services (CMS) Medlearn consolidated billing website may be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>.

It includes the following relevant information:

- General SNF CB information.
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB).
- Therapy codes that must be consolidated in a non-covered stay.
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS consolidated billing website may be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

Related Change Request (CR) Number: N/A

Effective Date: N/A

Implementation Date: N/A

Source: CMS Special Edition Medlearn Matters SE0439

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## SNF Consolidated Billing as it Relates to Certain Diagnostic Tests

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

**Note:** CMS revised this article to include a clarification statement, but no substantive changes were made. The original article was published in the [First Quarter 2005 Medicare A Bulletin](#) (pages 82).

### Provider Types Affected

Skilled nursing facilities (SNF), physicians, suppliers, providers, and radiology centers

### Provider Action Needed

This special edition is an informational article that describes SNF consolidated billing (CB) as it applies to certain diagnostic tests that include both a technical component (representing the test itself) and a professional component (representing the physician’s interpretation of the test). These tests commonly include diagnostic radiology procedures (such as X-rays) and laboratory tests, but can also include other types of diagnostic procedures (such as audiology services) as well.

**Clarification:** The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These “excluded” services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier).

### Background

When the SNF prospective payment system (PPS) was introduced in 1998, it not only changed the way SNFs are paid, but changed the way SNFs must work with suppliers, physicians, and other practitioners.

CB assigns the SNF the Medicare billing responsibility for virtually all of the services that the SNF’s residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. See Medlearn Matters Special Edition SE0431 at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

It contains a detailed overview of SNF CB and a list of the services excluded from SNF CB.

However, one of the service categories that the law *does* exclude from the SNF CB provision is physician services, which are separately billable to the Medicare Part B carrier. (See Medlearn Matters Special Edition article SE0445 for a more detailed discussion of SNF CB as it relates to services that are furnished as “incident to” a physician’s professional services. This article will be coming soon.) Since many diagnostic tests include both a technical component and a professional component, suppliers need to generate two bills. For example, with regard to diagnostic radiology services, such as X-rays, the physician service exclusion

applies only to the professional component of the diagnostic radiology service (representing the physician’s interpretation of the diagnostic test).

**The physician service is billed directly to the Medicare Part B carrier.**

Because the diagnostic radiology service’s technical component is already included within the SNF’s global per diem payment for its resident’s covered Part A stay, the outside supplier that actually furnishes the technical component would look to the SNF (rather than to Medicare Part B) for payment.

As indicated in the preceding discussion, these policies are not new, and have been in effect since the implementation of the SNF PPS in 1998. What has changed, though, is that the Centers for Medicare & Medicaid Services (CMS) installed electronic edits in 2002 that enable the claims processing system to detect automatically any claims that are inappropriately submitted to Part B for those services that are already included within the SNF’s global per diem payment for a resident’s covered Part A stay (such as the technical component of diagnostic tests).

As discussed above, because these services are already included within the SNF’s payment for its resident’s Medicare-covered stay, an outside entity that furnishes the services must look to the SNF, rather than to Medicare Part B, for payment.

### Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and may be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

The CMS Medlearn consolidated billing website may be found at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>.

It includes the following relevant information:

- General SNF consolidated billing information.
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing).
- Therapy codes that must be consolidated in a non-covered stay.
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

Also, the SNF PPS consolidated billing website may be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Matters SE0440

## SNF Consolidated Billing and Preventive/Screening Services

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

**Note:** CMS revised this article to include a clarification statement, but no substantive changes were made. The original article was published in the [First Quarter 2005 Medicare A Bulletin \(pages 78\)](#).

### Provider Types Affected

Skilled nursing facilities (SNFs), physicians, suppliers, and providers

### Provider Action Needed

This special edition is an informational article that describes SNF consolidated billing (CB) as it applies to preventive and screening services provided to SNF residents.

**Clarification:** The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These “excluded” services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier).

### Background

When the skilled nursing facility (SNF) prospective payment system (PPS) was introduced in the Balanced Budget Act of 1997 (BBA, P.L. 105-33, Section 4432), it changed the way SNFs are paid, and the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns to the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF’s residents receive during the course of a covered Part A stay. See Medlearn Matters article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article may be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

The BBA identified a list of services that are excluded from SNF CB. These services are primarily those provided by physicians and certain other types of medical practitioners, and they can be separately billed to Medicare Part B carriers directly by the outside entity that furnishes them to the SNF’s resident (Social Security Act, Section 1888(e)(2)(A)(ii)). Since the BBA did not list preventive and screening services among the services identified for exclusion, these services are included within the scope of the CB provision.

However, reimbursement for covered preventive and screening services, such as vaccines and mammographies, is subject to special billing procedures. As discussed in the May 12, 1998 *Federal Register* (63 FR 26296), since preventive services (such as vaccinations) and screening services (such as screening mammographies) do not appear on the exclusion list, they are subject to CB. Accordingly, if an SNF resident receives, for example, a flu vaccine during a covered Part A stay, the SNF itself is responsible for billing

Medicare for the vaccine, even if it is furnished to the resident by an outside entity.

Nevertheless, even though the CB requirement makes the SNF itself responsible for billing Medicare for a preventive or screening service furnished to its Part A resident, the SNF would not include the service on its Part A bill, but would instead submit a separate bill for the service to Part B. This is because the Part A SNF benefit is limited to coverage of “diagnostic or therapeutic” services (i.e., services that are reasonable and necessary to diagnose or treat **a condition that has already manifested itself**). (See Sections 1861(h) following (7), 1861(b)(3), and 1862(a)(1) of the Social Security Act.)

Accordingly, the Part A SNF benefit does not encompass screening services (which serve to detect the presence of a condition while it is still in an early, asymptomatic stage) or preventive services (which serve to ward off the occurrence of a condition altogether). Such services are always covered under Part B, even when furnished to a beneficiary during the course of a covered Part A SNF stay. Under Section 1888(e)(9) of the Social Security Act, payment for an SNF’s Part B services is made in accordance with the applicable fee schedule for the type of service being billed.

### Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and may be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf>.

The Centers for Medicare & Medicaid Services (CMS) Medlearn Consolidated Billing website is at: <http://www.cms.hhs.gov/medlearn/snfcode.asp>.

It includes the following relevant information:

- General SNF consolidated billing information.
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing).
- Therapy codes that must be consolidated in a non-covered stay.
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS consolidated billing website may be found at: <http://www.cms.hhs.gov/providers/snfpps/cb>.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

Related Change Request (CR) Number: N/A

Effective Date: N/A

Implementation Date: N/A

Source: CMS Special Edition Medlearn Matters SE0436

## Skilled Nursing Facility Demand Bills

When a provider informs a beneficiary who is occupying a Medicare certified bed that Medicare payment can no longer be made for his or her stay, and the beneficiary or authorized representative disputes this decision, he or she may request the provider submit a demand bill to Medicare for review, to determine if a skilled level of care is still indicated.

The beneficiary or the appointed representative who has legal authorization to handle the beneficiary's affairs, may request a demand bill. However, it is the responsibility of the skilled nursing facility (SNF) to assure that the representative requesting the demand bill review has been given legal authorization to conduct the beneficiary's financial affairs (durable power of attorney, etc.). The fiscal intermediary requests documentation to support the representative requesting a review on behalf of the beneficiary is authorized to do so.

**When determining if a beneficiary is eligible for Part A payment, medical and technical criteria must be present. Technical criteria must be established first. Failure to meet technical criteria results in the inability for Medicare to make payment even if clinical conditions for coverage exist.**

In order to meet technical criteria, one of the following situations must exist:

- A three-day qualifying inpatient hospital stay, not counting the day of discharge.
- Transfer to the SNF within 30 days of hospital discharge. This window can be extended by a physician's order to hold therapy.
- Certification by a physician, nurse practitioner or clinical nurse specialist upon admission the beneficiary requires skilled care in a skilled nursing home.
- Beneficiary is treated in the SNF for a condition that was treated during the qualifying hospital stay, or for one that arose during the stay.
- Beneficiary is enrolled in Part A and has benefit days to use.
- Beneficiary must reside in a Medicare-certified bed.

If the resident fails to meet technical criteria, the provider should issue a notice of noncoverage, and submit the claim using condition code 21.

**Note:** It is the provider's responsibility to assure the notice of noncoverage is complete. All notices must contain the date the beneficiary or legal representative received the notice. Failure to provide a timely and completed notice will result in the provider being held liable for the noncovered services.

After it has been determined the beneficiary meets technical criteria, the provider must determine if the beneficiary meets medical criteria by applying the rules governing Medicare SNF prospective payment system presumption of coverage and level of care criteria. Upon notification to the beneficiary or authorized representative that his or her medical condition no longer meets medical necessity for skilled care and the beneficiary or his or her legal representative disagrees, a demand bill must be submitted to the fiscal intermediary for a review.

Prior to submitting the demand bill to the fiscal intermediary, the provider must assure the following has occurred:

- The previous bill must reflect that the beneficiary is still a patient in the facility (patient status 30) and dates of services must not overlap with the demand bill. The demand bill must have only the days that the patient remained in the facility (e.g., the patient was in the SNF from May 1, 2005, through May 25, 2005. The dates of service for a covered stay are from May 1, 2005 through May 10, 2005. The dates of service for a noncovered level of care stay are from May 11, 2005 through May 25, 2005). The demand bill must be submitted with noncovered dates of service and charges (not for the entire bill of May 31, 2005) and condition code 20 must be placed in form locator 24.
- The health insurance prospective payment system code and revenue code 0022 must be present on the demand bill. If a minimum data set (MDS) has been completed, the provider must use the resource utilization group (RUG)-III group from that MDS, even if it is one of the top 26 RUG-III groups. If no assessment was completed, the provider may use the default code submitted on the claim.
- Liability is based on whether or not the notice of noncoverage was issued by the provider and properly acknowledged by the beneficiary.

A medical review of the records will not be performed on claims submitted for denials. These claims should be submitted with condition code 21 in form locator 24. It is recommended the provider write remarks indicating the specific reason for the denial (e.g., benefit exhaust, no qualifying stay, denial for secondary insurance, etc.)

Guidelines and billing requirements on demand bills are available on the CMS Online Internet Manual system, Pub. 100-4, Medicare Claim Processing, Chapter One, Section 60, and Chapter 6, Inpatient SNF, section 40.7 of the same manual. ❖

# HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

## Clarification for Billing Initial Preventive Physical Exam for Hospital Outpatient Prospective Payment System

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

This article is based on information contained in Change Request (CR) 3771 which contains instructions for all hospitals subject to the outpatient prospective payment system (OPPS) that bill for a Medicare beneficiary’s initial preventive physical examination (IPPE) along with the technical component of their ECG on the same claim.

#### CAUTION – What You Need to Know

Hospitals that are subject to OPPS (TOBs 12x and 13x) must use modifier 25 when billing the IPPE (Healthcare Common Procedure Coding System [HCPCS]) code G0344 along with the technical component of the ECG (HCPCS code G0367) on the same claim. This is due to the OPPS outpatient code editor (OCE), which contains an edit requiring modifier 25 on any evaluation and management (E/M) HCPCS code when there is also a status “S” or “T” HCPCS procedure code on the claim.

#### GO – What You Need to Do

Please see the Background and Additional Information Sections of this instruction for further details regarding this change.

### Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, Section 611) provides for coverage under Part B of one initial preventive physical examination (IPPE) for new beneficiaries only (subject to certain eligibility and other limitations, and effective for services furnished on or after January 1, 2005). The IPPE may be performed not later than six months after the date the individual’s first coverage begins under Medicare Part B.

Medicare will pay for only one IPPE per beneficiary per lifetime, and the common working file (CWF) will edit for this benefit. The total IPPE service includes an electrocardiogram (EKG), but the EKG performed as a component of the IPPE, will be billed separately with its own unique HCPCS code(s).

The following new HCPCS codes have been developed for the IPPE benefit:

- G0344** Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 6 months of Medicare enrollment
- G0366** Electrocardiogram, routine EKG with 12 leads; performed as a component of the initial preventive examination with interpretation and report

**G0367** EKG tracing only, without interpretation and report, performed as a component of the initial preventive examination

**G0368** EKG interpretation and report only, performed as a component of the initial preventive examination

If the EKG performed as a component of the IPPE is not performed by the primary physician or qualified nonparticipating provider (NPP) during the IPPE visit, another physician or entity may perform and/or interpret the EKG. The referring provider needs to make sure that the performing provider bills the appropriate G code for the screening EKG, and not a CPT code in the 93000 series. Both the IPPE and the EKG should be billed in order for the beneficiary to receive the complete IPPE service. If the same physician or NPP needs to perform an additional medically necessary EKG in the 93000 series on the same day as the IPPE, the provider should report the appropriate EKG CPT code(s) with modifier 59, indicating that the EKG is a distinct procedural service.

The instructions for billing the IPPE, released in CR 3638, Transmittal 417, dated December 22, 2004, failed to take into account an existing hospital OPPS OCE edit.

The OPPS OCE (Version 6.0) like all previous OPPS OCEs, contains an edit that 1) requires a modifier 25 on any evaluation and management (E/M) HCPCS code if 2) there is also a status “S” or “T” HCPCS procedure code on the claim.

The HCPCS code for the IPPE (or Welcome to Medicare Physical) uses an E/M code, **G0344**, and the HCPCS code for the technical component only of the EKG, **G0367**, has a status indicator of S.

**Therefore, this instruction directs hospital outpatient departments (subject to the hospital OPPS) that want to obtain payment for the IPPE (G0344) to do the following:**

- Append modifier 25 to the HCPCS code for the IPPE itself (HCPCS code G0344) when the technical component of the EKG (G0367) is billed on the same claim.

**Also, FIs are to process any provider requests for adjustments if the FI initially denied the claim for HCPCS code G0344.**

### Implementation

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

*Clarification for Billing Initial Preventive Physical Exam for Hospital Outpatient PPS (continued)*

**Additional Information**

Change Request (CR) 3638 (Transmittal 417, dated December 22, 2004, subject Initial Preventive Physical Examination (IPPE)) may be reviewed at the following CMS website: [http://www.cms.hhs.gov/manuals/pm\\_trans/R417CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R417CP.pdf).

See the Medicare Claims Processing Manual (Pub. 100-04), Chapter 18 (Preventive and Screening Services), Section 80.3 (Fiscal Intermediary Billing Requirements) for a list of bill types of facilities that can bill FIs for this service at the following CMS website: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c18.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c18.pdf).

For the physician/practitioner billing correct coding policy, please see the Medicare Claims Processing Manual (Pub. 100-04), Chapter 12 (Physicians/Nonphysician Practitioners), Section 30.6.1.1 (Initial Preventive Physical Examination (HCPCS Codes G0344, G0366, G0367, and G0368)) at the following CMS website: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c12.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c12.pdf).

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

From that Web page, look for CR 3771 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: 3771  
 Related CR Release Date: April 1, 2005  
 Related CR Transmittal Number: 516  
 Effective Date: January 1, 2005  
 Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 516, CR 3771

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## Billing for Blood and Blood Products Under the Hospital Outpatient Prospective Payment System

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

**Provider Types Affected**

Providers billing Medicare fiscal intermediaries (FIs) for services paid under the hospital outpatient prospective payment system (OPPS)

**Provider Action Needed**

This instruction provides information contained in Change Request (CR) 3681 which compiles and clarifies Medicare procedures and policies for the billing of blood and blood products in the hospital outpatient setting.

CR 3681 adds Section 231 to Chapter 4 of the Medicare Claims Processing Manual to address Medicare billing and payment for blood and blood products under the hospital outpatient prospective payment system (OPPS). **In particular, hospitals should note the portions of this instruction that inform them when to use new modifier BL when submitting claims for blood and blood products.**

**Background**

The Centers for Medicare & Medicaid Services (CMS) is clarifying Medicare coding, billing, and payment policies for blood and blood products under the OPSS and adding a new Section 231 to Chapter 4 of the Medicare Claims Processing Manual. The billing instructions in Section 231 address how OPSS providers are to bill for blood or blood products purchased from a community blood bank or how they are to bill when the OPSS provider runs its own blood bank and assesses a charge for the blood or blood product collected by its blood bank. Section 231 also describes policies on billing for autologous blood (including salvaged blood) and directed donor blood, a split unit of blood, irradiation of blood products, frozen and thawed blood and blood products, unused blood, transfusion services, and pheresis and apheresis services.

Effective for services furnished on or after July 1, 2005, for services paid under the OPSS (bill types 12x [Inpatient Part B Only] and 13x [Outpatient]) hospitals should report charges for blood and blood products in accordance with policies addressed in detail in the Medicare Claims Processing Manual, Chapter 4, Section 231, which is summarized as follows:

**New Modifier and Billing Requirements When an OPSS Provider Purchases Blood or Blood Products from a Community Blood Bank or When an OPSS Provider Assesses a Charge for Blood or Blood Products Collected in its Own Blood Bank that Reflects More than Blood Processing and Storage**

If an OPSS provider pays for the actual blood or blood product itself obtained from a community blood bank, or collects the blood or blood product in the OPSS provider's own blood bank and also assesses a charge for the blood, in addition to paying for processing and storage costs, the OPSS provider must separate the charge for the unit(s) of blood or blood product(s) from the charge for processing and storage services. The OPSS provider reports charges for the blood or blood product itself using revenue code series 038x with the line item date of service (LIDOS), the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL. The OPSS provider reports charges for processing and storage services on a separate line using revenue code 0390 or 0399 with the LIDOS, the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL.

Whenever an OPSS provider reports a charge for blood or blood products using revenue code 038x, the OPSS provider must also report a charge for processing and

**Billing for Blood and Blood Products Under the Hospital Outpatient Prospective Payment System (continued)**

storage services on a separate line using revenue code 0390 or 0399. Further, the same LIDOS, the same number of units, the same HCPCS code, and HCPCS modifier BL must be reported on both lines.

Effective for services furnished on or after July 1, 2005, the outpatient code editor (OCE) will return to providers any claim that reports a charge for blood or blood products using revenue code 038x without a separate line for processing and storage services using revenue code 0390 or 0399. Moreover, in order to process to payment, both lines must report the same line item date of service, the same number of units, and the same HCPCS code accompanied by modifier BL.

**Example**

Revenue Code	Description	HCPCS	Units	Date of Service	Charge
38x	Blood/Blood Product	P-code with modifier BL	1	02/15/05	\$ABC
39x	Blood Processing/Storage	P-code with modifier BL	1	02/15/05	\$XYZ

**Applicability of the Medicare Blood Deductible**

Units of whole blood or packed red cells for which only processing and storage charges are reported are not subject to the blood deductible. The Medicare blood deductible is applicable only if the OPSS provider purchases whole blood or packed red cells from a community blood bank or if the OPSS provider assesses a charge for blood collected in its own blood bank that reflects more than charges for blood processing and storage. If the beneficiary has not already fulfilled the annual blood deductible or replaced the blood, OPSS payment for the blood or blood product will be made for the processing and storage costs only. The beneficiary is liable for the blood portion of the payment as the blood deductible.

**Other Policies Related to Billing for Blood and Blood Products**

Please refer to the Medicare Claims Processing Manual, Chapter 4, Section 231 for policies regarding billing for:

- Autologous Blood (Including Salvaged Blood) and Directed Donor Blood. Section 231.3
- Split Unit of Blood. Section 231.4
- Irradiation of Blood Products. Section 231.5
- Frozen and Thawed Blood and Blood Products. Section 231.6
- Unused Blood. Section 231.7
- Transfusion Services. Section 231.8
- Pheresis and Apheresis services. Section 231.9.

Section 231.10 addresses CCI edits.

Section 231.1 provides billing instructions when an OPSS provider does not purchase blood or blood products that it procures from a community blood bank, or when the OPSS provider does not assess a charge for blood collected in its own blood bank other than charges for blood processing and storage.

**Correct Coding Initiative (CCI) Edits**

Hospitals should be aware that certain CCI edits may apply when billing for blood and blood product services. Hospitals should consult the most current list of CCI edits to determine whether they apply to the services or HCPCS blood product codes being reported. A file with the most current list of CCI edits applicable to Medicare Part B services paid by FIs under the OPSS is available at: <http://www.cms.hhs.gov/providers/hopps/>.

**Implementation**

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

**Additional Information**

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction, which also includes the new Section 231 of Chapter 4 of the Medicare Claims Processing Manual, may be viewed at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3681 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: 3681

Related CR Release Date: March 4, 2005

Related CR Transmittal Number: 18

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 496, CR 3681

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## April 2005 Outpatient Code Editor Specifications Version 6.1 for the Outpatient Prospective Payment System

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

### Provider Types Affected

All providers billing outpatient services to Medicare fiscal intermediaries (FIs) that are paid under the outpatient prospective payment system (OPPS)

### Provider Action Needed

This instruction is based on information contained in Change Request (CR) 3743 which is to 1) inform FIs that the April 2005 OPPS OCE specifications have been updated with new additions, changes, and deletions, and 2) insure that FIs install the updated April 2005 OPPS OCE (Version 6.1) into their systems.

### Background

Full details of version 6.1 of the OPPS OCE are contained in CR3743 and will not be repeated in this article; especially since many of the details are not changing, and providers paid under the OPPS are likely familiar with these details. The modifications of the outpatient code editor/ambulatory patient classification (OCE/APC) for the April 2005 release (V6.1) are summarized in the following table:

	Mod. Type	Effective Date	Edit	Description
1.	Logic	4/1/05	52	Modify observation criteria to look for required diagnoses only in the admitting or principal diagnosis fields.
2.	Logic			Apply selected OCE edits to bill type 43x (Religious non-medical health care institution) (see appendix F of the OCE specifications attached to CR3743).
3.	Logic	4/1/05	70	New edit 70 “CA modifier requires patient status code 20” – Return the claim to the provider (RTP). When a claim with modifier CA is submitted with inpatient-only procedure and patient status code is not 20, the claim will be returned to the provider.
4.	Logic	4/1/05	71	New edit 71 “Claim lacks required device code” – RTP  When a claim is submitted with a specified procedure without a code for the required device for that procedure, the claim will be returned to the provider.  Exceptions are made for procedures that are discontinued as reflected by the presence of a modifier 52, 73 or 74 on the claim.
5.	Logic		38	Modify criteria for edit 38 to require an implantation procedure on the same claim (instead of the same day), when a code with status indicator H is submitted
6.	Logic	1/1/05		Add new Status Indicator M – Service not billable to the F I – Payment Indicator 3
7.	Logic	1/1/05	72	New edit 72 “Service not billable to the Fiscal Intermediary” - RTP.  Apply to codes with Status Indicator = M
8.	Data		69	Apply to specified G-codes if date of service is after 1/29/05
9.				Make HCPCS/APC/SI and modifier changes, as specified by CMS.
10.	Content		19, 20, 39, 40	Implement version 11.0 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)
11.	Content		41	Add new rev code 0024, SI = B if submitted without HCPCS
12.	Content	4/1/03	41	Add new rev code 0658; SI = B if submitted without HCPCS
13.	Content	7/1/01	41	Change SI for rev code 0273; SI = N if submitted without HCPCS
14.	Content		41	Remove erroneous codes 0091 and 3100 from list of valid revenue codes
15.	Content	4/1/04	41	Delete revenue code 0184
16.	Content	10/1/03	41	Delete rev code 0909
17.	Content	1/1/05	22	Re-activate modifier 27
18.	Content	1/1/05	22	Re-activate modifier GX
19.	Content	4/1/05	71	Added new procedure/device code pairs for edit 71.



April 2005 Outpatient Code Editor Specifications Version 6.1 for the Outpatient Prospective Payment System (continued)

**Note:** You should also read through the specifications in the official instruction (CR 3743) issued to your intermediary, and note the highlighted sections which also indicate changes from the prior release of the software. Some OCE/ APC modifications in the release may also be retroactively added to prior releases. If so, the retroactive date appears in the “Effective Date” column in the above table.

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

From that Web page, look for CR 3743 in the CR NUM column on the right, and click on the file for that CR.

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**Implementation**

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

**Additional Information**

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: 3743

Related CR Release Date: March 4, 2005

Related CR Transmittal Number: 494

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 494, CR 3743

**April 2005 Update of the Hospital Outpatient Prospective Payment System: Summary of Payment Policy Changes**

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

**Provider Types Affected**

Hospitals and other providers submitting claims payable under the outpatient prospective payment system (OPPS) by Medicare fiscal intermediaries (FIs)

**Provider Action Needed**

**STOP – Impact to You**

Physicians, providers, and suppliers should note that this article is based on information contained in Change Request (CR) 3756, which describes changes to the OPPS to be implemented in the April 2005 OPPS update. CR 3756 further describes changes to, and billing instructions for, various payment policies to be implemented in the April 2005 OPPS update.

**CAUTION – What You Need to Know**

Unless otherwise noted, all changes addressed in CR 3756 are effective for services furnished on or after April 1, 2005.

**GO – What You Need to Do**

Please see the Background and Additional Information sections of this instruction for further details regarding these clarifications.

**Background**

This article is based on information contained in Change Request (CR) 3756, which describes changes to the

OPPS to be implemented in the April 2005 OPPS update.

The April 2005 OPPS outpatient code editor (OCE) and OPPS PRICER will reflect the following:

- The Healthcare Common Procedure Coding System (HCPCS)
- Ambulatory payment classification (APC)
- HCPCS modifier
- Revenue code additions, changes, and deletions identified in CR3756.

Unless otherwise noted, all changes addressed in CR 3756 are effective for services furnished on or after April 1, 2005. CR 3756 further describes changes to, and billing instructions for, various payment policies to be implemented in the April 2005 OPPS update. Key changes are as follows:

**1. New Status Indicator “M”**

New status indicator “M” was created for services that are not billable to the FI and not payable under the OPPS. Please refer to Attachment A of CR3756 for codes reportable with status indicator “M”. (Instructions for accessing CR 3756 will be supplied in the “Additional Information” section of this article.)

**2. New Services**

The following new services are assigned for payment under the OPPS:

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment	Minimum Unadjusted Copayment
C9723	04/01/05	S	1502	Dyn IR Perf Img	Dynamic infrared blood perfusion imaging (DIRI)	\$75.00	\$15.00
C9724	04/01/05	T	0422	EPS gast cardia plic	Endoscopic full-thickness plication in the gastric cardia using endoscopic plication system (EPS); includes endoscopy	\$1335.65	\$267.13

April 2005 Update of the Hospital Outpatient PPS: Summary of Payment Policy Changes (continued)

3. Clarification of Brachytherapy Source Descriptors

The Centers for Medicare & Medicaid Services (CMS) announced three new brachytherapy sources effective January 1, 2005, in the final rule dated November 15, 2005 and in CR 3632 (Transmittal 423, dated January 6, 2005, subject January 2005 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes), which may be found at the following CMS website: [http://www.cms.hhs.gov/manuals/pm\\_trans/R423CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R423CP.pdf).

Or, you may want to refer to Medlearn Matters article MM3632, located at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3632.pdf>.

Two of the brachytherapy source long descriptors, i.e., for C2634 and C2635, are incorrect in Transmittal 423.

The correct descriptors are found in Table 40 of the Code of Federal Regulations November 15, 2005 final rule (42CFR Part 419), which may be found via Government Printing Office (GPO) access in the Federal Register Online: November 15, 2004 (Volume 69, Number 219, page 65841) at the following GPO website:

<http://a257.g.akamaitech.net/7/257/2422/06jun20041800/edocket.access.gpo.gov/2004/04-24759.htm>.

Table 40. Separately Payable Brachytherapy Sources

HCPCS	Long descriptor	APC	APC title	New status indicator
C1716	Brachytherapy source, Gold 198, per source	1716	Brachytx source, Gold 198.	H
C1717	Brachytherapy source, High Dose Rate Iridium 192, per source.	1717	Brachytx source, HDR Ir-192	H
C1718	Brachytherapy source, Iodine 125, per source.	1718	Brachytx source, Iodine 125.	H
C1719	Brachytherapy source, Non-High Dose Rate Iridium 192, per source.	1719	Brachytx source, Non-HDR Ir-192.	H
C1720	Brachytherapy source, Palladium 103, per source.	1720	Brachytx source, Palladium 103.	H
C2616	Brachytherapy source, Yttrium-90, per source.	2616	Brachytx source, Yttrium-90.	H
C2632*	Brachytherapy solution, Iodine 125, per mCi.	2632	Brachytx sol, I-125, per mCi.	H
C2633	Brachytherapy source, Cesium-131, per source.	2633	Brachytx source, Cesium-131.	H
C2634**	Brachytherapy source, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source.	2634	Brachytx source, HA, I-125.	H
C2635**	Brachytherapy source, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source.	2635	Brachytx source, HA, P-103.	H
C2636**	Brachytherapy linear source, Palladium-103, per 1MM.	2636	Brachytx linear source, P-103.	H

\* Currently paid as a pass-through device category, scheduled to expire from pass-through payment as of January 1, 2005.

\*\* Newly created brachytherapy payment codes beginning January 1, 2005.

To clarify, CMS is restating the correct long descriptors for C2634 and C2635, as follows:

**C2634** – Brachytherapy Source, High Activity, Iodine-125, greater than 1.01 Mci (NIST), per source

**C2635** – Brachytherapy Source, High Activity, Paladium-103, greater than 2.2 Mci (NIST), per source

All other information for these two sources found in Transmittal 423 is correct and remains the same.

4. Drugs and Biologicals

a. Drugs with Payments Based on Average Sales Price (ASP)

The table below lists the drugs and biologicals whose payments under the OPSS will be established in accordance with the average sales price (ASP) methodology that is used to calculate payment for drugs and biologicals in the physician office setting.

In the 2005 OPSS final rule (69 FR 65777), it was stated that payments for drugs and biologicals based on average sales price (ASP) will be updated on a quarterly basis as later quarter ASP submissions become available.

In cases where adjustments to payment rates are necessary:

- CMS will incorporate changes to the payment rates in an appropriate quarterly release of the OPSS PRICER, and
- CMS will not be publishing the updated payment rates in the program instructions implementing the associated quarterly update of the OPSS.
- CMS will be posting the updated payment rates in the April update of the OPSS Addendum A and Addendum B on the CMS website.

Single-indication orphan drugs payable under OPSS are also listed below. The methodology used to establish payment rates for these drugs is discussed in the 2005 OPSS final rule (69 FR 219, p 65807), which may be reviewed at the following GPO website:

<http://a257.g.akamaitech.net/7/257/2422/06jun20041800/edocket.access.gpo.gov/2004/04-24759.htm>.

HCPCS	APC	Long Description
C9123	9123	Human fibroblast derived temporary skin substitute, per 247 square centimeters
C9127	9127	Injection, paclitaxel protein-bound particles, per 1 mg
C9128	9128	Injection, pegaptamib sodium, per 0.3 mg

April 2005 Update of the Hospital Outpatient PPS: Summary of Payment Policy Changes (continued)

C9203	9203	Injection, Perflerone lipid microspheres, per single use vial
C9205	9205	Injection, Oxaliplatin, per 5 mg
C9206	9206	Collagen-glycosaminoglycan bilayer matrix, per cm <sup>2</sup>
C9211	9211	Injection, Alefacept, for intravenous use per 7.5 mg
C9212	9212	Injection, Alefacept, for intramuscular use per 7.5 mg
C9218	9218	Injection, azacitidine, 1 mg
C9220	9220	Sodium hyaluronate per 30 mg dose, for intra-articular injection
C9221	9221	Acellular dermal tissue matrix, per 16cm <sup>2</sup>
C9222	9222	Decellularized soft tissue scaffold, per 1 cc
J0128	9216	Abarelix for injectable suspension, per 10 mg
J0135	1083	Injection, adalimumab, 20 mg
J0180	9208	Injection, IV, Agalsidase beta, per 1 mg
J0205	0900	Injection, Alglucerase, per 10 units
J0256	0901	Alpha 1 proteinase inhibitor-human, 10 mg
J0595	0703	Injection, Butorphanol tartrate 1 mg
J0878	9124	Injection, daptomycin per 1 mg
J1457	1085	Injection, gallium nitrate, 1 mg
J1785	0916	Injection imiglucerase, per unit
J1931	9209	Injection, laronidase, 0.1 mg
J2185	0729	Injection, meropenem, 100 mg
J2280	1046	Injection, moxifloxacin 100 mg
J2355	7011	Oprelvekin injection, 5 mg
J2357	9300	Injection, omalizumab, per 5 mg
J2469	9210	Injection, palonosetron HCl, 25 mcg
J2783	0738	Injection, rasburicase, 0.5 mg
J2794	9125	Injection, risperidone, long acting, 0.5 mg
J3240	9108	Injection Thyrotropin Alpha, 0.9 mg, provided in 1.1 mg vial
J3411	1049	Injection, Thiamine HCL 100 mg
J3415	1050	Injection, Pyridoxine HCL 100 mg
J3465	1052	Injection, voriconazole, 10 mg
J3486	9204	Injection, Ziprasidone mesylate, per 10 mg
J7308	7308	Aminolevulinic acid HCL for topical administration, 20%, single unit dosage form (354mg)
J7513	1612	Daclizumab, parenteral, 25 mg
J7518	9219	Mycophenolic acid, oral, per 180 mg
J7674	0867	Methacholine chloride administered as inhalation solution through a nebulizer, per 1 mg
J9010	9110	Alemtuzumab, 10 mg
J9015	0807	Aldesleukin, per single use vial
J9017	9012	Arsenic trioxide, 1 mg
J9035	9214	Injection, Bevacizumab, per 10 mg
J9041	9207	Injection, Bortezomib, 0.1 mg
J9055	9215	Injection, Cetuximab, per 10 mg
J9160	1084	Denileukin diftitox, 300 mcg
J9216	838	Interferon gamma 1-b, 3 million units
J9300	9004	Gemtuzumab ozogamicin, 5 mg
J9305	9213	Injection, Pemetrexed, per 10 mg
Q2019	1615	Injection, Basiliximab, 20 mg
Q4075	1062	Injection, Acyclovir, 5 mg
Q4076	1070	Injection, Dopamine HCL, 40 mg
Q4077	1082	Injection, Trepstinil, 1 mg
Q4079	9126	Injection, Natalizumab, per 1 mg

**b. Updated Payment Rates for Certain Drugs and Biologicals effective January 1, 2005 through March 31, 2005**

The payment rates for the drugs, biologicals, and services listed below were incorrect in the January 2005 OPSS PRICER. The corrected payment rates will be installed in the April 2005 OPSS PRICER, effective for services furnished on or after January 1, 2005 through March 31, 2005. Please refer to the CMS website for these payment rates.

HCCPS APC	Long Description
C9126	9126 Injection, Natalizumab, per 5 mg
C9222	9222 Decellularized soft tissue scaffold, per 1 cc
J0135	1083 Injection, Adalimumab, 20 mg
J0595	0703 Injection, Butorphanol tartrate 1 mg
J0256	0901 Injection, Alpha 1-Proteinase Inhibitor - Human 10 mg
J0205	0900 Injection, Alglucerase per 10 units
J1785	0916 Injection, Imiglucerase, per unit
J2355	7011 Injection, Oprelvekin, 5 mg
J3240	9108 Injection, Thyrotropin alpha, 0.9 mg
J7513	1612 Daclizumab, parenteral, 25 mg
J9015	0807 Aldesleukin, per single use vial
J9160	1084 Denileukin diftitox, 300 mcg
J9216	0838 Interferon gamma-1B, 3 million units
J9300	9004 Gemtuzumab ozogamicin, 5 mg
J9017	9012 Arsenic trioxide, 1 mg (Trisenox)
J9010	9110 Alemtuzumab, 10 mg
Q2019	1615 Injection, Basiliximab, 20mg
C9218	9218 Injection, azacitidine, 1 mg
43257	0422 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease
43228	0422 Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amendable to removal by hot biopsy forceps, bipolar cautery or snare technique
43830	0422 Gastrostomy, open; without construction of gastric tube (e.g. stamm procedure) (separate procedure)
0008T	0422 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate, with suturing of the esophagogastric junction.
C9724	0422 Endoscopic full-thickness plication in the gastric cardia using endoscopic plication system (EPS); includes endoscopy

**c. New HCPCS Codes for Intravenous Immune Globulin (IVIG)**

Effective April 1, 2005, the following codes are being added to the Healthcare Common Procedure Coding System (HCPCS) to appropriately distinguish between the lyophilized and non-lyophilized form of IVIG:

**April 2005 Update of the Hospital Outpatient PPS: Summary of Payment Policy Changes (continued)**

HCPCS	SI	APC	Short Descriptor	Long Descriptor
Q9941	K	0869	IVIG lyophil 1g	Injection, Immune Globulin, Intravenous, Lyophilized, 1g
Q9942	K	0870	IVIG lyophil 10 mg	Injection, Immune Globulin, Intravenous, Lyophilized, 10 mg
Q9943	K	0871	IVIG non-lyophil 1g	Injection, Immune Globulin, Intravenous, Non-Lyophilized, 1 mg
Q9944	K	0872	IVIG non-lyophil 10 mg	Injection, Immune Globulin, Intravenous, Non-Lyophilized, 10 mg

Effective for dates of service on or after April 1, 2005, codes J1563 and J1564 will no longer be paid by Medicare; therefore, the status indicator for these codes will be changed to “E”. These codes will be replaced with HCPCS codes Q9941 – Q9944 effective April 1, 2005. HCPCS code J1563 has been replaced with Q9941 and Q9943 and J1564 has been replaced with Q9942 and Q9944. OPSS payment for the new Q-codes may be found in the April update of OPSS Addendum A and Addendum B on the CMS Web site, which will be available at <http://www.cms.hhs.gov/providers/hopps/>.

**d. Billing and Payment for Nesiritide, J2324**

Effective January 1, 2005, CMS is correcting the payment rate for J2324, *Injection, Nesiritide, 0.25 mg*.

HCPCS	SI	APC	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
J2324	K	9114	Injection, Nesiritide, 0.25 mg	\$66.23	\$13.25

**e. Misclassified Drug: Billing and Payment for Vinorelbine Tartrate, Generic versus Brand Name Form**

In the 2005 OPSS final rule, CMS misclassified Vinorelbine Tartrate as a sole source product. Effective January 1, 2005, Vinorelbine Tartrate is reclassified as a multi-source product and is implemented with both a generic and brand name HCPCS code and payment amount. The two HCPCS codes listed in the following table are required under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) to enable Medicare to differentiate between the payment amounts for an innovator multiple source (brand name) drug and its noninnovator multiple-source (generic) form. Hospitals should note that the brand name form of Vinorelbine Tartrate should be reported with a new HCPCS code, C9440, which is created effective January 1, 2005.

HCPCS	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment	Effective Date
J9390	K	0855	Vinorelbine tartrate/10 mg	Vinorelbine tartrate, per 10 mg	\$52.78	\$10.56	01/01/05
C9440	K	9440	Vinorelbine tar, brand	Vinorelbine Tartrate, brand, per 10 mg	\$74.84	\$14.97	01/01/05

**f. New HCPCS Code for Injection, Natalizumab**

Hospitals are to report new HCPCS code Q4079, *Injection, Natalizumab, 1 mg* instead of C9126, *Injection, Natalizumab, 5 mg*, when billing for natalizumab furnished on or after April 1, 2005. Q4079 will be assigned to status indicator G beginning April 1, 2005.

**g. New HCPCS Code for Adenosine Injection**

Effective for services furnished on or after April 1, 2005, hospitals should use HCPCS C9223, *Injection, adenosine for therapeutic or diagnostic use, 6 mg* (not to be used to report any adenosine phosphate compounds, instead use A9270) instead of HCPCS codes J0150, *Injection, adenosine, for therapeutic use, 6 mg* (not to be used to report any adenosine phosphate compounds, instead use A9270) and J0152, *Injection, adenosine for diagnostic use, 30 mg* (not to be used to report any adenosine phosphate compounds, instead use A9270) Effective April 2005, J0150 and J0152 will be assigned to status indicator “B.”

**h. Payment for Drugs and Biologicals Recently Approved by the FDA**

Transmittal 188 (CR 3287), issued May 28, 2004, explains how hospitals may report new drugs and biologicals after Food and Drug Administration (FDA) approval but before assignment of product-specific HCPCS codes. The MMA requires, beginning in 2004, that payment for new drugs and biologicals after FDA approval but before assignment of product-specific HCPCS codes be equal to 95 percent of average wholesale price (AWP).

CMS is assigning the following product-specific HCPCS code for billing of two drugs that were approved by the FDA on December 17, 2004 and January 7, 2005, respectively.

HCPCS	SI	APC	Short Descriptor	Long Descriptor	Payment Rate Effective Date	Payment Rate	Minimum Unadjusted Copayment
C9127	K	9127	Paclitaxel protein pr	Injection, Paclitaxel Protein Bound Particles, per 1 mg	01/07/05	\$8.44	\$1.69
C9128	K	9128	Inj pegaptamib sodium	Injection, Pegaptamib Sodium, per 0.3 mg	12/17/04	\$1,054.70	\$210.94

*April 2005 Update of the Hospital Outpatient PPS: Summary of Payment Policy Changes (continued)*

For claims submitted prior to implementation of the April 2005 OPPS OCE, hospitals may bill for these drugs using HCPCS code C9399, *Unclassified Drug or Biological*, in accordance with CR 3287. For claims submitted on or after implementation of the April 2005 OPPS OCE, hospitals should bill for these drugs using their respective product-specific HCPCS codes.

**5. Billing for Venipuncture, Discontinued Code**

Effective for services furnished on or after January 1, 2005, HCPCS code G0001, *Routine venipuncture for collection of specimen*, is deleted from the OPPS OCE and discontinued from the HCPCS file. Hospitals paid under the OPPS (12x and 13x bill types) should report HCPCS codes 36415, *Collection of venous blood by venipuncture and* 36416, *Collection of capillary blood specimen (eg, finger, heel, ear stick)*.

**6. Billing for Contrast Agents**

Hospitals paid under the OPPS should continue reporting contrast agents, as follows:

- A4643 Supply of additional high dose contrast material(s) during magnetic resonance imaging, e.g., gadoteridol injection;
- A4644 Supply of low osmolar contrast material (100-199 mgs of iodine)
- A4645 Supply of low osmolar contrast material (200-299 mgs of iodine)
- A4646 Supply of low osmolar contrast material (300-399 mgs of iodine)
- A4647 Supply of paramagnetic contrast material, e.g., gadolinium
- C9202 Injection, suspension of microspheres of human serum albumin with octafluoropropane, per 3 ml
- C9203 Injection, perflorane lipid microspheres, per 10 ml vial
- C9112 Injection, perflutren lipid microsphere, per 2 ml vial

**7. Reactivation of OPPS Modifier 27**

Modifier 27 was erroneously deleted from the OPPS OCE software effective January 1, 2005. As a result, claims containing modifier 27 were returned to the provider for services furnished on or after January 1, 2005 through March 31, 2005. The April OCE release reactivated modifier 27 effective January 1, 2005. In the interim, for claims with dates of service 01/01/05 through 03/31/05, where the provider furnishes additional services that would be reported on the same claim as services related to modifier 27, the provider may wish to remove the charge for the services related to modifier 27 in order to receive payment for the remaining services. In this situation, the provider would submit an adjustment bill in April 2005 upon successful implementation of the OPPS OCE release to receive payment for the services related to modifier 27.

**8. Update to Cost-to-Charge ratio (CCR) Threshold**

Transmittal A-03-004 (CR 2197) issued January 17, 2003, instructed fiscal intermediaries to use statewide default CCR if the calculated CCR was above 1.604. Since CCR threshold has changed, please refer to Section III for the updated instruction. The statewide default CCRs were updated in the OPPS 2005 Final Rule, published on November 15, 2004.

**9. Changes in Billing for Observation Services (APC 0339)**

In the transmittal 423 (CR3632), issued on January 6, 2005 ( see this transmittal at [http://www.cms.hhs.gov/manuals/pm\\_trans/R423CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R423CP.pdf) ) CMS summarized several policy changes related to separate payment of APC 0339 for observation services provided in the hospital outpatient department, in order to simplify billing for hospitals. The changes are effective for services provided on or after January 1, 2005. But, CMS neglected to include as one of the changes the elimination of requirements for specific diagnostic testing. In CR 3756, CMS restates the changes of transmittal 423 and adds section 9.a. to include the elimination of requirements for specific diagnostic testing.

- a. The current requirements for specific diagnostic testing are removed. The following tests are no longer required to receive payment for APC 0339 (Observation) effective for services provided on or after January 1, 2005:
  - For congestive heart failure, a chest X-ray (71010, 71020, 71030), and electrocardiogram (93005) and pulse oximetry (94760, 94761, 94762)
  - For asthma, a breathing capacity test (94010) or pulse oximetry (94760, 94761, 94762)
  - For chest pain, two sets of cardiac enzyme tests; either two CPK (82550, 82552, 82553) or two troponins (84484, 84512) and two sequential electrocardiograms (93005)
- b. The descriptor for HCPCS code G0244 is changed to read: *Observation care provided by a facility to a patient with CHF, chest pain or asthma, minimum 8 hours*. The new descriptor clarifies that separate payment will be made for observation services only when a minimum of 8 hours of care have been provided to the beneficiary. Hospitals should report the number of hours the outpatient is in observation status.
- c. To receive separate payment for HCPCS code G0244, hospitals are required to report a qualifying ICD-9-CM diagnosis code for CHF, chest pain or asthma as either the Admitting Diagnosis/Reason for Patient Visit or Principal Diagnosis. The list of ICD-9-CM codes is published in the 2005 OPPS final rule. The code must be reported in the Admitting Diagnosis/Reason for Patient Visit field (form locator 76 or its electronic equivalent) or the Principal Diagnosis field (form locator 67 or its electronic equivalent) to qualify for separate payment for observation services.
- d. Observation time begins at the clock time documented in the patient’s medical record, which coincides with the time the patient is placed in a bed for the purpose of initiating observation care in accordance with a physician’s order.
- e. The ending time for observation occurs either when the patient is discharged from the hospital or is admitted as an inpatient. The time when a patient is “discharged” from observation status is the clock time when all clinical or medical interventions have been completed, including any necessary follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered that the patient be released or

## April 2005 Update of the Hospital Outpatient PPS: Summary of Payment Policy Changes (continued)

admitted as an inpatient. However, observation care does not include time spent by the patient in the hospital subsequent to the conclusion of therapeutic, clinical, or medical interventions, such as time spent waiting for transportation to go home.

### 10. Coverage Determinations

The fact that a drug, device, procedure, or service is assigned an HCPCS code and a payment rate under the OPSS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Fiscal intermediaries determine whether a drug, device, procedure, or service meets all program requirements for coverage, for example, that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

### 11. Attachment: Summary of April 2005 Data Changes

Attachment A of CR 3756 (see the Additional Information Section at the end of this article for information on viewing CR 3756) is the OPSS OCE Summary of Data Changes, effective April 1, 2005. This document summarizes all of the modifications made to APCs, HCPCS and CPT procedure codes, APC assignments, status indicators, modifiers, revenue codes, and edits to update the OPSS OCE for the April 1, 2005 quarterly release.

Your FIs will begin using this OCE and the revised OPSS PRICER on April 4, 2005 and will also take the following actions:

- Mass adjust payment for claims with HCPCS codes listed in item 4.b. above of this article (Updated payment rates for drugs and biologicals effective January 1, 2005), that were (1) incorrectly paid for services furnished on or after January 1, 2005 through March 31, 2005; and (2) processed prior to installation of the April 2005 OPSS PRICER
- Return to provider claims for IVIG services billed with J1563 and J1564 that are submitted after the installation of the April 2005 OPSS OCE. J1563 is replaced with Q9941 and Q9943 and J1564 is replaced with Q9942 and Q9944. These Q- codes shall be reported to Medicare from April 1, 2005 through December 31, 2005. (Note: Q-codes will be deleted December 31, 2005 and replaced with new J-codes effective January 1, 2006.)
- Mass adjust payment for claims with J2324 that were (1) incorrectly paid for services furnished on or after January 1, 2005 through March 31, 2005; and (2) processed prior to installment of the April 2005 OPSS PRICER.

- Return to provider claims for natalizumab billed with C9126 that are submitted after the installation of the April 2005 OPSS OCE.
- Return to provider claims for adenosine billed with J0150 and J0152 that are submitted after the installation of the April 2005 OPSS OCE.
- Return to provider claims for Injection, Paclitaxel protein bound particles, per 1 mg and injection, pegaptamib sodium, per 0.3 mg billed with C9399 that are submitted after installation of the April 2005 OPSS OCE.
- Effective with cost reporting periods ending September 30, 2005 or later, fiscal intermediaries are instructed to use the statewide default CCR if the calculated CCR is above 1.2. If the calculated CCR is greater than 1.2, enter the applicable statewide average urban or rural hospital default ratio that you currently use to determine CCRs for new providers in the provider's outpatient provider specific file.

The statewide default CCRs were updated in the OPSS 2005 Final Rule, published on November 15, 2004.

### Implementation

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

### Additional Information

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

From that Web page, look for CR 3756 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: 3756

Related CR Release Date: March 30, 2005

Related CR Transmittal Number: 514

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 514, CR 3756

# PROVIDER AUDIT ISSUES

## Calculating Payment-to-Cost Ratios To Determine Transitional Corridor Payments

The Centers for Medicare & Medicaid Services (CMS) has revised the payment-to-cost ratio (PCR) calculations to determine transitional corridor payments under the outpatient prospective payment system (OPPS) and the criteria under which a provider may request a recalculation of its cost-to-charge ratio. The PCR calculation was listed incorrectly. The revised PCR calculation adjusts the payment calculation in the payment-to-cost ratio. This only affects providers with the CRNA exception.

The corrected instructions listed below are effective July 25, 2005.

### Calculating a PCR for Hospital Cost Report Periods Ending on or After January 1, 1996, and Before September 30, 1996

#### Step 1 – Determining Payments

Calculate payment amounts from the cost report for each type of service as described in A through E, then determine total payments as described in F:

- A. Calculate payment for ambulatory surgical center procedures. (Use Worksheet E, Part C.) Payment is the lesser of:
  1. Line 6;
  2. Line 9; or
  3.  $(0.58 \times \text{line 1 of Worksheet E, Part C}) + (0.42 \times \text{lesser of line 6 or line 9 of Worksheet E, Part C})$ .
- B. Calculate payment for radiology services subject to the blended payment methodology. (Use Worksheet E, Part D.) Payment is the lesser of:
  1. Line 6;
  2. Line 9; or
  3.  $(0.58 \times \text{line 2 of Worksheet E, Part D}) + (0.42 \times \text{lesser of line 6 or line 9 of Worksheet E, Part D})$ .
- C. Calculate payment for other diagnostic services subject to the blended payment methodology. (Use Worksheet E, Part E.) Payment is the lesser of:
  1. Line 6;
  2. Line 9; or
  3.  $(0.50 \times \text{line 2 of Worksheet E, Part E}) + (0.50 \times \text{lesser of line 6 or line 9 of Worksheet E, Part E})$ .
- D. Calculate payment for all other services. (Use Worksheet D, Part V, column 9.) Payment is the sum of the amounts for these lines and any subscripts of these lines:
  1. Lines 37 through 49;
  2. Lines 53 through 62;
  3. Line 63, excluding any costs that are not attributable to OPPS services, e.g., costs of FQHCs, RHCs, etc., and
  4. Line 68, excluding any costs not attributable to OPPS services.
- E. Calculate payment for vaccines. Payment is the amount on Worksheet D, Part VI, line 3.
- F. Calculate total payments by:
  1. Adding amounts determined for A through E in Step 1, above
  2. The net amount is the payment for the cost reporting period that will be used in calculating the provider's PCR.

#### Step 2 – Determining Costs

Determine costs for cost centers and individual services following A through C, then calculate total costs as described in D.

- A. Multiply the cost-to-charge ratio (or other statistical ratio in the case of a provider that was an all-inclusive rate provider during the base year) for a cost center from Worksheet C, Part I, column 7, times the charges for that cost center on Worksheet D Part V, columns 2, 3, 4 and 5 to determine outpatient costs for the following lines (i.e., cost centers) and any subscripts of these lines:
  1. Lines 37 – 49;
  2. Lines 53 – 62;
  3. Line 63, excluding any costs that are not attributable to OPPS services, e.g., costs of federally qualified health centers (FQHCs), rural health clinics (RHCs), and
  4. Line 68, excluding any costs not attributable to OPPS services.

**Note:** For providers apportioning costs to Medicare on other than a charge basis, e.g., all-inclusive rate providers: Multiply the unit cost for each department calculated on Worksheet C, Part I, column 7 times the equivalent Medicare units reported on Worksheet D, Part V, columns 2, 3, 4, and 5 for the following lines and any subscripts of these lines:

1. Lines 37 – 49;
2. Lines 53 – 62;
3. Line 63, excluding any costs that are not attributable to OPPS services, e.g., costs of FQHCs, RHCs, and
4. Line 68, excluding any costs not attributable to OPPS services.

- A. Determine the costs for all departments by adding the cost calculated for all lines in step A.
- B. Determine the costs of vaccines by taking the amount from Worksheet D Part VI, line 3.

*Calculating Payment-to-Cost Ratios To Determine Transitional Corridor Payments (continued)*

- C. Calculate total costs by:
  1. Adding the costs determined in B and C in Step 2, above; and
  2. Subtracting the cost from Worksheet D, Part V, line 102, column 9 (CRNA costs).

The net amount is the cost for the cost reporting period that will be used in calculating the provider's PCR.

**Step 3 – Calculate the PCR**

Calculate the provider's PCR by dividing the total payments calculated in Step 1. F. by the total costs calculated in Step 2. D.

**Calculating a PCR for Cost Report Periods Ending on or After September 30, 1996 and Before January 1, 2001**

**Step 1 – Determining Payments**

Calculate payment amounts from the cost report for each type of service as described in A through E, then determine total payments as described in F:

- A. Calculate payment for ambulatory surgical center procedures. (Use Worksheet E, Part C.) Payment is the lesser of:
  1. Line 6;
  2. Line 7; or
  3.  $(0.58 \times \text{line 1 of Worksheet E, Part C}) + (0.42 \times \text{lesser of line 6 or line 7 of Worksheet E, Part C})$ .
- B. Calculate payment for radiology services subject to the blended payment methodology. (Use Worksheet E, Part D.) Payment is the lesser of:
  1. Line 6;
  2. Line 7; or
  3.  $(0.58 \times \text{line 2 of Worksheet E, Part D}) + (0.42 \times \text{lesser of line 6 or line 7 of Worksheet E, Part D})$ .
- C. Calculate payment for other diagnostic services subject to the blended payment methodology. (Use Worksheet E, Part E.) Payment is the lesser of:
  1. Line 6;
  2. Line 7; or
  3.  $(0.50 \times \text{line 2 of Worksheet E, Part E}) + (0.50 \times \text{lesser of line 6 or line 7 of Worksheet E, Part E})$ .
- D. Calculate payment for all other services. (Use Worksheet D, Part V, column 9.) Payment is the sum of the following lines and all subscripts of these lines:
  1. Lines 37 through 49;
  2. Lines 53 through 62;
  3. Line 63, excluding any amounts that are not attributable to OPPS services, e.g., costs of FQHCs, RHCs, and
  4. Line 68, excluding any costs not attributable to OPPS services.
- E. Calculate payment for vaccines. Payment is the amount on Worksheet D, Part VI, line 3.
- F. Calculate total payments by:
  1. Adding amounts determined for Step 1, A through E, above

- 2. The net amount is the total payment for the cost reporting period that will be used in calculating the provider's PCR.

**Step 2 – Determining Costs**

Determine costs for cost centers and individual services as described in A through C, then calculate total costs as described in D.

- A. Multiply the cost-to-charge ratio (or other statistical ratio in the case of a provider that was an all-inclusive rate provider during the base year) for a cost center from Worksheet C, Part I, column 9, times the charges for that cost center on Worksheet D, Part V, columns 2, 3, 4 and 5 to determine outpatient costs for the following lines (i.e., cost centers) and all subscripts of these lines:

- 1. Lines 37 – 49;
- 2. Lines 53 – 62;
- 3. Line 63, excluding any charges on line 63 which are not attributable to OPPS services, e.g., FQHC services, RHC services), and
- 4. Line 68, excluding any charges that are not attributable to OPPS services.

**Note:** For providers apportioning costs to Medicare on other than a charge basis, e.g., all-inclusive rate providers, multiply the unit cost for each department calculated on Worksheet C, Part I, column 9, times the equivalent Medicare units reported on Worksheet D, Part V, columns 2, 3, 4 and 5 for the following lines and all subscripts of these lines:

- 1. Lines 37 – 49;
- 2. Lines 53 – 62;
- 3. Line 63, excluding any costs that are not attributable to OPPS services, e.g., costs of FQHCs, RHCs, and
- 4. Line 68, excluding any costs not attributable to OPPS services.

- B. Determine the costs for all departments by adding the cost calculated for all lines in step A.
- C. Determine the costs of vaccines by taking the amount from Worksheet D, Part VI, line 3.
- D. Calculate total costs by:
  1. Adding the costs determined in B and C in Step 2, above; and
  2. Subtracting the cost from Worksheet D, Part V, line 102, column 9 (CRNA costs).

The net amount is the cost for the cost reporting period that will be used in calculating the provider's PCR.

**Step 3 – Calculate the PCR**

Calculate the provider's PCR by dividing the total payments calculated in Step 1. F. by the total costs calculated in Step 2. D.

Note that any hospital that did not have a full cost reporting period ending before December 31, 2001 will not have a PCR.

Source: CMS Pub. 100-4, Transmittal 485, CR 3661



## Resubmission of Outpatient Prospective Payment System Services for Eligible Outlier Payment

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

### Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for services paid under the outpatient prospective payment system (OPPS)

### Provider Action Needed

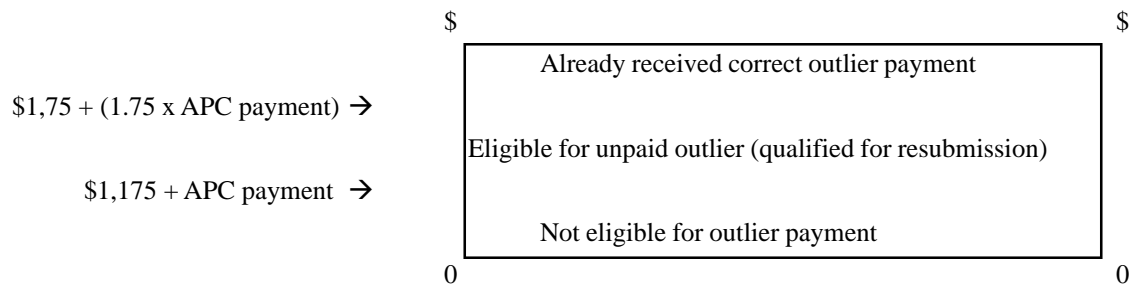
Effective for claims with line item dates of service (LIDOS) on or after January 1, 2005, the OPSS PRICER software calculates outlier payments for OPSS services using a new formula to determine if costs exceed the outlier threshold. If they exceed the outlier threshold, a separate calculation is made to determine the outlier payment amount. The threshold to become eligible for those outlier payments was incorrectly set above the appropriate threshold. Claims that met the higher threshold received the correct outlier payment. However, some claims near the threshold did not receive an outlier payment even though they should have.

Therefore, beginning April 15, 2005, the Centers for Medicare & Medicaid Services (CMS) is encouraging providers to resubmit claims with OPSS services that meet **all** of the following criteria (only OPSS services that meet the following criteria are eligible for unpaid outliers):

- LIDOS is on or after January 1, 2005 and before April 1, 2005, and
- Claims submitted prior to April 4, 2005, and
- Line item cost<sup>1</sup> exceeds \$1,175 plus the line item payment amount, and
- Line item cost is less than \$1,175 plus (1.75 x line item payment amount).

<sup>1</sup> Determined by the provider’s line item charge multiplied by the provider’s cost-to-charge ratio.

**Note:** Information below illustrates what claims qualify to receive outlier payment when resubmitted. The area in the middle pertains to the claims that meet the criteria listed above.



### Additional Information

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

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

Related Change Request (CR) Number: N/A

Effective Date: N/A

Source: CMS Special Edition Medlearn Article SE0523

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## *FRAUD AND ABUSE*

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### **New Program Safeguard Contractor for Florida**

The Centers for Medicare & Medicaid Services (CMS) recently awarded a new contract to EDS (Electronic Data Systems) and its subcontractor IntegriGuard, LLC, to establish the Florida Benefit Integrity Support Center. This project is part of the CMS Medicare Integrity Program (MIP) to engage program safeguard contractors (PSC) in pursuit of Medicare fraud, waste, and abuse in Florida.

As the prime contractor, EDS replaces TriCenturion, Inc., effective March 1, 2005, as the PSC responsible for combating and preventing Medicare fraud and abuse in Florida. In this capacity EDS is generally responsible for data analysis, investigation, and case development for the Florida Benefit Integrity Support Center.

The Florida Benefit Integrity Support Center does not replace the Medicare program administration work performed by First Coast Service Options, Inc., the current fiscal intermediary (Part A) and carrier (Part B) in Florida. First Coast Service Options will continue its current responsibilities including processing and paying claims, performing customer service, reviewing the medical necessity of claims unrelated to suspected fraud and abuse, and auditing facilities for Medicare expenses and reimbursement. As a note, allegations of suspected fraud, waste, and abuse in Florida are to be reported to First Coast Service Options as it is this contractor responsibility to screen the allegations for possible errors in billing or processing or misunderstandings. Allegations of suspected fraud will be forwarded to the Florida Benefit Integrity Support Center only after possible errors or misunderstandings are ruled-out.

The Florida Benefit Integrity Support Center will create a focused resource to detect and deter fraud in the Medicare program. In this capacity, it will develop administrative solutions, investigations, and cases for referral to law enforcement, as well as provide ongoing support to law enforcement as needed. Additional responsibilities include coordination of benefit integrity activities in the region, and dissemination of relevant benefit integrity information to First Coast Service Options, health care providers, and Medicare beneficiaries. ❖

# THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

## Administrative Simplification Compliance Act Enforcement of Mandatory Electronic Submission of Medicare Claims

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

**Note:** This article was revised on January 31, 2005, to reflect a new CR release date and CR Transmittal number since the CR was re-issued. All other information in the article remains the same. This article was previously published in the [Second Quarter 2005 Medicare A Bulletin](#) (pages 66-67).

### Provider Types Affected

All Medicare providers

### Provider Action Needed

#### STOP – Impact to You

If you don't submit your Medicare claims electronically, your payments could be affected (unless you meet specific exception criteria mentioned below).

#### CAUTION – What You Need to Know

The Administrative Simplification Compliance Act (ASCA) prohibits Medicare from making payments on or after October 16, 2003, for claims that are not submitted electronically. You must submit your claims electronically, unless you meet one of the exceptions listed below.

#### GO – What You Need to Do

Make sure that your billing staff submits your Medicare claims electronically. Or, if you believe that you meet one of the exception criteria, make sure that you appropriately complete the “Request for Documentation” letter from your carrier or fiscal intermediary to process your claims.

### Background

Section 3 of the ASCA, PL107-105, and the implementing regulation at 42 CFR 424.32, requires you, with limited exceptions, to submit all your initial claims for reimbursement under Medicare electronically, on or after October 16, 2003.

Further, ASCA amendment to Section 1862(a) of the Act prescribes that “no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services” for which a claim is submitted in a nonelectronic form. Consequently, unless you fit one of the exceptions listed below, any paper claims that you submit to Medicare will not be paid. In addition, if it is determined that you are in violation of the statute or rule, you may be subject to claim denials, overpayment recoveries, and applicable interest on overpayments.

There are some exceptions to this electronic claim submission requirement. They include the following:

- You are a small provider – a provider billing a Medicare fiscal intermediary that has fewer than 25 full-time equivalent (FTE) employees, and a physician, practitioner, or supplier with fewer than ten FTE employees that bills a Medicare carrier.
- A dentist.

- A participant in a Medicare demonstration project in which paper claim filing is required due to the inability of the Applicable Implementation Guide, adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to report data essential for the demonstration.
- A provider that conducts mass immunizations, such as flu injections, and may be permitted to submit paper roster bills.
- A provider that submits claims when more than one other payer is responsible for payment prior to Medicare payment.
- A provider that only furnishes services outside of the United States.
- A provider experiencing a disruption in electricity and communication connections that are beyond its control.
- A provider that can establish an “unusual circumstance” exists that precludes submission of claims electronically.

The process for post-payment based enforcement is as follows:

- Your Medicare contractor will analyze reports displaying the number of paper claims that all providers submitted each quarter.
- By the end of the month following the quarter, selected providers who have submitted the highest numbers of paper claims will be reviewed.
- Medicare contractors will ask these providers to provide information that establishes the exception criteria listed above.

If you, as one such provider, do not respond to this initial “Request for Documentation” letter within 45 days of receipt, your contractor will notify you by mail that Medicare will deny and not pay any paper claims that you submit beginning ninety days after the date of the initial request letter. If you **do** respond to this initial letter, and your response does not establish eligibility to submit paper claims, the contractor will notify you by mail of your ineligibility to submit paper claims. This Medicare decision is not subject to appeal.

## ELECTRONIC DATA INTERCHANGE

### ASCA Enforcement of Mandatory Electronic Submission of Medicare Claims (continued)

In these letters, your Medicare contractor will also tell you how to obtain free and commercially available HIPAA-compliant billing software packages.

If you respond with information that does establish eligibility to submit paper claims, the contractor will notify you by mail that you meet one or more exception criteria to the requirements in Section 3 of the ASCA, Pub.L. 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, and you will be permitted to submit paper claims.

However, you will be cautioned that if your situation changes to the point that you no longer meet the exception criteria, you will be required to begin electronic submission of your claims. If you are permitted to submit paper claims, your carrier/intermediary will not review your eligibility to submit paper claims again for at least two years.

#### Additional Information

You can learn more about the instructions issued to your intermediary/carrier regarding ASCA Enforcement of Mandatory Electronic Submission of Medicare Claims at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

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This material provides a basic overview of the consumer privacy protection rules adopted by the United States Department of Health and Human Services in conformance with the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996. This material does not interpret these rules or attempt to apply the rules to your particular circumstances. The information provided is (1) for your information only, (2) subject to change without notice, and (3) provided "as is" without warranty of any kind, expressed or implied. FIRST COAST SERVICE OPTIONS, INC. DISCLAIMS RESPONSIBILITY FOR ANY CONSEQUENCES OR LIABILITY ATTRIBUTABLE TO OR RELATED TO ANY USE, NON-USE, OR INTERPRETATION OF INFORMATION CONTAINED OR NOT CONTAINED IN THIS MATERIAL. FIRST COAST SERVICE OPTIONS, INC. DISCLAIMS ANY LIABILITY FOR ANY DIRECT, SPECIAL, INDIRECT, INCIDENTAL, OR CONSEQUENTIAL LOSSES OR DAMAGES RELATED TO THE ACCURACY OR COMPLETENESS OF THIS MATERIAL. The information provided is no substitute for your own review and analysis of the relevant law.

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## ELECTRONIC DATA INTERCHANGE

### Standardization of Fiscal Intermediary Use of Group and Claim Adjustment Reason Codes and Calculation and Balancing of TS2 and TS3 Segment Data Elements

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

#### Provider Types Affected

Providers who bill Medicare fiscal intermediaries (FIs)

#### Provider Action Needed

##### STOP – Impact to You

Effective July 1, 2005, the Center for Medicare & Medicaid Services (CMS) will require FIs to report a specific group code in combination with specific reason codes in electronic remittance advice (ERA) and in standard paper remittance advice (SPR) transactions. In addition, CMS has put forth additional requirements for the FI regarding correct calculation for TS2 and TS3 segment data elements in remittance advice transactions.

Look for CR 3440 in the CR NUM column on the right, and click on the file for that CR. These instructions provide more detail on what constitutes an "unusual circumstance" that precludes submission of claims electronically.

You might also want to look at the online manual 100.04, chapter 24, Section 90, Subsection 5 (Enforcement). You can find this manual at: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c24.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c24.pdf).

If you have any questions, please contact your contractor at his toll-free number: <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: 3440

Related CR Release Date: January 27, 2005 (CR re-issued)

Related CR Transmittal Number: 450

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 450, CR 3440

#### CAUTION – What You Need to Know

FIs will not use a patient responsibility (PR) group code unless a claim indicates that a provider obtained an advanced beneficiary notice (ABN) for a service not generally considered as reasonable and necessary for treatment of a patient.

#### GO – What You Need to Do

To ensure accurate understanding of remittance advice transactions, please review the information included here and remain current with guidelines pertaining to ERA and SPR transactions.

*Standardization of Fiscal Intermediary Use of Group and Claim Adjustment Reason Codes ... (continued)*

**Background**

Effective July 1, 2005, CMS will require FIs to report a specific group code in combination with specific reason codes. In addition, CMS has put forth additional requirements for the FI regarding correct calculation for TS2 and TS3 segment data elements.

The X12 835 remittance advice and 837 coordination of benefits (COB) implementation guides (IG) require that a group code that assigns financial responsibility for a nonpaid amount is reported in conjunction with continuing effort to foster standardized reporting among FIs, CMS will require FIs to report a specific group code in combination with specific reason codes.

Medicare FIs are permitted to use the following group codes in combination with specific reason codes:

- CO (Contractual obligation) – provider is financially liable
- CR (Correction and reversal) – no financial liability
- OA (Other adjustment) – no financial liability
- PR (Patient responsibility) – patient is financially liable.

Please note that although X12 permits use of group code PI (payer initiated), with an adjustment reason code, CMS has never permitted Medicare FIs to use this group code as it fails to identify financial liability for the unpaid amount.

FIs will not use alternate group and reason code combinations unless a claim indicates that a provider obtained an advanced beneficiary notice (ABN) or other notice of non-coverage for a service Medicare may not pay because it is generally not considered reasonable and necessary for treatment of a patient or if the item and/or service is one for which the financial liability protections in Section 1879 of the Social Security Act (SSA) could apply.

**Example:**

**Case One:** A patient signed an ABN indicating that:

- The provider advised the patient before rendering and billing for a service that the service is not usually covered by Medicare because it is deemed to be not necessary and reasonable, AND
- The patient still requested the service and agreed to pay for the service if denied by Medicare:

Group code PR (patient responsibility) applies with reason code 50 (used to deny a service not considered reasonable and necessary).

**Case Two:** The provider did not obtain an ABN from a patient for a service not considered reasonable and necessary. In this case, group code CO (contractual obligation) applies with reason code 50.

A provider is prohibited from billing a Medicare beneficiary for any adjustment amount identified with a CO group code, but may bill a beneficiary for an adjustment amount identified with a PR group code.

In addition, CMS has also put forth additional requirements for the FI regarding TS2 and TS3 Segment Data Elements. Most of these data elements report totals for categories of data elements reported elsewhere in an 835.

Although the X12 835 IG does not specifically require that these totals balance against the applicable individual data elements, CMS will require that these totals balance. In most cases, the amounts to be included in a TS2 or TS3 data element totals are evident from the applicable semantic note.

The following two tables list the semantic notes from the X12 workbook that apply to these segments and data elements. When reported, these data elements must comply with these semantic notes.

**TS3 Segment – Transaction Statistics**

Number	Code/Description of Code
01	TS301 is the provider number.
02	TS302 is the facility type code
03	TS303 is the last day of the provider’s fiscal year.
04	TS304 is the total number of claims.
05	TS305 is the total of reported charges.
06	TS306 is the total of covered charges.
07	TS307 is the total of noncovered charges.
08	TS308 is the total of denied charges.
09	TS309 is the total provider payment.
10	TS310 is the total amount of interest paid.
11	TS311 is the total contractual adjustment.
12	TS312 is the total Gramm-Rudman Reduction.
13	TS313 is the total Medicare Secondary Payer (MSP) primary payer amount.
14	TS314 is the total blood deductible amount in dollars.
15	TS315 is the summary of non-lab charges.
16	TS316 is the total coinsurance amount.
17	TS317 is the Health Care Financing Administration Common Procedural Coding System (HCPCS) reported charges.
18	TS318 is the total Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.
19	TS319 is the total deductible amount.
20	TS320 is the total professional component amount.
21	TS321 is the total Medicare Secondary Payer (MSP) patient liability met.
22	TS322 is the total patient reimbursement.
23	TS323 is the total periodic interim payment (PIP) number of claims.
24	TS324 is total periodic interim payment (PIP) adjustment.

**TS2 Transaction Supplemental Statistics**

Number	Code/Description of Code
01	TS201 is the total diagnosis related group (DRG) amount.
02	TS202 is the total federal specific amount.
03	TS203 is the total hospital specific amount.
04	TS204 is the total disproportionate share amount.
05	TS205 is the total capital amount.
06	TS206 is the total indirect medical education amount.
07	TS207 is the total number of outlier days.
08	TS208 is the total day outlier amount.
09	TS209 is the total cost outlier amount.
10	TS210 is the diagnosis related group (DRG) average length of stay.

## Standardization of Fiscal Intermediary Use of Group and Claim Adjustment Reason Codes ... (continued)

- 11 TS211 is the total number of discharges.
- 12 TS212 is the total number of cost report days.
- 13 TS213 is the total number of covered days.
- 14 TS214 is total number of non-covered days.
- 15 TS215 is the total Medicare Secondary Payer (MSP) pass-through amount calculated for a non-Medicare payer.
- 16 TS216 is the average diagnosis-related group (DRG) weight.
- 17 TS217 is the total prospective payment system (PPS) capital, federal-specific portion, diagnosis-related group (DRG) amount.
- 18 TS218 is the total prospective payment system (PPS) capital, hospital-specific portion, diagnosis-related group (DRG) amount.
- 19 TS219 is the total prospective payment system (PPS) disproportionate share, hospital diagnosis-related group (DRG) amount.

### Additional Information

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

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR 3685. 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 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: 3685  
Related CR Release Date: February 4, 2005  
Related CR Transmittal Number: 470  
Effective Date: July 1, 2005  
Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 470, CR 3685

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## Claim Status Code/Claim Status Category Code Update

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

### Provider Types Affected

All providers submitting health care claim status transactions to Medicare carriers, including durable medical equipment carriers (DMERCs), and fiscal intermediaries

### Provider Action Needed

This is a reminder item regarding the periodic update of certain code sets used as a result of the Health Insurance Portability and Accountability Act (HIPAA). Effective July 1, 2005, the Medicare claim processing system will update its lists of health care claims status codes and health care claims status category codes with all applicable code changes posted online with the "new as of 10/04" and prior date designations.

### Background

Under HIPAA, code sets that characterize a general administrative situation, rather than a medical condition or service, are referred to as non-clinical or non-medical code sets.

Claim status category codes and claim status codes are used in the health care claim status response (277) transaction:

- Claim status category codes indicate the general payment status of the claim.
- Claim status codes provide more detail about the status communicated in the general claim status category codes.

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These codes are available online at:

<http://www.wpc-edi.com/codes/Codes.asp>.

### Additional Information

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

On the above page, scroll down the CR NUM column on the right to find the link for CR 3715. Click on the link to open and view the file for the CR.

If you have questions regarding this issue, you may also contact your intermediary 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: 3715  
Related CR Release Date: March 4, 2005  
Related CR Transmittal Number: 490  
Effective Date: July 1, 2005  
Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 490, CR 3715

## Electronically Requesting and Receiving Information Regarding Claims Using the ASC X12N276/277 Claims Status Inquiry/Response Transactions

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

### Provider Types Affected

Physicians, providers and suppliers billing Medicare carriers and intermediaries.

### Provider Action Needed

#### STOP – Impact to You

This special edition discusses how health care providers may want to implement the ASC X12N 276/277 claims status inquiry/response transactions and benefit by being able to request and receive the status of claims **in one standard format, for all health care plans.**

#### CAUTION – What You Need to Know

Implementing the ASC X12N 276/277 would make electronic claim status requests and receipt of responses feasible for small providers, and eliminate the need to:

- Maintain redundant software, and
- Send and review claim status requests and responses manually.

#### GO – What You Need to Do

Providers who implement the ASC X12N 276/277 may create a more efficient follow-up process and also achieve an increase in cash flow each month by greatly reducing the administrative costs incurred by supporting multiple formats and manually processing claim status requests.

### Background

Even though there has been a significant increase in the number of providers who use electronic health care transactions, providers have faced the burden of sending information to various health plans in multiple formats. Even when different plans accept information in similar formats, they frequently have additional requirements that further complicate efficient information interchange. Consequently, providers have been burdened with additional administrative work in order to electronically process health care transactions (including claims status requests and responses). This has increased the costs and decreased the efficiency of processing claims status requests and responses.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes administrative simplification provisions meant to reduce and simplify the administrative demands faced by health care providers. HIPAA:

- 1) Directed the federal government to adopt national standards for the transfer of certain health care data; and
- 2) Requires all payers to use national standard transaction formats and code sets, such as the health care claims status category codes and the health care claim status codes issued by the Claim Adjustment Status Code Maintenance Committee.

Medicare carriers and intermediaries must periodically update their claims system with the most current health care claim status codes for use with:

- The Health Care Claim Status Request (ASC X12N 276), and
- The Health Care Claim Response (ASC X12N 277).

The ASC X12N 276 (Claims Status Inquiry Transaction) is used to transmit request(s) for status of specific health care claim(s), and the ASC X12N 277 (Claims Status Response Transaction) can be used for any of the following:

- As a response to a health care claim status request (276)
- As a notification about health care claim(s) status, including front end acknowledgments
- As a request for additional information about a health care claim(s).

Most health care providers who are currently using an electronic format and who wish to request claim status electronically using the ASC X12N 276/277 may incur some conversion costs.

However, after implementation, providers will benefit by being able to request and receive the status of claims **in one standard format, from all health care plans.** This would make electronic claim status requests and receipt of responses feasible for small providers, and eliminate the need to:

- Maintain redundant software, and
- Send and review claim status requests and responses manually.

It is possible that providers who implement the ASC X12N 276/277 can create a more efficient follow up process and also achieve an increase in cash flow each month by greatly reducing the administrative costs incurred by supporting multiple formats and manually processing claim status requests.

#### It’s time to start using this transaction.

Medicare can accept transmission of the ASC X12N 276 (your electronic request on the status of a previously submitted claim) and respond with an ASC X12N 277 (our electronic answer back to you).

**Currently, CMS sends out over 10,000 responses (277s) per month, and you too can benefit from is process. It could help you reduce the time required to follow up with Medicare as well as with any payer from 20 minutes to a few seconds.**

### Additional Information

An informative article entitled “Realizing Savings from the HIPAA Transaction Standards: How to Get There from Here,” which was prepared by Martin A. Brutscher, Partner, McBee Associates, Inc., may be reviewed at the following website: [http://www.mcbeeassociates.com/HFMA\\_white\\_paper.pdf](http://www.mcbeeassociates.com/HFMA_white_paper.pdf).

### *Claims Status Code/Claims Status Category Code Update (continued)*

The article shows the types of results that may be available to providers who implement the ASC X12N 276/277 as well as other HIPAA transactions.

Also, the Medicare Claims Processing Manual (Pub. 100-04), Chapter 31 (ANSI X12N Formats), Section 20 (ANSI X12N 276/277 Claims Status Request/Response Transaction Standard) may be reviewed at the following Centers for Medicare & Medicaid Services (CMS) website: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c31.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c31.pdf).

The X12 276/277 version 4010A1 implementation guide, as well as the claim status codes and category codes, may be downloaded without charge at: <http://www.wpc-edi.com/hipaa>.

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If you have any questions regarding this issue, contact the EDI department of your carrier/intermediary at their toll-free number. If you bill for Medicare Part A services, including outpatient hospital services, that number may be found at: <http://www.cms.hhs.gov/providers/edi/anum.asp>.

If you bill for Medicare Part B services, that number may be found at: <http://www.cms.hhs.gov/providers/edi/bnum.asp>.

Medlearn Matters Number: SE0524

Related Change Request (CR) Number: N/A

Source: CMS Special Edition Medlearn Article SE0524



# EDUCATIONAL RESOURCES

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staff to determine how they can identify our organization as an approved sender to your individual e-mail address. We recommend requesting them to ensure that mail from the 'ib.bcentral.com' domain be permitted.

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### Email Providers (Internet Service Providers [ISPs])

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If you are still experiencing problems not receiving FCSO *eNews* notices, we ask that you please send an email to us at [providerwebsite@fcsoc.com](mailto:providerwebsite@fcsoc.com) indicating the actions you've taken and the issues you continue to experience. We will contact you to assist with resolving them.

*Please pass this information along to other interested parties.*

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- Psychiatric Services (B)
- Ambulatory Surgical Centers (B)
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- Ophthalmology Services(B)
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- Cardiology(B)
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**Addresses****CLAIMS STATUS****Coverage Guidelines****Billing Issues Regarding****Outpatient Services, CORE, ORF, PHP**

Medicare Part A Customer Service  
P. O. Box 2711  
Jacksonville, FL 32231-0021

**PART A REDETERMINATION**

Medicare Part A Redetermination and Appeals  
P. O. Box 45053  
Jacksonville, FL 32232-5053

**MEDICARE SECONDARY PAYER (MSP)****Information on Hospital Protocols****Admission Questionnaires****Audits**

Medicare Secondary Payer  
Hospital Review  
P. O. Box 45267  
Jacksonville, FL 32232-5267

**General MSP Information****Completion of UB-92 (MSP Related)****Conditional Payment**

Medicare Secondary Payer  
P. O. Box 2711  
Jacksonville, FL 32231-0021

**Automobile Accident Cases****Settlements/Lawsuits****Other Liabilities**

Auto/Liability Department – 17T  
P. O. Box 44179  
Jacksonville, FL 32231-4179

**PROVIDER EDUCATION**

Medicare Education and Outreach  
P. O. Box 45157  
Jacksonville, FL 32232-5157

**Seminar Registration Hotline**

1-904-791-8103

**ELECTRONIC CLAIM FILING “DDE Startup”**

Direct Data Entry (DDE)  
P. O. Box 44071  
Jacksonville, FL 32231-4071

**FRAUD AND ABUSE**

Complaint Processing Unit  
P. O. Box 45087  
Jacksonville, FL 32232-5087

**PART A RECONSIDERATION****Claims Denied at the Redetermination Level**

MAXIMUS  
QIC Part A East Project  
Eastgate Square  
50 Square Drive  
Victor, NY 14564-1099

**OVERPAYMENT COLLECTIONS****Repayment Plans for Part A Participating Providers****Cost Reports (original and amended)****Receipts and Acceptances****Tentative Settlement Determinations****Provider Statistical and Reimbursement (PS&R) Reports****Cost Report Settlement (payments due to provider or Program)****Interim Rate Determinations****TEFRA Target Limit and Skilled Nursing Facility Routine Cost Limit Exceptions****Freedom of Information Act Requests (relative to cost reports and audits)**

Provider Audit and Reimbursement Department (PARD)  
P.O. Box 45268  
Jacksonville, FL 32232-5268  
1-904-791-8430

**MEDICARE REGISTRATION****American Diabetes Association****Certificates**

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

**Telephone Numbers****PROVIDERS**

Customer Service Center Toll-Free  
1-877-602-8816  
Speech and Hearing Impaired  
1-877-660-1759

**BENEFICIARY**

Customer Service Center Toll-Free  
1-800-MEDICARE  
1-800-633-4227  
Speech and Hearing Impaired  
1-800-754-7820

**ELECTRONIC MEDIA CLAIMS**

EMC Start-Up  
1-904-791-8767, option 4

Electronic Eligibility  
1-904-791-8131

Electronic Remittance Advice  
1-904-791-6865

Direct Data Entry (DDE) Support  
1-904-791-8131

PC-ACE Support  
1-904-355-0313

Testing  
1-904-791-6865

Help Desk  
(Confirmation/Transmission)  
1-904-905-8880

**Medicare Websites****PROVIDERS**

Florida Medicare Contractor  
[www.floridamedicare.com](http://www.floridamedicare.com)  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)

**BENEFICIARIES**

Centers for Medicare & Medicaid Services  
[www.medicare.gov](http://www.medicare.gov)

**Other Important Addresses****REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY****Home Health Agency Claims Hospice Claims**

Palmetto Government Benefit Administrators – Gulf Coast  
34650 US Highway 19 North, Suite 202  
Palm Harbour, FL 34684-2156

**RAILROAD MEDICARE****Railroad Retiree Medical Claims**

Palmetto Government Benefit Administrators  
P. O. Box 10066  
Augusta, GA 30999-0001

**DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)****Durable Medical Equipment Claims Orthotic and Prosthetic Device Claims Take Home Supplies****Oral Anti-Cancer Drugs**

Palmetto Government Benefit Administrators  
P. O. Box 100141  
Columbia, SC 29202-3141



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***MEDICARE A BULLETIN***

*FIRST COAST SERVICE OPTIONS, INC. ❖ P.O. Box 2078 ❖ JACKSONVILLE, FL 32231-0048*

**\* ATTENTION BILLING MANAGER \***

