Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

In This Issue...

Features

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

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

Routing Suggestions:

- ☐ Medicare Manager
- ☐ Reimbursement Director
- ☐ Chief Financial Officer
- ☐ Compliance Officer
- ☐ DRG Coordinator
- ☐ _____
- ☐ _____
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

Table of Contents

Medicare A Bulletin

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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:

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

Reader Survey—*Medicare A Bulletin*

We want readers of this publication to find it to be a helpful tool that is easy to use and undestand . This survey is your opportunity to suggest ways we can better meet your needs. After the survey closes, we will publish the results on our website and work to implement suggested enhancements as appropriate. Thank you for taking the time to complete this survey!

Please complete the questions below and return your reply to us by March 31, 2005.

Overall Satisfaction

On a scale of 5 to 1, with 5 being very satisfied and 1 being very dissatisfied, how satisfied are you with the publication overall? Please ***circle*** the number that best applies.

5 4 3 2 1

Accuracy

"When I read the *Medicare A Bulletin* I feel comfortable that the information presented is accurate."

5 4 3 2 1

"When I read the *Medicare A Bulletin* I am confident that the information is up-to-date."

5 4 3 2 1

Clarity

"Medicare rules and guidelines are complex; however, I generally find the articles in the *Medicare A Bulletin* clear."

5 4 3 2 1

"Medicare rules and guidelines are complex; however, I usually find the articles in the *Medicare A Bulletin* easy to read."

5 4 3 2 1

Value

"The *Medicare A Bulletin* assists me in performing my job."

5 4 3 2 1

Layout/Format

"The *Medicare A Bulletin* is arranged in a manner that makes it easy to find the information I need."

5 4 3 2 1

Comments/Feedback –

What else could we do to improve the publication for you?

Please remove this page and mail it to:
Medicare Communication and Education – Publications
Attention : Robert Hannan
P.O. Box 45270 – 10T
Jacksonville, FL 32232-5270

or you may **fax** your survey to (904) 791-6292.

About *The Medicare A Bulletin*

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

Publication Name	Publication Date	Effective Date of Changes
First Quarter 2005	**Mid-November 2004**	**January 1, 2005**
Second Quarter 2005	Mid-February 2005	April 1, 2005
Third Quarter 2005	Mid-May 2005	July 1, 2005
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 dowload the *Bulletin* from our provider education website. Providers who cannot obtain the *Bulletin* from the Internet are required to register with us to receive a complimentary hardcopy (please see the hardcopy registration form on page 90).

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

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

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

What Is in the *Bulletin*?

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

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

The Medicare A Bulletin Represents Formal Notice of Coverage Policies

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

Do You Have Comments?

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

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

Sign up to our *eNews* electronic mailing list

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

GENERAL INFORMATION

New Policy and Refinements on Billing Noncovered Charges to Fiscal Intermediaries

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

This instruction refines guidance in Chapter 1, Section 60 of Medicare's Online Publication 100-04, Medicare Claims Processing Manual. It serves to effect compliance with the Health Insurance Portability and Accountability Act (HIPAA) in ensuring all services not covered by Medicare may be submitted and accepted on Medicare claims, which in turn can be crossed over to subsequent payers.

Background

Basic comprehensive instructions on billing noncovered charges to FIs are found in Chapter 1, Section 60 of Medicare's Online Publication 100-4 on Claims Processing, and summarizes several prior program memoranda.

(See Transmittal R25CP, Change Request (CR) 2634, October 31, 2003, *Billing Noncovered Charges to Fiscal Intermediaries – Summary and New Instructions*, at: *http://www.cms.hhs.gov/manuals/pm_trans/R25CP.pdf*.)

The scope of these instructions is limited to institutional fee-for-service claims and not other types of transactions using claim formats.

Since publication of the summary instructions and one clarification (see Transmittal R133CP, CR 3115, April 2, 2004, *Billing Noncovered Charges to Fiscal Intermediaries – Summary and New Instructions – Clarification*, at *http://www.cms.hhs.gov/manuals/pm_trans/R133CP.pdf*), the Centers for Medicare & Medicaid Services (CMS) has become aware of other required refinements and new need(s) including the following:

- Allowing totally noncovered provider-liable outpatient claims without either condition codes 20 or 21 – **NEW NEED**; your FI will accept and process to completion totally noncovered outpatient claims as long as either: (1) condition code 20 or 21 appears on the claim; (2) no other indicators appear at the claim or line level to indicate a possibility of beneficiary liability; or (3) all indicators at the claim or line level indicate provider, not beneficiary, liability.
- Providing additional guidance on billing bundled services related to an advance beneficiary notice (ABN) with specific examples for rural health clinics (RHCs), federally qualified health clinics (FQHCs) and laboratory panel tests billed on institutional claims – **REFINEMENT.**
- Bypassing of some edits related to noncovered ambulance line items billed as noncovered using modifiers QM or QN so those claims/line items can process to completion – **REFINEMENT.**
- Other updates to website addresses, conforming text, and comparable administrative changes.

Finally, although the basic principles of billing noncovered charges are static, there will be some ongoing adjustments required because of changes in related policy areas, which is the case with any type of billing. For example, as CMS refines its beneficiary financial protection notices, such as the ABNs and notices of exclusion from Medicare benefits (NEMBs), the policies on billing noncovered charges will also be subject to review and potentially change, because they are intertwined with these notices in terms of determination of liability. (See NEMBs listed on CMS website *http://www.cms.hhs.gov/medicare/bni/*.)

Policy related to ABNs and similar notices has been evolving rapidly since 2000 and the ramifications of changes in this policy area for billing are likely to continue into 2005.

Implementation

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

Additional Information

Revisions to the Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-01) and the Medicare Claims Processing Manual (Pub. 100-04) are attached to the official instruction issued to your FI. You may view that instruction by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3416 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: 3416
Related CR Release Date: October 22, 2004
Related CR Transmittal Number: 12
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

Source: CMS Pub 100-4 Transmittal 332, CR 3416

Revisions to January 2005 Average Sales Price Drug Pricing File

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

Provider Types Affected

Providers who bill fiscal intermediaries and carriers (including DMERCs) for the affected drugs

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is replacing payment limits for the first quarter of 2005 for certain Medicare Part B drugs, effective January 1, 2005.

CAUTION – What You Need to Know

The revised payment limits apply to dates of service on or after January 1, 2005, and on or before March 31, 2005. Please note that the related CR 3695 makes revisions to the earlier CR 3539 and that the revised payment limits in this notification supercede the payment limits for these codes in any publication published prior to this document.

GO – What You Need to Do

To ensure accurate claims processing, please review the information included here and stay current with guidelines on Medicare Part B drugs and biologicals.

Background

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

The ASP payment methodology is based on data submitted to CMS by manufacturers at the 11-digit national drug code (NDC) level. CMS uses published drug pricing compendia and other sources to identify the number of billable units per NDC.

Through receipt of additional data, CMS has determined that certain payment limits included in the first quarter of calendar year 2005 (1Q05) Medicare Part B drug pricing file require revision. The revised payment 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 supercede the payment limits for these codes in any publication published prior to this document.

The affected drugs and the associated revised payment limits are contained in the following table.

HCPCS	Short Description	HCPCS Code Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit
90747*	ENGERIX-B	40 mcg	$113.91	$113.91
J0835	Inj cosyntropin per0.25 MG	0.25 mg	$64.60	$64.60
J1563	IV immune globulin	1 g	$56.72	$56.72
J1564	Immune globulin 10 mg	10 mg	$0.57	$0.57
J1655	Tinzaparin sodium injection	1000 IU	$2.60	$2.60
J2324	Nesiritide	0.25 mg(revised)	$73.33	$73.33
J3315	Triptorelin pamoate	3.75 mg	$180.93	$180.93
J3470	Inj hyaluronidase	up to 150 units	$20.00	$20.00
J7030	Sodium chloride	1000 cc	$0.10	$0.10
J7350	Injectable human tissue	10 mg	$4.53	$4.53
J7611	Albuterol concentrated form	1 mg	$0.07	$0.07
J8501	Oral aprepitant	5 mg	$4.62	$4.62
J9185	Fludarabine phosphate inj	50 mg	$272.09	$272.09
J9214	Intron-A	1 unit	$13.12	$13.12
Q0179	Zofran	8 mg	$30.86	$30.86
Q2014	Geref	0.5 mg	$8.77	$8.77

*The revised payment limit for 90747 is based on the pricing methodology for vaccines (95 oercent AWP).

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

Additional Information

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

On the above page, scroll down the CR NUM column on the right to find the link for CR 3695. Click on the link to open and view the file for the CR.

You may also refer to the earlier CR 3539 for additional background information – CR 3695 makes revisions to information provided in CR 3539.

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

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

Related Change Request (CR) Number: 3695
Related CR Release Date: January 13, 2005
Related CR Transmittal Number: 134
Effective Date: January 1, 2005
Implementation Date: January 18, 2005

Source: CMS Pub. 100-20, Transmittal 134, CR 3695

Instructions for Completion of Form CMS-1450

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

Provider Types Affected

Providers who submit Form CMS-1450 to Medicare intermediaries for billing

Provider Action Needed

STOP – Impact to You

The National Uniform Billing Committee (NUBC) has approved the use of a new condition code and value code.

CAUTION – What You Need to Know

A new condition code form locator (FL) 24-30 (80 – Home Dialysis – Nursing Facility) and a new value code FL 39-41 (P1-Do Not Resuscitate Order [DNR]) have been added to the updated instructions and a definition has been removed from patient status code for FL 19 (Type of Admission/Visit).

GO – What You Need to Do

To ensure accurate claims processing, please review the information included here and stay current with updated instructions for completion of form CMS-1450 for billing (Medicare Claims Processing Manual, Chapter 25, Section 60).

Background

Section 42 CFR 424.5(a)(5) requires providers of services to submit a claim for payment prior to any Medicare reimbursement.

The CMS-1450 Part A claim form is used to collect claim information for payment. Instructions for completion are the same for inpatient and outpatient claims unless otherwise stated.

Please note the following updates:

- For Type of Admission/Visit (FL 19) the definition from code 9 "Information Not Available" will be removed (but the code will be kept).
- **Effective April 1, 2005**, Medicare intermediaries, including regional home health intermediaries (RHHIs), will accept, in FL 24-30, the condition code 80 "Home Dialysis – Nursing Facility."
- **Effective January 1, 2005**, Medicare intermediaries will accept, in FL 39-41, the value code of P1 – Do Not Resuscitate Order (DNR). ***This code is for public health data reporting only.*** This code indicates that a DNR order was written at the time of or within the first 24 hours of the patient's admission to the hospital and is clearly documented in the patient's medical record.

Additional Information

The official instruction issued regarding this change can be found online, referenced via CR 3543, at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

On the above online page, scroll down the CR NUM column on the right to find the link for CR 3543. Click on the link to open and view the file for the CR.

The revised Chapter 25, Section 60 of the Medicare Claims Processing Manual is attached to CR 3543 and this chapter provides the updated instructions for completion of form CMS-1450 for billing.

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

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

Related Change Request (CR) Number: 3543
Related CR Release Date: November 12, 2004
Related CR Transmittal Number: 368
Effective Date: January 1, 2005 and April 1, 2005 as noted in the article
Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 368, CR 3543

Provider Customer Service Program—Changes to Medicare Part A Provider Call Center Inquiries

The Provider Customer Service Program (PCSP) launched by First Coast Service Options, (FCSO) and the Centers for Medicare & Medicaid Services (CMS) this month continues to move forward. As we outlined in our previous communications (see the *What's New* Page on our website), our goal is to offer to our provider community services and technologies to help you access the information you need to better manage your business. And, we continue to strive to deliver timely responses to your questions.

Beginning February 1, 2005, and continuing through a 30-day grace period until March 2, 2005, FCSO Part A Customer Service Representatives will continue to answer multiple questions per call. Effective March 3, 2005, **three** questions per call will be the maximum allowed. In the past, a small number of providers have addressed more than **three** questions per call.

Implementing this change will enable us to improve the quality and timeliness of service to all our customers.

As always, you are able to perform a variety of self-service functions by calling our IVR at 1-877-602-8816. You can check claim status and eligibility, access information from CMS and FCSO Part A Publications, and obtain definitions for remittance codes. We developed this guide to improve your ability to navigate through the options available on IVR. To access the guide on this website, go to the "Contact Us" section on the navigation bar. Then, click on the link to the guide **under** the Medicare Part A bar.

Psychotherapy Notes

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

Provider Types Affected

Psychotherapists and providers billing Medicare carriers or fiscal intermediaries (FIs) for psychotherapy services.

Provider Action Needed

This article and related CR 3457 provide information about instructions to Medicare carriers/intermediaries not to deny claims for psychotherapy on the basis that providers failed to produce psychotherapy notes in response to a broad carrier/intermediary request for documentation. Providers are exempt from submitting psychotherapy notes without patient authorization when the notes in question fit the Final Privacy Rule, 45 CFR, Section 164.501. However, patient authorization is not required for the release of information excluded from the definition of psychotherapy notes, and the provider should release the nonpsychotherapy note material to demonstrate medical necessity. If the provider does not submit sufficient information to demonstrate that services were medically necessary, the claim will be denied.

Background

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 a medical record (see Final Privacy Rule, 45 CFR, Part 164.501).

The definition of psychotherapy notes expressly excludes the following information:

- Medication prescription and monitoring,
- Counseling session start and stop times,
- Modalities and frequencies of treatment furnished,
- Results of clinical tests, and any summary of: diagnosis, functional status, treatment plan, symptoms, prognosis, progress, and progress to date.

The preceding class of information does not qualify as psychotherapy note materials, and physically integrating this information into protected psychotherapy notes does not automatically transform it into protected information.

It is important to note that if a provider has combined information excluded from the definition of psychotherapy notes with a psychotherapy note (e.g., symptoms), it is the responsibility of the provider to extract the information needed to support that a Medicare claim is reasonable and necessary.

Also, providers are exempt from submitting psychotherapy notes without patient authorization when the notes in question fit the Privacy Rule definition in, 45 CFR, Part 164.501.

Implementation

The implementation date for this instruction is February 22, 2005.

Related Instructions

The Medicare Program Integrity Manual (Pub. 100-08), Chapter 3, Subsection 3.4.1.2 (Additional Documentation Requests [ADR] During Prepayment or Postpayment MR) has been revised to reflect this change. The updated manual instructions are attached to the official instruction released to your carrier/intermediary. You may view that instruction by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that web page, look for CR 3457 in the CR NUM column on the right, and click on the file for that CR.

Additional Information

The Code of Federal Regulations, Title 45 (Public Welfare and Human Services), Part 164 (Security and Privacy), Subpart E (Privacy of Individually Identifiable Health Information), Section 164.501 (Definitions) [45 CFR, Sec. 164.501] can be found at the following Health and Human Services (HHS) websites:
http://www.hhs.gov/ocr/hipaa/privrulepd.pdf
http://www.hhs.gov/ocr/regtext.html.

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: 3457
Related CR Release Date: January 21, 2005
Related CR Transmittal Number: 98
Effective Date: February 22, 2005
Implementation Date: February 22, 2005

Source: CMS Pub. 100-8, Transmittal 98, CR 3457

Coming Soon—The New Medicare Prescription Drug Program

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

The First in a Series of Medlearn Matters Articles for Providers On Medicare's New Prescription Drug Program

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

On January 1, 2006, a very important new benefit will be available to your Medicare patients. These new Medicare Prescription Drug Plans will be of significant value to your patients by providing assistance with prescription drug expenses. This program is authorized under the Medicare Modernization Act of 2003 (MMA). Your patients may ask you about this new benefit.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) is preparing an extensive campaign for both providers and beneficiaries, and will be disseminating information to these audiences. Over the next year, as materials are developed, you will be notified through a series of Medlearn Matters articles and other resources. Some providers will choose to be active in giving information to their Medicare patients, and we will help you do that. CMS encourages and appreciates the work providers are willing to do to help people with Medicare learn about this important new benefit.

GO – What You Need to Do

Stay informed. Go to the newly established website: *http://www.cms.hhs.gov/medicarereform/pdbma/* and check it often as new information is always being added. This easy-to-use website has a "General Information" link to the press releases, issue papers, fact sheets, and full copies and summaries of both regulations. Users can follow the menu and select the area that best matches their area of interest. Refer your Medicare patients to information resources – **1-800- MEDICARE** and *http://www.medicare.gov*.

Background

On December 8, 2003, the Medicare Modernization Act (MMA) was enacted, adding a very important new benefit to the Medicare program. This new benefit takes effect on January 1, 2006, and provides a much needed new drug benefit to help serve the 41 million Americans who rely on Medicare for their health care needs.

On January 21, 2005, Health and Human Services Secretary Tommy G. Thompson announced the final regulations establishing the new Medicare prescription drug benefit program. This is a very important step in making this great addition to the Medicare program a reality for your Medicare patients.

This is a very special time for your patients with Medicare, full of many exciting program improvements and enhancements. Great opportunities exist right now, through the MMA, to make the Medicare program more personalized and more up to date, and to keep it up to date. The Medicare Drug Benefit is a major step in that direction. A very important step toward fulfilling that opportunity is in the final regulation for the Medicare Drug Benefit program. Along with the new Medicare preventive benefits, this major program improvement brings Medicare's coverage up to date with 21st Century prevention-minded medicine.

WE NEED YOUR HELP

Because people with Medicare trust their physicians, other clinicians, pharmacists, and other health care providers, you are in a unique position to direct them to the resources available to help them learn about the new benefit. If any of your patients rely on caregivers, CMS appreciates your efforts to get this information into their hands as well.

CMS will be pursuing a number of activities to make sure the physician, provider, and supplier communities know about this new benefit, understand how it works, and will be highlighting the information that may be of most value to your Medicare patients. As educational materials are developed, you will be notified of their availability. These materials will help you and your staff to understand the new benefit. CMS will keep you up-to-date with education and outreach efforts on the new drug benefit. Here's how you can stay connected:

- Pay attention to correspondence from your Medicare carrier or fiscal intermediary or 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.
- 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). Medlearn Matters articles provide succinct and timely messages on Medicare claims processing and other changes. These articles can be found on the web at: *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. Information regarding these open door forums may be found on the Web at: *http://www.cms.hhs.gov/opendoor*.

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

Source: CMS Special Edition Medlearn Matters SE0501

Medicare Prescription Drug, Improvement and Modernization Act of 2003 Information for Medicare Rural Health Providers, Suppliers, and Physicians

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

Provider Types Affected

Medicare rural providers, suppliers, and physicians

Provider Action Needed

This Special Edition summarizes and explains rural health provisions included in the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003.

Hospital Inpatient Prospective Payment System (PPS)

MMA Section 401 – *As of April 1, 2004*

The urban and rural standardized amounts under the Hospital Inpatient PPS will be permanently equalized by establishing a single base payment or standardized amount for hospitals in all areas of the 50 states, the District of Columbia, and Puerto Rico. The Centers for Medicare & Medicaid Services (CMS) has implemented the following:

- Equalized the standard amounts from April 1, 2003 to March 31, 2004
- Increased the large urban and other area national adjusted amounts for Puerto Rico retroactive to October 1, 2003
- Equalized the Puerto Rico-specific urban and other area rates.

Although these changes were not effective in Medicare systems until April 1, 2004, CMS has calculated the payment necessary to make up for the six months that Puerto Rico and other areas did not receive payments equal to Puerto Rico urban rates.

MMA Section 401(d)(2) – *From April 1, 2004 through September 30, 2004*

Puerto Rico-specific other area rates will exceed the Puerto Rico urban rate so that the requirements of the provision can be implemented without reprocessing claims.

MMA Section 402 – *For discharges on or after April 1, 2004*

The Disproportionate Share Hospital (DSH) adjustment for rural hospitals, rural referral centers, Sole Community Hospitals (SCHs), and urban hospitals with fewer than 100 beds will be increased. The cap on the adjustment will be 12 percent, except for hospitals classified as rural referral centers. The formulas to establish a hospital's DSH payment adjustment are based on the following:

- Hospital's location
- Number of beds
- Status as a rural referral center or SCH.

Under section 1886(d)(5)(F) of the Social Security Act (SSA), Medicare makes additional DSH payments to acute hospitals that serve a large number of low-income Medicare and Medicaid patients as part of its Inpatient PPS.

The new DSH adjustment is not applicable to Pickle Hospitals, as defined at section 1886(d)(5)(F)(i)(II) of the SSA.

Effective April 1, 2001, as specified in §211 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000, all inpatient PPS hospitals that meet the number of beds requirement are eligible to receive DSH payments when their DSH patient percentage meets or exceeds 15 percent.

MMA Section 504 – *For discharges occurring on April 1, 2004 through September 30, 2004*

The current blend of input into Medicare payments will be changed from 50 percent for national and 50 percent for Puerto Rico to 62.5 percent for national and 37.5 percent for Puerto Rico.

On October 1, 2004, the blend will be further adjusted to 75 percent for national and 25 percent for Puerto Rico.

For discharges occurring on or after April 1, 2004 through September 30, 2004, the new fixed-loss amount used to determine the cost outlier threshold is $30,150.

This fixed-loss amount is part of the equation used to determine inpatient operating and capital-related costs in both the operating PPS and the capital PPS. Because the fixed-loss amount is being changed for discharges during this period, the resultant new capital PPS rates are $413.48 for national and $202.96 for Puerto Rico.

These rates were determined by an updated national Geographic Adjustment Factor/Diagnosis-Related Group (GAF/DRG) adjustment factor of 1.0025 with an outlier adjustment of 0.9508 and a Puerto Rico GAF/DRG adjustment factor of 1.0011 with an outlier of 0.9922.

Hospital Inpatient PPS Wage Index

MMA Section 403(b) – *For discharges occurring on or after October 1, 2004*

The percentage of hospital inpatient PPS payment adjustment based on the area hospital wage index will be decreased from 71.1 percent to 62 percent. These payments are adjusted by the hospital wage index of the area where the hospital is located or the area in which the hospital is classified. The decrease in the percentage of hospital inpatient PPS adjustment is applicable only if the hospital would receive higher total payments.

Hospital Market Basket Weight Updates

MMA Section 404 – *By October 1, 2005*

The frequency with which CMS revises the category weights, re-evaluates the price priorities for the category weights, and rebases the hospital market basket will be determined. The hospital market basket weights are currently updated once every five years. Annual Hospital Inpatient PPS standardized amount increases are determined in part by the projected increase in the hospital market basket, which is the factor used to estimate the change in price of goods and services used to furnish inpatient hospital care.

MMA of 2003 Information for Medicare Rural Health Providers, Suppliers, and Physicians (continued)

Critical Access Hospitals (CAHs)

MMA Section 405(a)

CAHs will be paid under the *Standard Method Payment – Cost-Based Facility Services with Billing of Carrier for Professional Services*, unless they elect to be paid under the Optional (Elective) Payment Method.

For cost reporting periods beginning on or after January 1, 2004:

Outpatient CAH services payments have been increased to the lesser of the following:

- Eighty percent of the 101 percent of reasonable costs for CAH services, which is up from 100 percent of reasonable costs for CAH services; **or**
- One hundred and one percent of the reasonable cost of the CAH in furnishing CAH services minus the applicable Part B deductible and coinsurance amounts.

As of January 1, 2004:

The Optional Payment Method – Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for professional services for outpatient CAH services is based on the sum of the following:

- The lesser of 80 percent of 101 percent of the reasonable cost of the CAH in furnishing CAH services **or** 101 percent of the outpatient services less applicable Part B deductible and coinsurance amounts;
  and
- One hundred and fifteen percent of the allowable amount, after applicable deductions, under the Medicare physician fee schedule for physician professional services. Payment for non-physician practitioner professional services is 115 percent of 85 percent of the allowable amount under the MPFS.

MMA Section 405(a) – *For cost reporting periods beginning on or after January 1, 2004*

Reimbursement for services furnished will be based on 101 percent of the CAH's reasonable costs, up from 100 percent of reasonable costs.

MMA Section 405(b) – *For services furnished on or after January 1, 2005*

Cost-based reimbursement is extended to on-call emergency room physician's assistants, nurse practitioners, and clinical nurse specialists who are on-call emergency room providers.

MMA Section 405(c) – *For services furnished on or after July 1, 2004*

Periodic interim payments will be paid every two weeks to CAHs that provide inpatient services and meet certain requirements.

MMA Section 405(d) – *For cost reporting periods beginning on and after July 1, 2004*

Physicians or other practitioners providing professional services in the hospital are not required to reassign their Part B benefits to the CAH in order for the CAH to select the Optional Payment Method. The following applies:

- For CAHs that elected the Optional Payment Method before November 1, 2003 for a cost reporting period that began on or after July 1, 2001, the effective date of this rule is retroactive to July 1, 2001.
- For CAHs that elected the Optional Payment Method on or after November 1, 2003, the rule will be effective for cost reporting periods beginning on or after July 1, 2004.

MMA Section 405(e) – *Beginning on January 1, 2004*

Prior to January 1, 2004, a CAH could not operate more than 15 acute care beds or more than 25 beds if it included up to 10 swing beds.

CAHs may operate up to 25 beds for acute (hospital-level) inpatient care, subject to the 96-hour average length of stay for acute care patients. For CAHs with swing bed agreements, any of its beds may be used to furnish either inpatient acute care or swing bed services.

MMA Section 405(f) – *The Medicare Rural Hospital Flexibility Program (FLEX)*

This program has been reauthorized to make grants to all states in the amount of $35 million in each of fiscal years (FY) 2005 through 2008. The FLEX program makes grants for specified purposes to states and eligible small rural hospitals.

MMA Section 405(g) – *For cost reporting periods beginning on or after October 1, 2004*

CAHs may establish psychiatric units and rehabilitation units that are distinct parts (DP) of the hospital. The total number of beds in each CAH DP may not exceed ten. These beds will not count against the CAH inpatient bed limit. The psychiatric and rehabilitation DPs must meet the applicable requirements for such beds in short-term general hospitals, and Medicare payments will equal payments to units of short-term general hospitals for these services.

MMA Section 405(h) – *Until January 1, 2006*

States can continue to certify facilities as necessary providers in order for them to be designated as CAHs.

Low Volume Hospitals

MMA Section 406 – *Effective October 1, 2004*

Low volume hospitals can receive an additional percentage increase, capped at 25 percent, based on the relationship between the cost-per-case and the number of discharges for acute inpatient hospitals. A low volume hospital is a hospital that has fewer than 800 discharges during the fiscal year and is located more than 25 road miles from another acute care hospital.

Hospice

MMA Section 408 – *Effective December 8, 2003*

Nurse practitioners can serve as the attending physician for a patient who elects the hospice benefit. Nurse practitioners acting as the attending physician are prohibited from certifying the terminal diagnosis.

MMA Section 409 – *Demonstration project*

A demonstration project will be conducted for five years to test delivery of hospice care in rural areas, under which Medicare eligible individuals without a caregiver at home may receive care in a facility of 20 or fewer beds. This facility will not have to offer hospice services in the community or comply with the 20 percent limit on inpatient days.

MMA of 2003 Information for Medicare Rural Health Providers, Suppliers, and Physicians (continued)

MMA Section 512 – *Effective on or after January 1, 2005*

MMA provides for coverage of certain physician's services for certain terminally ill patients. Beneficiaries entitled to these services are those who have not yet elected the hospice benefit and have not previously received these services. The covered services include evaluating the patient's need for pain and symptom management, including the need for hospice care, counseling the beneficiary on end-of-life issues and care options, and advising the beneficiary regarding advanced care planning. The covered services are those furnished by a physician who is the medical director or employee of a hospice program.

Federally Qualified Health Centers (FQHCs)

MMA Section 410 – *For services furnished on or after January 1, 2005*

Professional services provided by physicians, physician's assistants, nurse practitioners, and clinical psychologists who are affiliated with FQHCs are excluded from the Skilled Nursing Facility (SNF) PPS in the same manner such services would be excluded if provided by individuals not affiliated with FQHCs.

MMA Section 431 – *Safe harbor*

A final rule will be published that contains standards for a new safe harbor to the anti-kickback statute.

Under this safe harbor, prohibitions against kickbacks will not apply to remuneration under a contract, lease, grant, loan, or other agreement between certain FQHCs and any individual or entity that provides items, services, donations, or loans to the FQHC. The arrangement must contribute to the FQHC's ability to maintain or increase the availability or quality of services provided to a medically underserved population. These standards will determine whether the arrangement:

- Results in savings of federal grant funds or increased funds to the FQHC;
- Expands or limits a patient's freedom of choice; and
- Protects a health care professional's independent judgment regarding the provision of medically appropriate treatment.

Rural Health Clinics (RHCs)

MMA Section 410 – *For services furnished on or after January 1, 2005*

Professional services provided by physicians, physician's assistants, nurse practitioners, and clinical psychologists who are affiliated with RHCs are excluded from the SNF PPS, in the same manner as such services would be excluded if provided by individuals not affiliated with RHCs.

Rural Community Hospitals (RCHs)

MMA Section 410(A) – *Not before October 1, 2004 or later than January 1, 2005*

A five-year demonstration program will be conducted to test the advisability and feasibility of establishing RCHs to provide Medicare covered inpatient hospital services in rural areas. A RCH is a hospital located in a rural area, or reclassified as such, with fewer than 51 acute care beds that is not currently designated or eligible for designation as a CAH and makes 24-hour emergency care services available.

DP psychiatric and rehabilitation beds do not count toward the bed limit. Not more than 15 hospitals in states with low population densities will be selected to participate in the demonstration. Medicare payment to the hospitals will be on the basis of reasonable costs or a "target amount" of prior year reasonable costs plus the increase in the inpatient hospital update factor.

Hold Harmless Reimbursement Provisions

MMA Section 411 – *Beginning with cost reporting periods on and after January 1, 2004*

Hold harmless reimbursement provisions for hospital Outpatient Department (OPD) services performed at small rural hospitals and SCHs will be extended for two years. Under the hold harmless reimbursement provisions, small rural hospitals and SCHs with no more than 100 beds are paid no less under the Hospital OPD PPS than they would have been paid under the prior reimbursement system for covered OPD services provided before January 1, 2004.

Effective January 1, 2006, payments to small rural hospitals and SCHs may be increased if a study finds that rural costs of providing outpatient services is greater than urban costs of providing outpatient services.

Work Geographic Adjustment

MMA Section 412 – *Work geographic index*

The work geographic index will be raised to 1.0 in any physician payment locality where the index is less than 1.0 during 2004, 2005, and 2006. The work geographic index reflects the geographic variation in average professional compensation in one area compared to the national average.

Medicare Incentive Payment Programs for Physician Scarcity Areas (PSAs) and Health Professional Shortage Areas (HPSAs)

MMA Section 413 – *For services furnished on or after January 1, 2005 and before January 1, 2008*

For services furnished on or after January 1, 2005 and before January 1, 2008, a new PSA incentive payment of five percent will be available to primary care and specialty physicians in areas that have few physicians available. Counties will be identified based separately on the ratio of primary care physicians to Medicare eligible individuals residing in the county and on the ratio of specialist care physicians to Medicare eligible individuals residing in the county. To the extent that it is feasible, a rural census tract of a metropolitan statistical area, commonly known as the Goldsmith Modification area, will be counted as a scarcity area.

Effective January 1, 2005, the HPSA incentive payment will be paid automatically for services furnished in full county primary care geographic area HPSAs and mental health HPSAs rather than having the physician identify that the services are furnished in such areas. Services provided in areas other than full county HPSAs will still require the submission of a modifier to receive the bonus payment.

CMS will develop a user-friendly website that contains HPSA and PSA information, and before the beginning of the calendar year, a list of the HPSAs for which the incentive payments will automatically be made for the year.

MMA of 2003 Information for Medicare Rural Health Providers, Suppliers, and Physicians (continued)

Ambulance Services

MMA Section 414 – *Effective July 1, 2004*

An alternate fee schedule phase-in formula will be established for certain providers and suppliers based on a specified blend of the national fee schedule and a regional fee schedule based on census division. This provision is designed to ease the transition to the national fee schedule. If the alternate phase-in formula for a census division results in higher payment, all providers and suppliers in that region will be paid under that formula and their phase-in will last through 2010. Mileage payment increases are as follows:

- Through 2008, mileage payments for ground ambulance trips that are longer than 50 miles will be increased by one-quarter of the payment per mile otherwise applicable to the trip.
- Through 2009, the base payment rate for ambulance trips that originate in rural areas with a population density in the lowest quartile of all rural county populations will be increased by 22.6 percent. This increase is based on the estimated average cost per trip in the lowest quartile as compared to the average cost in the highest quartile of all rural county populations.
- Through 2006, payments will be increased by two percent for rural ground ambulance services and by one percent for non-rural ground ambulance services.

MMA Section 415 – *Effective January 1, 2005*

Rural air ambulance services will be reimbursed at the air ambulance rate if the services:

- Are reasonable and necessary based on the patient's condition at or immediately prior to transport; and
- Meet equipment and crew requirements.

Rural air ambulance services are deemed medically necessary when they are requested by:

- A physician or other qualified person who reasonably determines that land transport would threaten the patient's survival or health; or
- Recognized state or regional emergency medical services personnel.

In most cases, the presumption of medical necessity does not apply if:

- There is a financial or employment relationship between the person requesting the air ambulance or his/her immediate family and the entity furnishing the service; or
- The entity requesting the service owns the entity furnishing the service.

Outpatient Hospital Clinical Diagnostic Laboratory Tests

MMA Section 416 – *For cost reporting periods beginning July 1, 2004 through June 30, 2006*

Part B covered outpatient hospital clinical diagnostic laboratory tests furnished by rural hospitals with fewer than 50 beds located in rural areas with a population density in the lowest quartile of all rural county populations will be reimbursed on a reasonable cost basis.

Telemedicine

MMA Section 417 – *Telemedicine demonstration*

This section extends the telemedicine demonstration four additional years and authorizes an additional $30 million in funding. This demonstration uses high-capacity computer systems and medical informatics to improve primary care and prevent health complications in Medicare eligible individuals with diabetes mellitus who live in isolated rural and inner city areas.

Originating Telehealth Sites

MMA Section 418 – *For Telehealth service beginning on January 1, 2006*

The Health Resources & Services Administration (HRSA), in consultation with CMS, will evaluate the feasibility of including SNFs in the list of permissible originating sites for telehealth services beginning on January 1, 2006.

Home Health (HH) Agencies

MMA Section 421 – *For Medicare Part A and Part B episodes and visits beginning on April 1, 2004 and before April 1, 2005*

There will be a payment increase of five percent to HH agencies for services furnished in rural areas.

MMA Section 701(a) and 701(b) – *HH Payment Update*

These sections provide for holding the HH payment update at the current rate of the HH market basket percentage increase for the last calendar quarter of 2003 and the first calendar quarter of 2004.

Beginning with the last three calendar quarters of 2004 and continuing through calendar years 2005 and 2006, the HH update will be based on the HH market basket percentage increase minus 0.8 percent.

Beginning in 2005, the annual HH PPS update will be effective in January of each year rather than in October.

Unused Resident Positions

MMA Section 422 – *Effective July 1, 2005*

Resident positions from hospitals that have not met their resident full-time equivalent (FTE) cap for the most recently settled or submitted (subject to audit) cost reporting period will be redistributed.

Redistribution of these positions is based on the difference between the hospital's otherwise applicable FTE cap or "otherwise applicable resident limit" and the number of resident slots filled in the most recently settled/submitted cost reporting period or the "reference resident level."

There are some exceptions regarding the expansion of existing programs or previously approved new residency programs that may apply to the calculation of the "reference resident level." Unused residency positions are limited to no more than 25 FTEs. They will be redistributed based on location, with priority given in the following order:

1) Rural hospitals
2) Small urban hospitals
3) Hospitals that are the only ones with a particular residency program in the state. Whether the hospital will be likely to fill such positions within the first three cost periods after the determination is made will be taken into account.

MMA of 2003 Information for Medicare Rural Health Providers, Suppliers, and Physicians (continued)

Expanded Responsibilities of Office of Rural Health Policy
MMA Section 432 – *Effective December 8, 2003*

The HRSA Office of Health Policy's responsibilities will be expanded to include the administration of grants, cooperative agreements, contracts, and other activities that will improve health care in rural areas.

Medicare Payment Advisory Commission (MedPAC) Study
MMA Section 433

The MedPAC will analyze how certain rural sections in the MMA affect total payments, growth in costs, capital spending, and other payments.

Frontier Extended Stay Clinics (FESCs)
MMA Section 434(a) – *Demonstration Project*

A demonstration project will be conducted for three years under which FESCs located in isolated rural areas are treated as Medicare providers. The clinics must be located at least 75 miles from the nearest acute care hospital or be inaccessible by public road. The clinics also must be designed to address the needs of seriously ill, critically ill, or injured patients who, because of adverse weather conditions or for other reasons, need monitoring and observation for a limited period of time.

Indirect Medical Education (IME) Adjustment
MMA Section 502

For discharges occurring between April 1, 2004 and October 1, 2004, the IME add-on percentage will be 5.98 percent; during FY 2005, 5.79 percent; during FY 2006, 5.58 percent; during FY 2007, 5.38 percent; and during FY 2008 and future years, 5.5 percent.

Graduate Medical Education
MMA Section 711

For cost reporting periods beginning on or after October 1, 2004 through September 30, 2013, the freeze on updates to the hospital per resident amounts that exceed 140 percent of the geographically adjusted national average will be reinstated.

MMA Section 712

For cost reporting periods beginning on or after October 1, 2003, regardless of the reduction in the initial period of board eligibility by relevant medical boards, the geriatric exception to allow up to two years of additional training in a geriatrics program is considered part of the initial residency period.

MMA Section 713

For a one-year period beginning on January 1, 2004, hospitals will be allowed to count residents who are training at non-hospital sites in osteopathic and allopathic family programs that have been in existence as of January 1, 2002, regardless of the financial arrangement between the hospital and the supervisory teaching physician.

Additional Information

For detailed information about the MMA, please visit: *http://www.cms.hhs.gov/medicarereform*.

For the MMA Update, please visit: *http://www.cms.hhs.gov/mmu*.

Related Change Request (CR) Number: N/A
Effective Date: N/A
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Source: CMS Special Edition Medlearn Matters SE0450

Recovery Audit Contract Initiative

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

Provider Types Affected

Physicians, providers, and suppliers, especially in California, Florida, and New York

Provider Action Needed

Physicians, providers, and suppliers should note that this initiative is designed to determine whether the use of recovery audit contracts (RACs) will be a cost-effective means of ensuring that you receive correct payments and to ensure that taxpayer funds are used for their intended purpose. As the states with the largest Medicare expenditure amounts, California, Florida, and New York have been selected for pilot RACs that will begin during the first part of 2005 and last for three years. Contractors selected for this pilot program will identify and collect Medicare claim overpayments that were not previously identified by the Medicare affiliated contractors (MACs), which include carriers, fiscal intermediaries (FIs), and durable medical equipment regional carriers (DMERCs).

Background

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, Section 306) directs the secretary of the U.S. Department of Health & Human Services (HHS) to demonstrate the use of RACs under the Medicare integrity program in 1) identifying underpayments and overpayments, and 2) recouping overpayments under the Medicare program (for services for which payment is made under Part A or Part B of Title XVIII of the Social Security Act).

A small percentage of claims (less than five percent) are examined during medical review of claims performed by the MACs, and in annual studies of the Medicare program, claims payment error rates of between six percent and ten percent have been identified. It is further estimated that in the last two fiscal years, Medicare has inappropriately paid out billions of dollars. There is growing concern that the Medicare trust funds may not be adequately protected against erroneous payment through current administrative procedures.

This pilot program is designed to determine whether the use of RACs will be a cost-effective means of adding resources to ensure correct payments are being made to providers. Contractors selected for this pilot program will identify and collect Medicare claim overpayments that were not previously identified by the MACs. To accomplish this, the following is planned:

- There will be RACs for both Medicare Secondary Payer (MSP) and non-MSP claims and activity.
- Compensation for RACs will be provided through retention of a percentage of the overpayment recoveries.

Recovery Audit Contract Initiative (continued)

The following provides additional details about the RACs pilot program:

- Claims reviewed by RACs will have been submitted to the carriers/intermediaries at least a year before to ensure that the ordinary processing will have been completed.
- RACs will 1) perform data analysis to identify areas of investigation, and 2) request claim history information from the carriers/intermediaries.
- Non-MSP RACs will identify and recover claim overpayments only. They will not be permitted to establish cost report overpayments.
- RACs will apply national coverage policies and local coverage determinations (LCDs) that have been approved by the MACs.
- The collection policies to be applied by this pilot will be the same as those currently in effect for the carriers/ intermediaries, including assessment of interest on the portion of any debt that is unpaid 30 days after issuance of the demand letter.
- No new policy will be applied.

In addition:

- Providers will be permitted to appeal any negative determinations to their MAC; and
- If underpayments are determined, the information will be forwarded to the MACs for processing and payment.

CMS selected the following three states with the largest Medicare benefit payment amounts as the pilot states for the recovery audit contracts:

- California
- Florida
- New York

CMS released a request for proposal (RFP) to interested qualified bidders and expects the contractor selections to be made in the beginning of 2005. It is expected that RACs will start work in May of 2005, and the duration of the pilot contracts will be three years.

Each of the three pilot states will have 1) one contractor for non-MSP claim overpayment recovery and 2) another (or possibly the same) contractor for MSP recoveries. To avoid a conflict of interest, current Medicare contractors are not eligible to bid on these contracts.

A complete evaluation of the pilot program will be made before extending it in the three designated states or to additional states.

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*.

Find out more about the Medicare Prescription Drug and Modernization Act of 2003 (MMA) at the following CMS web site: *http://www.cms.hhs.gov/medicarereform/*.

In addition, Section 306 was taken from the MMA and is provided below:

House Rpt.108-181 – PROVIDING FOR CONSIDERATION OF H.R. 1, THE MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003, AND H.R. 2596, HEALTH SAVINGS AND AFFORDABILITY ACT OF 2003

SEC. 306. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.

(a) IN GENERAL- The Secretary shall conduct a demonstration project under this section (in this section referred to as the 'project') to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the Medicare program for services for which payment is made under part A or B of title XVIII of the Social Security Act. Under the project-

1) Payment may be made to such a contractor on a contingent basis;
2) Such percentage as the Secretary may specify of the amount recovered shall be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and
3) The Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(b) SCOPE AND DURATION-

1) SCOPE – The project shall cover at least 2 States that are among the States with-
   (A) The highest per capita utilization rates of Medicare services, and
   (B) At least 3 contractors.
2) DURATION – The project shall last for not longer than 3 years.

(c) WAIVER - The Secretary shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

(d) QUALIFICATIONS OF CONTRACTORS-

1) IN GENERAL – The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has the appropriate clinical knowledge of and experience with the payment rules and regulations under the Medicare program or the entity has or will contract with another entity that has such knowledgeable and experienced staff.
2) INELIGIBILITY OF CERTAIN CONTRACTORS – The Secretary may not enter into a recovery audit contract under this section with an entity to the extent that the entity is a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h), a carrier under section 1842 of such Act (42 U.S.C. 1395u), or a Medicare Administrative Contractor under section 1874A of such Act.
3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY – In

Recovery Audit Contract Initiative (continued)

awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, or under the Medicaid program under Title XIX of the Social Security Act.

(e) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD – A recovery of an overpayment to a provider by a recovery audit contractor shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(f) REPORT – The Secretary shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the Medicare program and recommendations on the cost-effectiveness of extending or expanding the project information means information about a conviction for a relevant crime or a finding of patient or resident abuse.

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

Source: CMS Special Edition Medlearn Matters SE0469

The Centers for Medicare & Medicaid Services Doctors' Office Quality Information Technology Demonstrations: Providing Leadership in the Adoption of Electronic Health Records

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

Provider Types Affected

All providers

Impact on Providers

This article is informational only.

Background

Recent studies have highlighted the potential for health care information technology (HIT) to improve the quality, safety, and efficiency of health care. Systems that enhance patient-clinician communication, access to patient information, as well as decision support and reference data hold the promise of improving the efficiency and effectiveness of healthcare delivery. Additionally, enhanced HIT infrastructure allows the implementation of improved tracking and surveillance applications, which are important in battling emerging public health threats. The Medicare Modernization Act of 2003 encourages the use of HIT to manage the clinical care of beneficiaries.

Furthermore, there is great interest in the integration of HIT in health care systems by patients, payers, and health policy leaders alike. A recent Institute of Medicine (IOM) report, *Fostering Rapid Advances in Health*, called for significant reforms in the practice and organization of medicine and recommended that the U.S. Department of Health & Human Services (DHHS) undertake a number of demonstration projects to stimulate innovation in the adoption of HIT systems in health care.

Despite this momentum, physician offices remain largely unengaged in terms of their adoption and use of e-health technologies. Given that the bulk of patient care is provided in ambulatory settings, the lack of HIT integration precludes potentially significant improvements in quality and efficiency in the delivery of health care. Through its role as a major payer of health care services and sponsor of both the largest national quality improvement program in the Nation, and innovative disease management demonstrations, CMS is actively engaged in fostering IT integration in the Nation's health care system.

The CMS Doctors' Office Quality Information Technology (DOQ-IT) is a major project created to promote electronic health records (EHR) in ambulatory care. This two-year special study demonstration is designed to improve quality of care, patient safety, and efficiency for services provided to Medicare beneficiaries by promoting the adoption of electronic medical records (EMR)/electronic health records (EHR) and HIT in primary care physician offices. This demonstration involves four states: California, Arkansas, Massachusetts and Utah. Lumetra, the California quality improvement organization (QIO), is the lead Medicare QIO and is coordinating the effort through the QIO program in the other three states. The information gained from DOQ-IT will be used solely for the purposes of disseminating the use of HIT, and studying the role of HIT in improving health care delivery in the ambulatory setting. DOQ-IT will not be merged with any enforcement or program integrity efforts.

Additional Information

For additional information please see *http://www.doqit.org* or contact James Sorace MD at jsorace@cms.hhs.gov.

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

Source: CMS Special Edition Medlearn Matters SE0505

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 fiscal intermediaries (FIs) for rural air ambulance services

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 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 which 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 in advance for review and approval. Your intermediary will post instructions for submission of the protocol on its website.

Your intermediary must review the protocol to ensure the contents are consistent with the statutory requirements of 1862(1)(A) directing that all services paid for by Medicare must by reasonable and necessary for the diagnosis or treatment of an illness or injury. The intermediary 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 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 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.

Medical Review of Rural Air Ambulance Service (continued)

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

The official instruction issued to your intermediary 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*.

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 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: 3571
Related CR Release Date: January 14, 2005
Related CR Transmittal Number: 93
Effective Date: January 1, 2005
Implementation Date: February 14, 2005

Source: CMS Pub. 100-8, Transmittal 93, CR 3571

MEDICARE SECONDARY PAYER

Modification to Online Medicare Secondary Payer Questionnaire

The Centers for Medicare & Medicaid Services (CMS) has modified the Internet Only Manual, Pub.5 Medicare Secondary Payer, Chapter 3 –MSP Provider Billing Requirements, Section 20.2.1. – Admission Questions to Ask Medicare Beneficiaries. Question 6 was a duplicate of Question 5 in the Online Medicare Secondary Payer Manual. Question 6 is being changed to reflect the appropriate follow-up question/answer.

Implementation Date

This modification is effective for date of admissions provided on or after February 22, 2005.

Admission Questions to Ask Medicare Beneficiaries

The following chart lists questions *that can be used* to ask Medicare beneficiaries upon each inpatient and outpatient admission. Providers use this chart as a guide to help identify other payers that may be primary to Medicare. *If you choose to use this questionnaire, please note that it was developed to be used in sequence. Instructions are listed after the questions to facilitate transition between questions. The instructions will direct them to the next appropriate question to determine Medicare Secondary Payer situations.*

Part I

1. Are you receiving Black Lung (BL) Benefits?
___ Yes; Date benefits began: CCYY/MM/DD

BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.
___ No.

2. Are the services to be paid by a government program such as a research grant?
___ Yes; Government Program will pay primary benefits for these services
___ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
___ Yes.

DVA IS PRIMARY FOR THESE SERVICES.
___ No.

4. Was the illness/injury due to a work related accident/condition?
___ Yes; Date of injury/illness: CCYY/MM/DD

Modification to Online Medicare Secondary Payer Questionnaire (continued)

Name and address of WC plan:
_____

Policy or identification number: _____
Name and address of your employer:
_____

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS, GO TO PART III.
___ No. **GO TO PART II.**

Part II
1 Was illness/injury due to a non-work related accident?
___ Yes; Date of accident: CCYY/MM/DD
___ No. **GO TO PART III**

2. What type of accident caused the illness/injury?
___ Automobile.
___ Non-automobile.
Name and address of no-fault or liability insurer:
_____
_____
_____
Insurance claim number: _____

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.
___ Other

3. Was another party responsible for this accident?
___ Yes;
Name and address of any liability insurer:
_____
_____
_____
Insurance claim number: _____

LIABILITY INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.
___ No. **GO TO PART III**

Part III
1. Are you entitled to Medicare based on:
___ Age. **Go to Part IV.**
___ Disability. **Go to Part V.**
___ ESRD. **Go to Part VI.**

Part IV - Age
1. Are you currently employed?
___ Yes.
Name and address of your employer:
_____
_____
_____
___ No. Date of retirement: CCYY/MM/DD
___ *No. Never Employed*

2. Is your spouse currently employed?
___ Yes.
Name and address of spouse's employer:
_____
_____
_____
___ No. Date of retirement: CCYY/MM/DD
___ *No. Never Employed*

Modification to Online Medicare Secondary Payer Questionnaire (continued)

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?
___ Yes.
___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.**

4. Does the employer that sponsors your GHP employ 20 or more employees?
___ Yes. **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**
Name and address of GHP:
_____
_____
_____
Policy identification number: _____
Group identification number: _____
Name of policyholder: _____
Relationship to patient: _____
___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

Part V - Disability
1. Are you currently employed?
___ Yes.
Name and address of your employer:
_____
_____
_____
___ No. Date of retirement: CCYY/MM/DD
2. Is a family member currently employed?
___ Yes.
Name and address of your employer:
_____
_____
_____
___ No.

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a family member's current employment?
___ Yes.
___ *No.* ***STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.***

4. Does the employer that sponsors your GHP employ 100 or more employees?
___ Yes. **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**
Name and address of GHP:
_____
_____
_____
Policy identification number: _____
Group identification number: _____
Name of policyholder: _____
Relationship to patient: _____
Membership Number: _____

___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

Modification to Online Medicare Secondary Payer Questionnaire (continued)

Part VI - ESRD

1. Do you have group health plan (GHP) coverage?

Name and address of GHP:

_____
_____
_____

Policy identification number: _____
Group identification number: _____
Name of policyholder: _____
Relationship to patient: _____
Name and address of employer, if any, from which you receive GHP coverage:

_____
_____
_____

___ No. **STOP. MEDICARE IS PRIMARY.**

2. Have you received a kidney transplant?

___ Yes. Date of transplant: CCYY/MM/DD
___ No.

3. Have you received maintenance dialysis treatments?

___ Yes. Date dialysis began: CCYY/MM/DD

If you participated in a self-dialysis training program, provide date training started:
CCYY/MM/DD
___ No

4. Are you within the 30-month coordination period?

___ Yes
___ No. **STOP. MEDICARE IS PRIMARY.**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

___ Yes.
___ No. **STOP. GHP IS PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.**

6. *Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?*

___ Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**
___ No. **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primarily based on age or disability entitlement?

___ Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**
___ No. **MEDICARE CONTINUES TO PAY PRIMARY.**

If no MSP data are found in CWF for the beneficiary, the provider still asks the questions found in section 20.1 and provides any MSP information on the bill using the proper uniform billing codes. This information will then be used to update CWF through the billing process.

Source: CMS Pub. 100-5, Transmittal 23, CR 3504

GENERAL COVERAGE

Update for All PET Scan Services Performed in Critical Access Hospitals

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

Provider Types Affected

Providers and suppliers who bill Medicare carriers and fiscal intermediaries for PET scan services

Provider Action Needed

STOP – Impact to You

This article explains updates to the Medicare Claims Processing Manual related to 2-deoxy-2- [F-18] fluoro-D-glucose positron emission tomography (FDG-PET) scans.

CAUTION – What You Need to Know

Information for the payment method for all PET scans provided in critical access hospitals has also been added to the Medicare Claims Processing Manual.

GO – What You Need to Do

Use of the correct codes and understanding of the reimbursement methods will help Medicare make prompt and correct payments for PET Scan services.

Background

The radiology services and other diagnostic procedures chapter of the Medicare Claims Processing Manual has been updated in regard to billing requirements and coverage for 2-deoxy-2- [F-18] fluoro-dglucose positron emission tomography (FDG-PET) Scans for the differential diagnosis of front-temporal dementia (FTD) and alzheimer's disease (AD).

There are three updates to the Medicare Claims Processing Manual related to FDG-PET scans.

- The previous edit to allow HCPCS G0336 (PET imaging, brain imaging for the differential diagnosis of AD with aberrant features vs. FTD) to be billed no more than once in a beneficiary's lifetime has been removed.
- Medicare carriers and fiscal intermediaries must ensure that an appropriate diagnosis code accompanies the claim with HCPCS G0336. When submitting a claim for a FDG-PET scan, one of the following diagnosis codes must accompany the HCPCS G0336 code: 290.0, 290.10 – 290.13, 290.20 – 290.21, 290.3, 331.0, 331.11, 331.19, 331.2, 331.9, 780.93. Line items with HCPCS code G0336 will be denied if one of the above diagnosis codes is not provided. Such denials will be reflected by claim adjustment reason code 11.
- The payment method for ALL PET scan claims submitted for services provided in critical access hospitals (CAHs) is as follows: CAHs under Method I have technical services paid at 101% of reasonable cost; CAHs under Method II have technical services paid at 101 percent of reasonable cost; and professional services are paid at 115 percent of the Medicare physician fee schedule database.

Affected providers should issue an advanced beneficiary notice to beneficiaries advising them of potential financial liability in the event that one of the appropriate diagnosis codes is not present on the claim.

All other billing requirements for PET Scans for dementia and neurodegenerative diseases remain the same.

Additional Information

The revised portion of Chapter 13, Section 60 of the Medicare Claims Processing Manual can be found as part of the official instruction issued to your carrier/intermediary regarding these changes. That instruction, CR 3640, may be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that web page, look for CR 3640 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: 3640
Related CR Release Date: January 14, 2005
Related CR Transmittal Number: 428
Effective Date: September 15, 2004
Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 428, CR 3640

New Low Risk Diagnosis Code (V72.31) for Pap Smear and Pelvic Examination

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

Provider Types Affected

Physicians billing Medicare carriers and providers billing Medicare fiscal intermediaries for screening Pap smears and pelvic examinations

Provider Action Needed
STOP – Impact to You

Medicare is modifying its claims processing edits for claims for screening Pap smears and pelvic examinations.

CAUTION – What You Need to Know

To ensure accurate Medicare processing of claims for these services, effective July 1, 2005, Medicare is establishing a separate edit for HCPCS code Q0091 – screening Papanicolaou (Pap) smear, obtaining, preparing and sending cervical or vaginal smear to laboratory, to prevent incorrectly paying for claims submitted outside of the frequency, one screening every two year for low risk beneficiaries and one screening every year for high risk beneficiaries. Also, Medicare will accommodate a new diagnosis code, V72.31, in Medicare system edits that are in place for Pap smear and pelvic examination for low risk beneficiaries.

GO – What You Need to Do

Be aware of the specifics in this article to assure accurate and timely processing of your Medicare claims for screening Pap smears and pelvic examination.

Background

Medicare pays for one screening Pap smear every two years for low-risk beneficiaries and one screening Pap smear every year for high-risk beneficiaries.

Currently, HCPCS code Q0091 is not part of the Medicare system editing for screening Pap smear claims. Since Medicare only pays for **one screening Pap smear every two years for low risk beneficiaries,** claims billed outside of this frequency have been processed incorrectly. This has happened on those occasions when physicians perform a screening Pap smear (Q0091) that should not be covered by Medicare because the low-risk patient has already received a covered screening Pap smear (Q0091) in the past two years but requests that the physician perform a screening Pap smear each year. Beginning for dates of service on and after July 1, 2005, these types of claims will deny appropriately. Medicare is establishing a separate edit for Q0091 to capture and reject claims submitted outside of this frequency. In instances where unsatisfactory screening Pap smear specimens have been collected and sent to the clinical laboratory and the clinical laboratory is unable to interpret the test results, another specimen is needed. When billing for sending another specimen to the clinical laboratory, the physicians should use HCPCS code Q0091 along with modifier 76, which will bypass the frequency editing and allow payment to be made for reconveyance of the specimen.

Effective for services rendered on and after July 1, 2005, where physicians must perform a screening Pap smear that they know will not be covered by Medicare because the low-risk beneficiary has already received a covered screening Pap smear in the past two years, the physicians can bill Q0091. The claim will be denied appropriately as being not reasonable and necessary. Thus, in these instances, the physician/provider should be aware that an advance beneficiary notice (ABN) is necessary, since the claim will be denied. The physician/provider should use **modifier GA** on the claim to indicate that an ABN has been obtained.

Finally, physicians/providers should note that a new diagnosis code V72.31 will be added to the edits in Medicare system for low-risk beneficiaries. The V72.31 diagnosis code is to be used on Pap smear and pelvic examination claims to indicate the beneficiary is a low risk patient, but only when a full gynecological examination is performed.

The following chart lists the diagnosis codes that Medicare recognizes for low-risk or high-risk patients for screening Pap smear services with V72.31 recognized as of July 1, 2005.

Low Risk Diagnosis Codes	**Definitions**
V76.2	Special screening for malignant neoplasms, cervix
V76.47	Special screening for malignant neoplasm, vagina
V76.49	Special screening for malignant neoplasm, other sites

Note: Providers use this diagnosis for women without a cervix.

V72.31	Routine gynecological examination

Note: This diagnosis should only be used when the provider performs a full gynecological examination.

High Risk Diagnosis Code

V15.89	Other

Implementation Date

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

Additional Information

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

From that Web page, look for CR 3659 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 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: 3659
Related CR Release Date: January 21, 2005
Related CR Transmittal Number: 440
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 440, CR 3659

Modification to Reporting Diagnosis Codes for Screening Mammography Claims

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

Provider Types Affected

All providers billing Medicare carriers or fiscal intermediaries for screening mammography claims

Provider Action Needed

This article modifies instructions to allow reporting of either diagnosis code V76.11 or V76.12. Providers should note that to ensure proper coding, one of the following diagnosis codes should be reported on screening mammography claims:

- **V76.11** – "Special screening for malignant neoplasm, screening mammogram for high-risk patients" or;
- **V76.12** – "Special screening for malignant neoplasm, other screening mammography"

Background

Effective January 1, 1998, providers only reported diagnosis code V76.12 on screening mammography claims. Effective July 1, 2005, the Centers for Medicare & Medicaid Services (CMS) will now allow reporting of either V76.11 or V76.12 as appropriate.

Implementation

Implementation is July 5, 2005.

Additional Information

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

From that Web page, look for CR 3562 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: 3562
Related CR Release Date: January 14, 2005
Related CR Transmittal Number: 426
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 426, CR 3562

Influenza Treatment Demonstration

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

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

Physicians, providers, and suppliers should note that Medicare will cover four new flu medications, including—where applicable—their generic equivalents. These medications are Amantadine Hydrocloride; Zanamivir, Inhalation Power Administered through Inhaler; Oseltamivir Phosphate, Oral; and Rimantadine Hydrochloide, Oral.

These drugs will be paid under a demonstration from the Centers for Medicare & Medicaid Services (CMS) for dates of service through May 31, 2005. In addition, physicians, providers and suppliers that enroll in Medicare before May 31, 2005 may also file claims for drugs furnished under this demonstration for dates of service beginning when the provider or supplier completes such enrollment.

Background

The Centers for Disease Control and Prevention (CDC) recommends that individuals in the following groups should be vaccinated against influenza annually:

- Adults aged 65 years and older
- Residents of nursing homes and long term care facilities
- Those with underlying chronic medical conditions.

Early in the flu vaccination season it was reported that there would be a shortage of vaccine due to manufacturing problems. Although it appears that there will be ample flu vaccine, many Medicare beneficiaries may not have been vaccinated and remain at risk. Vaccination against flu is still the best protection; however, for those Medicare beneficiaries who have been unable to receive a flu vaccination, the next best approach to protect them is to provide coverage for antiviral medicines that can prevent the complications of influenza infection by reducing the duration and severity of the infection. The shorter the duration of the infection, the less time the individual is contagious to others. In some cases, the antiviral medicine can also act as a primary preventive agent.

Influenza Treatment Demonstration (Continued)

Influenza Treatment Demonstration

CMS is undertaking a demonstration project to measure the impact of providing coverage for certain antiviral drugs to treat and/or prevent influenza.

The Influenza Treatment Demonstration will provide coverage to Medicare beneficiaries for Food and Drug Administration (FDA)-approved drugs for the treatment and targeted prevention of influenza. Specifically, under this demonstration, Medicare will cover certain anti-viral drugs when furnished:

- To a beneficiary with symptoms of influenza;
- As a prophylaxis for a beneficiary exposed to a person with a diagnosis of influenza; or
- To a beneficiary in an institution where there has been an outbreak of influenza.

Note: However, the demonstration does not cover these anti-viral drugs for general prophylactic use.

The following drugs (including, when applicable, bioequivalents or generic equivalents) are included in the demonstration:

- Amantadine hydrocloride, oral
- Zanamivir, inhalation power administered through inhaler
- Oseltamivir phosphate, oral
- Rimantadine hydrochloide, oral.

The drugs under this demonstration must be furnished incident to a physician service or must be prescribed by a physician (or other practitioner authorized by sate law to prescribe such drugs). Except as noted below, all ancillary Medicare rules apply to the furnishing of these drugs to Medicare beneficiaries under this demonstration. Also, information regarding treatment and drug dosage of these influenza antiviral medications is included in the Additional Information Section of this special edition.

The demonstration will include dates of service through May 31, 2005. Also, note that **a**ll claims for drugs furnished under this demonstration **must be filed no later than December 31, 2005.**

Physicians, providers, and suppliers that enroll in Medicare before May 31, 2005 may also file claims for drugs furnished under this demonstration for dates of service beginning when the provider or supplier completes such enrollment.

Payment Amounts

Both the Medicare copayment and deductible apply to all claims under this demonstration, including claims for Medicare Advantage (MA) beneficiaries. The exception is in the calculations of co-payments for beneficiaries participating in the Drug Discount Card program. These beneficiaries will pay the lesser of 20 percent Medicare allowable amount or 20 percent negotiated drug discount sponsor's price for antiviral medicines, plus $.20 (20 percent of a $1.00 administrative charge). A chart explaining how to do the calculations for determining copayment amount for Drug Discount Card participants is attached. CMS will also make this chart available on its website at *http://www.cms.hhs.gov/researchers/demos/flu* and will update cost information monthly. Finally, no deductible will apply to claims from federally qualified health centers (FQHCs).

Except as noted below, the Medicare allowed amount for these demonstration drugs will be based on 95 percent of the average wholesale price (AWP) for the brand name of each drug (Zanamivir and Oseltamivir phosphate) covered under this demonstration, determined in accordance with customary Medicare payment policy. For drugs marketed as bioequivalent or generics (Amantadine and Rimantadine), the allowed amount will be based on 90 percent of AWP.

For the duration of the demonstration, the allowed HCPCS codes/charges are as follows:

G9017 Amantadine Hydrocloride, Oral, per 100 mg, (for use in a Medicare-approved demonstration project), $0.76.

G9018 Zanamivir, Inhalation Powder Administered Through Inhaler, per 10 mg, (for use in a Medicareapproved demonstration project), $5.43.

G9019 Oseltamivir Phosphate, Oral, per 75 mg, (for use in a Medicare-approved demonstration project), $6.99.

G9020 Rimantadine Hydrochloride, Oral, per 100 mg, (for use in a Medicare-approved demonstration project),$1.65.

G9033 Amandatine Hydrocloride, oral, brand, per 100 mg (for use in a Medicare-approved demonstration project), $1.32

G9034 Zanamivir, inhalation powder administered through Inhaler, brand, per 10 mg, (for use in a Medicare-approved demonstration project), $5.43

G9035 Oseltamivir phosphate, oral brand, per 75 mg, (for use in a Medicare-approved demonstration project), $6.99.

G9036 Rimantadine hydrochloride, oral brand, per 100 mg, (for use in a Medicare-approved demonstration project), $2.17.

Those entities that are to be paid on a basis other than of 90 percent or 95 percent of AWP are as follows:

- Indian health service (IHS) hospitals will be reimbursed on the basis of the outpatient all-inclusive rate.
- IHS critical access hospitals (CAHs) will be reimbursed on the basis of a facility-specific visit rate.

Influenza Treatment Demonstration (Continued)

- Rural health clinics (RHCs) and federally qualified health centers (FQHCs) will be reimbursed on the basis of the all-inclusive rate when one of the drugs is furnished as part of a billable encounter under revenue code 052x. An encounter cannot be billed if furnishing the drug is the only service the RHC/FQHC provides. (Although the provision of these drugs in and by themselves does not constitute a billable encounter in the RHC/FQHC setting, the cost of the drugs can be claimed on the RHC/FQHC cost report and bundled into the all-inclusive payment rate calculation.)
- Maryland hospitals that are under the jurisdiction of the Health Services Cost Review Commission (HSCRC) are paid under the Maryland waiver.

Billing Instructions

Claims for drugs furnished under this demonstration may be submitted by enrolled Medicare providers as follows: hospitals including CAHs, skilled nursing facilities (SNFs), renal dialysis facilities (RDFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs) and by enrolled physicians, other practitioners, or other suppliers that are authorized under state law to dispense these drugs.

Except as noted below, providers, physicians, and other suppliers must follow customary Medicare billing and claims processing rules.

- An entity possessing a supplier number issued by the National Supplier Clearinghouse (NSC) must bill the DMERC having jurisdiction for the location of the beneficiary's permanent residence.
- All hospitals (other than Indian Health Service [IHS] hospitals, IHS-CAHs, Maryland hospitals as noted above, and hospitals which do not have a supplier number issued by the NSC) must bill the appropriate DMERC using the CMS-1500 or electronic equivalent. Otherwise, billing by the hospital is to the fiscal intermediary on the CMS-1450/UB-92 or electronic equivalent.
- All other institutional providers, not possessing an NSC-issued supplier number, must bill the fiscal intermediary on the CMS-1450/ UB-92 or electronic equivalent.
- All physicians, practitioners, and other suppliers, not possessing an NSC-issued supplier number, must submit claims to their local area carrier using the CMS-1500 or electronic equivalent.
- HHAs should follow billing requirements already in place for vaccines when billing for these drugs as specified in Pub. 100-4, Chapter 18, Section 10.2.3, which may be accessed at *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.
- All institutional providers billing their fiscal intermediary must submit a separate claim for these drugs.
- Roster billers submit claims in accordance with the instructions specified in Pub.100-4, Chapter 18, Section 10.3, except:
  - HCPCS codes G0008, G0009, 90657, 90658, 90659, and 90732 should not be reported on the same roster bill under this demonstration.
  - An administration fee will not be paid for drugs administered under this demonstration.
  - Roster billers must bill different dates of service, dosages, codes, and quantities on different roster or claims forms.
  - Payment may be made for MA beneficiaries under this demonstration and such claims should be reported to the provider's regular carrier or intermediary.
  - Medicare Advantage (MA) plans, if enrolled in-fee-for service billing, must bill for these items using their normal procedures for billing for Medicare fee-for-service items and services. Providers and suppliers may submit claims for MA beneficiaries to their normal FI or carrier.

Acceptance of assignment is mandatory for all claims submitted under this demonstration and Medicare secondary payer (MSP) rules apply to claims under this demonstration.

Implementation

The implementation date for this instruction is January 17, 2005.

Additional Information

Treatment and Drug Dosage of Influenza Antiviral Medications[1]

You are referred to the Centers for Disease Control and Prevention website (Antiviral Agents for Influenza: Background Information for Clinicians) at: *http://www.cdc.gov/flu/professionals/antiviralback.htm*.

Treatment

For the treatment of influenza, controlled studies have found that neuraminidase inhibitor drugs (Zanamivir, Oseltamivir) and adamantane derivative drugs (Amantadine, Rimantadine) administered within 48 hours of illness onset, decrease viral shedding and reduce the duration of influenza A illness by approximately one day compared with placebo. The usual recommended duration of treatment is five days.

Influenza Treatment Demonstration (Continued)

Chemoprophylaxis

Known exposure: For chemoprophylaxis of known exposure, treatment should begin within two days of contact with an infected individual and continue for two weeks.

In lieu of vaccination: To be maximally effective as prophylaxis in lieu of vaccination, influenza antiviral medications must be taken each day for the duration of influenza activity in the community. However, one study of amantadine or rimantadine prophylaxis reported that the drugs could be taken only during the period of peak influenza activity in a community.[2]

Outbreak in an institution: For residents of an institution, chemoprophylaxis is recommended during an outbreak, and should be continued for at least two weeks. If surveillance indicates that new cases continue to occur, chemoprophylaxis should be continued until approximately one week after the end of the outbreak.

[1] Source: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5306a1.htm.

[2] Patriarca PA, Arden NH, Koplan JP, Goodman RA. Prevention and control of type A influenza infections in nursing homes: benefits and costs of four approaches using vaccination and amantadine. Ann Intern Med 1987; 107:732—40.

Dosage:

Recommended Daily Dosage of Influenza Antiviral Medications for Treatment and Prophylaxis[3]

Antiviral Agent	**Age Groups (yrs)**	
	64-64	**> 65**
Amantadine* (Symmetrel®)		
Treatment, influenza A	100mg twice daily §	< 100 mg/day
Prophylaxis, influenza A	100mg twice daily §	< 100 mg/day
Rimantadine (Flumadine®)		
Treatment, ** influenza A	100mg twice daily §§	100 mg/day
Prophylaxis, influenza A	100mg twice daily §	100 mg/day
Zanamivir*††† (Relenza®)**		
Treatment, influenza A and B	10mg twice daily	10mg twice daily
Oseltamivir (Tamiflu®)		
Treatment, §§§ influenza A and B	75mg twice daily	75mg twice daily
Prophylaxis, influenza A and B	75mg/day	75mg/day

***** The drug package insert should be consulted for dosage recommendations for administering amantadine to persons with creatinine clearance < 50 ml/min/1.73m 2.

† 5 mg/kg of amantadine or rimantadine syrup = 1 tsp/22 lbs.

§ Children > 10 years who weigh <40 kg should be administered amantadine or rimantadine at a dosage of 5 mg/kg/day.

A reduction in dosage to 100 mg/day of rimantadine is recommended for persons who have severe hepatic dysfunction or those with creatinine clearance < 10 mL/min. Other persons with less severe hepatic or renal dysfunction taking 100 mg/day of rimantadine should be observed closely, and the dosage should be reduced or the drug discontinued, if necessary.

** Only approved by FDA for treatment among adults.

§§ Rimantadine is approved by FDA for treatment among adults. However, certain experts in the management of influenza consider it appropriate also for treatment among children. (See American Academy of Pediatrics, 2000 Red Book.)

Older nursing-home residents should be administered only 100 mg/day of rimantadine. A reduction in dosage to 100 mg/day should be considered for all persons aged > 65 years if they experience possible side effects when taking 200 mg/day.

******* Zanamivir administered via inhalation using a plastic device included in the medication package. Patients will benefit from instruction and demonstration of the correct use of the device.

††† Zanamivir is not approved for prophylaxis.

§§§ A reduction in the dose of oseltamivir is recommended for persons with creatinine clearance <30 ml/min.

[3] *http://www.cdc.gov/flu/professionals/antiviralback.htm*

Further Claims Preparation Instructions

Because Medicare carriers will hold claims received until Medicare systems changes are made on January 17, 2005, interest will be paid to providers, where applicable, when the held claims are processed on or after January 17, 2005. In addition, physicians, providers, and suppliers should note the following:

- The type of service code for these claims is “1”.
- An appropriate diagnosis code must be included on the claim in order to be HIPAA compliant.
- Carriers will apply the 5 percent reduction in payment on claims from nonparticipating physicians.

Influenza Treatment Demonstration (Continued)

- Assignment is mandatory for all claims filed under this demonstration.
- Providers billing for services under this demonstration for hospice patients should include condition code 07 on the claim.
- Hospitals, SNFs, CORFs, renal dialysis facilities, CAHs, IHS hospitals, and IHS CAHs should use revenue code 0636 along with the appropriate HCPCS code.
- Billing for codes G9017, G9018, G9019, G9020, G9033, G9034, G9035, or G9036 must be done on separate claims and **no other codes may be present on such claims.**
- For claims submitted to intermediaries, providers should use types of bill (TOB) 12x, 13x, 22x, 23x, 34x, 72x, 75x, or 85x. **Claims submitted with any other TOB for services under this demonstration will be returned to the provider.**
- Drugs covered under this demonstration will be payable even if the beneficiary has already received a flu vaccine.
- Beneficiaries may receive no more than two of the drugs permitted under this demonstration (e.g., the same drug twice or a combination of two different drugs).
- Medicare will not pay for HCPCS code G0008 (administration fee) under this demonstration.

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***.**

From that Web page, look for CR 3696 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.

ATTACHMENT: LOOK-UP TABLE FOR CALCULATING BENEFICIARY CO-PAYMENT FOR ANTIVIRAL INFLUENZA TREATMENT

INSTRUCTIONS FOR USING THIS TABLE

Note: **This table is only used to calculate the beneficiary co-payment amount for those participating in the Medicare Drug Discount Card Program.**

1. Locate the name of the Medicare Drug Discount Card Sponsor in column A, or the Sponsor's plan number in column B.
2. Locate the prescribed medicine in column C through I.
3. Find the cost per unit for the prescribed medicine for the specific Card Sponsor.
4. Multiply the unit cost of the medicine by the number of units in the prescription, PLUS $1.00, to calculate the total Drug Card Sponsor's cost.
5. Multiply the Medicare Allowed Payment Amount by the number of units in the prescription to calculate the Medicare allowed cost.
6. Compare the total cost of the Drug Card Sponsor with the total cost of the Medicare allowed cost.
7. If the total Medicare allowed cost is less than the total Drug Card Sponsor's cost the co-payment will be 20 percent of the Medicare Allowed cost.
8. If the total Drug Card Sponsor's cost is less than the Medicare allowed cost the co-payment will be 20 percent of the Drug Card Sponsor's costs.

** In either case Medicare will reimburse the pharmacy 80 percent of the Medicare allowed cost.

Related Change Request (CR) Number: 3696
Related CR Release Date: January 21, 2005
Related CR Transmittal Number: N/A
Effective Date: December 1, 2004
Implementation Date: January 17, 2005.

Source: CMS Pub. 100-20, Transmittal 136, CR 3696

MEDICARE ALLOWED PAYMENT AMOUNT		$0.76	$0.76	$1.32	$5.43	$1.65	$2.17	$6.99
(includes 5% or 10% reduction from AWP)					(per 10mg)			
A	B	C	D	E	F	G	H	I
Plan Name	Dnum	AMANTADINE 100MG CAPSULE	AMANTADINE 100MG TABLET	FLUMADINE 100MG TABLET	RELENZA 5MG DISKHALER	RIMANTADINE 100MG TABLET	SYMMETREL 100MG TABLET	TAMIFLU 75MG GELCAP
Anthem Drug Discount Card	D7000	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
MedCare USA, Powered by MedImpact	D7001	0.0864	0.2113	0.4195	0.4901	0.3227	0.2451	1.2622
aClaim RxSavings Club	D7002	0.0871	0.1680	0.4147	0.4689	0.2567	0.2545	1.3328
AmeriHealth RxSavings	D7005	0.1082	0.2089		0.4954		0.2545	1.2831
InStil Health Solutions	D7007	0.0864	0.2113	0.4195	0.4901	0.3227	0.2451	1.2622
HealthSpring of Alabama Prescription Advantage	D7008	0.0994	0.2112	0.4195	0.4765	0.3224	0.2574	1.2562
HealthSpring of Illinois Prescription Advantage	D7009	0.0994	0.2112	0.4195	0.4765	0.3224	0.2574	1.2562
HealthSpring Prescription Advantage	D7010	0.0994	0.2112	0.4195	0.4765	0.3224	0.2574	1.2562
Texas HealthSpring Prescription Advantage	D7011	0.0994	0.2112	0.4195	0.4765	0.3224	0.2574	1.2562
Horizon RxSavings	D7013	0.1082	0.2089		0.4954		0.2545	1.2831
Priority Plus	D7015	0.0871	0.1680	0.4290	0.4932	0.2567	0.2633	1.2685
PBM Plus Senior Care	D7016	0.1181	0.2401	0.4767	0.5561	0.3024	0.2925	1.5320
The Pharmacy SmartCard	D7017	0.0560	0.1300	0.4147	0.5182	0.2750	0.2423	1.3328
myPharmaCare	D7019	0.1028	0.2089	0.4147	0.4787	0.3187	0.2423	1.3328
Liberty Prescription Discount Card	D7020	0.0933	0.1800	0.4147	0.4787	0.2750	0.2423	1.2348
ScriptSave Premier	D7021	0.1119	0.2161	0.4290	0.5063	0.3300	0.2507	1.3137
Blue Cross Blue Shield of Alabama's BlueRx	D7027	0.0889	0.2089	0.4147	0.4787	0.2794	0.2545	1.2348
Aetna Rx savings Card (SM)	D7028	0.1119	0.2161	0.4290	0.5063	0.3300	0.2507	1.3137
RxSavings distributed by Reader's Digest	D7029	0.1119	0.2161		0.5483		0.2779	1.4171
RxSavings distributed by Reader's Digest	D7029	0.1121	0.2401		0.5956		0.2925	1.4937
RxSavings distributed by MCS Life Insurance Company	D7030	0.1121	0.2401		0.5956		0.2925	1.4937
Anthem Drug Discount Card VA	D7031	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card NH	D7032	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card CO	D7033	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card IN	D7034	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348

MEDICARE ALLOWED PAYMENT AMOUNT		$0.76	$0.76	$1.32	$5.43	$1.65	$2.17	$6.99
(includes 5% or 10% reduction from AWP)					(per 10mg)			
A	B	C	D	E	F	G	H	I
Plan Name	Dnum	AMANTADINE 100MG CAPSULE	AMANTADINE 100MG TABLET	FLUMADINE 100MG TABLET	RELENZA 5MG DISKHALER	RIMANTADINE 100MG TABLET	SYMMETREL 100MG TABLET	TAMIFLU 75MG GELCAP
Anthem Drug Discount Card ME	D7035	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card KY	D7036	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card OH	D7037	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card CT	D7038	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Preferred Prescription Discount Card	D7041	0.0965	0.2089	0.4147	0.4703	0.3190	0.2545	1.2140
Prescription Discount Card	D7042	0.0965	0.2089	0.4147	0.4799	0.3190	0.2545	1.2377
BlueSaver Premier	D7043	0.1095	0.2113	0.4195	0.4944	0.3227	0.2451	1.2831
First Health Services Medicare Drug Discount Card	D7046	0.1119	0.1920	0.4290	0.5360	0.2934	0.2633	1.3788
First Health Services Medicare Drug Discount Card	D7046	0.1119	0.2161	0.4290	0.5360	0.3300	0.2633	1.3788
ArgusRx	D7047	0.0933	0.1800	0.4147	0.4753	0.2750	0.2545	1.2225
RxSavings	D7049	0.1119	0.2161		0.5483		0.2779	1.4171
RxSavings	D7049	0.1121	0.2401		0.5956		0.2925	1.4937
RxSavings distributed by BlueCross BlueShield of Tennessee	D7057	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by BlueCross BlueShield of South Carolina	D7058	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by Wellmark BlueCross BlueShield	D7060	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by Fidelis Care New York	D7062	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by OSF HealthPlans	D7063	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by Premier Plus	D7064	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by Texan Plus	D7066	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by Mennonite Mutual Aid Association	D7068	0.1119	0.2161		0.5483		0.2779	1.4171
RxSavings distributed by UCare Minnesota	D7069	0.1082	0.2089		0.4954		0.2545	1.2831
EnvisionRx Plus	D7070	0.1057	0.2041	0.4290	0.4867	0.3117	0.2507	1.3788

MEDICARE ALLOWED PAYMENT AMOUNT		$0.76	$0.76	$1.32	$5.43	$1.65	$2.17	$6.99
(includes 5% or 10% reduction from AWP)					(per 10mg)			
A	B	C	D	E	F	G	H	I
Plan Name	Dnum	AMANTADINE 100MG CAPSULE	AMANTADINE 100MG TABLET	FLUMADINE 100MG TABLET	RELENZA 5MG DISKHALER	RIMANTADINE 100MG TABLET	SYMMETREL 100MG TABLET	TAMIFLU 75MG GELCAP
Rx Savings Access Card	D7071	0.1082	0.2089	0.4147	0.4786	0.3190	0.2423	1.2348
Pharmacy Care Alliance (Option A)	D7072	0.1011	0.2160	0.4290	0.4884	0.3297	0.2632	1.2869
Pharmacy Care Alliance (Option B)	D7073	0.1011	0.2160	0.4290	0.4884	0.3297	0.2632	1.2869
AARP Prescription Discount Card	D7074	0.1011	0.2280	0.4529	0.5182	0.3480	0.2779	1.3635
SHL RxCard	D7075	0.1028						1.3328
ScripSolutions Freedom	D7076	0.1095	0.2113	0.5638	0.5144	0.3224	0.2574	1.2501
ScripSolutions Choice	D7077	0.1095	0.2113	0.5638	0.5144	0.3224	0.2574	1.2501
American Advantage-Med	D7079	0.1004	0.2089	0.4243	0.4924	0.3190	0.2479	1.2885
American Prescription Plan	D7080	0.1119	0.2161		0.5483		0.2779	1.4171
PrimeScript	D7081	0.1082	0.2089	0.4290	0.5182	0.3190	0.2633	1.3328
SXC Health Solutions, Inc.	D7082	0.0933	0.1800	0.4147	0.4787	0.2750	0.2423	1.2348
Walgreens Health Initiatives Prescription Discount Drug Card	D7083	0.0995	0.1920	0.4147	0.4742	0.2934	0.2545	1.2228
Walgreens Health Initiatives Prescription Discount Drug Card	D7083	0.1244	0.2401	0.4767	0.5956	0.3748	0.2925	1.5320
PrecisionDiscounts (Option A)	D7084	0.0746	0.1755	0.4290	0.4966	0.2748	0.2633	1.2808
Public Sector Partners Prescription Drug Discount Card	D7086	0.0933	0.1800	0.4147	0.5182	0.2750	0.2423	1.2103
Rx for Less delivered through UPMC for Life	D7087	0.1095	0.2113	0.4195	0.4872	0.3227	0.2574	1.3482
Sav-Rx Med-Advantage Prescription Discount Card	D7088	0.1004	0.2089	0.4243	0.4882	0.3190	0.2479	1.2801
U Share Prescription Drug Discount Card	D7089	0.0965	0.2089	0.4147	0.4703	0.3190	0.2545	1.2140
Community Care Rx	D7090	0.0884	0.1637	0.4147	0.4935	0.3024	0.2423	1.3328
Community Care Rx	D7090	0.0884	0.1637	0.4147	0.4935	0.3024	0.2423	1.3328
Criterion Advantage	D7091	0.0884	0.1637	0.4147	0.4935	0.3024	0.2423	1.3328
Criterion Advantage	D7091	0.0884	0.1637	0.4147	0.4935	0.3024	0.2423	1.3328
Golden Buckeye	D7092	0.0884	0.1637	0.4147	0.4935	0.3024	0.2423	1.3328

MEDICARE ALLOWED PAYMENT AMOUNT		$0.76	$0.76	$1.32	$5.43	$1.65	$2.17	$6.99
(includes 5% or 10% reduction from AWP)					(per 10mg)			
A	B	C	D	E	F	G	H	I
Plan Name	Dnum	AMANTADINE 100MG CAPSULE	AMANTADINE 100MG TABLET	FLUMADINE 100MG TABLET	RELENZA 5MG DISKHALER	RIMANTADINE 100MG TABLET	SYMMETREL 100MG TABLET	TAMIFLU 75MG GELCAP
Advantra X-tra Drug Discount Card Program	D7095	0.1082	0.2089		0.4954		0.2545	1.2831
BD Advantage Drug Discount Card	D7096	0.1119	0.2161				0.2779	1.4171

HOSPITAL SERVICES

Clarification of Medicare's Transfer Policy Under the Inpatient Prospective Payment System

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

Provider Types Affected

Hospitals paid under the Inpatient Prospective Payment System (IPPS) by Medicare fiscal intermediaries (FIs)

Provider Action Needed

Affected hospitals should note that this special edition article addresses the circumstances in which:

1) A patient is admitted to a hospital.
2) It is determined that the patient requires surgery or additional treatment.
3) The patient wants to be transferred in order to have a particular surgeon perform the surgery or possibly to be closer to home.

Background

Transfers between hospitals occur when a patient is admitted to one hospital and is subsequently transferred to another hospital for additional treatment once the patient's condition has stabilized or a diagnosis is established. In certain circumstances, a patient is admitted to a hospital, it is determined that surgery or additional treatment is required, and the patient subsequently desires to be transferred to another hospital so that he/she can have a particular surgeon perform the surgery or possibly to be closer to home.

In this situation:

- Beneficiaries may transfer from one hospital to another as long as the second hospital participates in the Medicare program.
- The patient must be formally released/discharged from the initial hospital before the process of transferring to another hospital can proceed.

According to 42 Code of Federal Regulations (CFR) 412.4 (d), the hospital that transfers the inpatient to another Medicare hospital, under the circumstances described in paragraph (b)(1) or (c) of that section of the CFR, is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the amount that would have been paid if the patient had been discharged to another setting.

The payment is determined by dividing the appropriate IPPS rate by the geometric mean length of stay for the specific diagnosis related group (DRG) under which the patient was treated. The graduated payment is two times the per diem rate for the first day and the per diem amount for each subsequent day up to the full DRG payment.

The first hospital receives the per diem payment from Medicare Part A as described in the previous paragraph and the second hospital performing the surgery would receive Medicare's payment for the assigned DRG. Both hospitals may want to work closely with the Medicare Part A intermediary regarding any additional billing.

Additional Information

The following was taken from the Code of Federal Regulations Title 42, Volume 2, Parts 400 to 429, revised as of October 1, 2000. It is also available at the following GPO website: *http://www.access.gpo.gov/nara/cfr/waisidx_00/42cfr412_00.html*.

TITLE 42-PUBLIC HEALTH, CHAPTER IV
HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES
PART 412-PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES
Table of Contents: Subpart A-General Provisions, Sec. 412.4 Discharges and Transfers.

(a) Discharges. Subject to the provisions of paragraphs (b) and (c) of this section, a hospital inpatient is considered discharged from a hospital paid under the prospective payment system when-

(1) The patient is formally released from the hospital; or
(2) The patient dies in the hospital.

(b) Transfer-Basic rule. A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this part if the discharge is made under any of the following circumstances:
(1) From a hospital to the care of another hospital that is-
(i) Paid under the prospective payment system; or
(ii) Excluded from being paid under the prospective payment system because of participation in an approved Statewide cost control program as described in subpart C of part 403 of this chapter.
(2) From one inpatient area or unit of a hospital to another inpatient area or unit of the hospital that is paid under the prospective payment system.

(c) Transfers-Special 10 DRG rule. For discharges occurring on or after October 1, 1998, a discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in Sec. 412.60(c), to one of the qualifying diagnosis-related groups (DRGs) listed in paragraph (d) of this section and the discharge is made under any of the following circumstances-
(1) To a hospital or distinct part hospital unit excluded from the prospective payment system under subpart B of this part.
(2) To a skilled nursing facility.
(3) To home under a written plan of care for the provision of home health services from a home health agency and those services begin within three days after the date of discharge.

Clarification of Medicare's Transfer Policy Under the Inpatient Prospective Payment System (continued)

(d) Qualifying DRGs. The qualifying DRGs for purposes of paragraph (c) of this section are DRGs 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483.

(e) Payment for discharges. The hospital discharging an inpatient (under paragraph (a) of this section) is paid in full, in accordance with Sec. 412.2(b).

(f) Payment for transfers.

(1) General rule. Except as provided in paragraph (f)(2) or (f)(3) of this section, a hospital that transfers an inpatient under the circumstances described in paragraph (b) or (c) of this section, is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the amount that would have been paid under subparts D and M of this part if the patient had been discharged to another setting. The per diem rate is determined by dividing the appropriate prospective payment rate (as determined under subparts D and M of this part) by the geometric mean length of stay for the specific DRG to which the case is assigned. Payment is graduated by paying twice the per diem amount for the first day of the stay, and the per diem amount for each subsequent day, up to the full DRG payment.

(2) Special rule for DRGs 209, 210, and 211. A hospital that transfers an inpatient under the circumstances described in paragraph (c) of this section and the transfer is assigned to DRGs 209, 210 or 211 is paid as follows:

(i) 50 percent of the appropriate prospective payment rate (as determined under subparts D and M of this part) for the first day of the stay; and

(ii) 50 percent of the amount calculated under paragraph (f)(1) of this section for each day of the stay, up to the full DRG payment.

(3) Transfer assigned to DRG 385. If a transfer is classified into DRG 385 (Neonates, died or transferred) the transferring hospital is paid in accordance with Sec. 412.2(b).

(4) Outliers. Effective with discharges occurring on or after October 1, 1984, a transferring hospital may qualify for an additional payment for extraordinarily high-cost cases that meet the criteria for cost outliers as described in subpart F of this part.

[63 FR 41003, July 31, 1998, as amended at 65 FR 47106, Aug. 1, 2000]

If you have any questions regarding this issue, 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: N/A
Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Matters SE0459

Use of Modifiers 52, 73 and 74 for Reduced or Discontinued Services

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

Provider Types Affected

Providers and hospitals paid under the hospital outpatient prospective payment system (OPPS) by Medicare fiscal intermediaries (FIs)

Provider Action Needed

This article and related CR 3507 clarifies 1) the definition of anesthesia for purposes of billing for services furnished in the hospital outpatient department and 2) the use of modifiers 52, 73 and 74 that are reported under OPPS for reduced or discontinued services.

Background

Because of recent questions received by the Centers for Medicare & Medicaid Services (CMS), CR 3507 was issued to clarify:

- The definition of anesthesia for purposes of billing for services furnished in the hospital outpatient department.
- The CMS policy regarding the use of modifiers 52, 73, and 74 reported under OPPS.

For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include:

- Local, regional block(s),
- Moderate sedation/analgesia ("conscious sedation"),
- Deep sedation/analgesia, and
- General anesthesia.

The OPPS modifiers 52, 73 and 74 are used to report procedures that are discontinued by a physician due to unforeseen circumstances, and for surgeries and certain diagnostic procedures requiring

- The hospital **may receive 50 percent of the OPPS** payment amount for the discontinued procedure if:
  - The procedure is discontinued after 1) the beneficiary was prepared for the procedure **and** 2) the beneficiary was taken to the room where the procedure was to be performed.
- The hospital **may receive the full OPPS payment amount** for the discontinued procedure if:
  - The procedure is discontinued after 1) the beneficiary has received anesthesia **or** 2) the procedure was started (e.g., scope inserted, intubation started, incision made).

Use of Modifiers 52, 73 and 74 for Reduced or Discontinued Services (continued)

To provide additional clarity:

- Modifier 73 is used by the facility to indicate that a surgical or diagnostic procedure **requiring anesthesia** was terminated due to extenuating circumstances that threatened the well being of the patient after the patient had been prepared for the procedure and been taken to the procedure room.
- Modifier 74 is used by the facility to indicate that a surgical or diagnostic procedure **requiring anesthesia** was terminated after the induction of anesthesia or after the procedure was started, e.g., the incision made, intubation started, or scope inserted.
- Modifier 52 is used to indicate partial reduction or discontinuation of radiology procedures and other services that do not require anesthesia.

Note: Discontinued radiology procedures that do not require anesthesia may not be reported using modifiers 73 and 74.

Implementation

The implementation date for CR 3507 is February 22, 2005.

Additional Information

The Medicare Claims Processing Manual (Pub. 100-04), Chapter 4, has been revised to reflect these clarifications. The 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*.

From that Web page, look for CR 3507 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: 3507
Related CR Release Date: January 21, 2005
Related CR Transmittal Number: 442
Effective Date: February 22, 2005
Implementation Date: February 22, 2005

Source: CMS Pub. 100-4, Transmittal 442, CR 3507

Override of Medicare System Edit for Observation Services Exceeding 48 Hours

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

Provider Types Affected

Hospitals

Provider Action Needed

STOP – Impact to You

Medicare system edits do not allow claims to be paid for observation services greater than 48 hours.

CAUTION – What You Need to Know

When the hours are found to be reasonable and necessary, fiscal intermediaries (FIs) will be able to override the Medicare system edits on affected hospital outpatient claims submitted with units of services for observation greater than 48 hours.

GO – What You Need to Do

You must give the beneficiary an advance beneficiary notice (ABN) per the Medicare Claims Processing Manual, Chapter 30, Financial Liability Protections, 40.3.1, if you submit claims for observation services greater than 48 hours.

Background

Currently, Medicare edits do not allow claims greater than 48 hours that are submitted showing the units of service for observation (revenue code 0762) for processing. The FI suspends the claim and will request complete medical documentation to review the medical necessity of all observation services billed.

If additional hours are not found to be reasonable and necessary, all hours beyond 48 hours are denied and shown as a noncovered service on the claim. However, if the hours are found to be reasonable and necessary the claims cannot be processed at this time for payment due to the Medicare system edit.

Changes will be made by Medicare to allow the edit to be overridden to allow payment of these claims as of April 1, 2005.

Additional Information

For details on policy see Section 70.4 of the Medicare Benefit Policy Manual.

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

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

Related Change Request (CR) Number: 3311
Related CR Release Date: October 22, 2004
Related CR Transmittal Number: 120
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

Source: CMS Pub. 100-204, Transmittal 120, CR 3311

Fact Sheet Available on "Inpatient Rehabilitation Facility Classification Requirements"

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

Provider Types Affected

All hospitals or units of a hospital that are classified under subpart B of part 412 of the Medicare regulations as inpatient rehabilitation facilities (IRFs). Medicare payments to IRFs are based on the IRF prospective payment system (PPS) under subpart P of part 412.

Provider Action Needed

No provider action is necessary. The Centers for Medicare & Medicaid Services (CMS) has issued Fact Sheet #1 titled "Inpatient Rehabilitation Facility Classification Requirements." The fact sheet is informational only and elaborates on the revised classification requirements for IRFs described in CR 3334 (Transmittal 221) and CR 3503 (Transmittal 347) issued on June 25, 2004 and October 29, 2004, respectively. The purpose of the fact sheet is to update the status of the initiatives that CMS is actively pursuing and to highlight specific aspects of the operational procedures as described regarding the classification requirements for IRFs. We are also addressing the provision of the Consolidated Appropriations Act, of 2005 regarding how the application of the revised classification requirements may affect IRFs. The fact sheet can be accessed via the CMS IRF website.

The direct Web address to the fact sheet is: *http://www.cms.hhs.gov/providers/irfpps/fs1classreq.pdf*.

Or the "Fact Sheet" links can be used from the IRF home page at: *http://www.cms.hhs.gov/providers/irfpps/default.asp*.

Additional Information

To view CR 3334, please go to: *http://www.cms.hhs.gov/manuals/pm_trans/R221CP.pdf*.

To view CR 3503, go to: *http://www.cms.hhs.gov/manuals/pm_trans/R347CP.pdf*.

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

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

Related Change Request (CR) Number: 3334, 3503
Related CR Release Date: June 25, 2004 (CR 3334), October 29, 2004 (CR 3503)
Related CR Transmittal Number: 221 (CR 3334), 347(CR 3503)
Effective Date: July 1, 2004, N/A
Implementation Date: July 1, 2004 (CR 3334), November 29, 2004 (CR 3503)

Source: CMS Special Edition Medlearn Matters SE0509

Change in the Type of Bill for Billing Diagnostic and Screening Mammographies

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

Provider Types Affected

Hospitals

Provider Action Needed

STOP – Impact to You

Effective April 1, 2005, the correct type of bill (TOB) for billing Medicare for diagnostic and screening mammographies is 13x.

CAUTION – What You Need to Know

Effective for dates of service of April 1, 2005 and later, diagnostic screening and mammographies should no longer be billed using TOB 14x. Payment will not be made for such services if billed with TOB 14x for services on or after April 1, 2005.

GO – What You Need to Do

Make sure that billing staffs are aware of this change to avoid payment delays.

Additional Information

This change applies to hospitals billing on TOB 13x for HCPCS codes of *76082*, *76083*, *76090*, *76091*, *76092*, G0202, G0204, and G0206.

TOB 22x, 23x and 85x remain as appropriate TOBs for providers other than hospitals.
If you have additional 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: 3469
Related CR Release Date: October 29, 2004
Related CR Transmittal Number: 337
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 337, CR 3469

Update to Fiscal Year 2005 Wage Index for Hospital Inpatient and Outpatient Prospective Payment Systems

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

Provider Types Affected

Providers who bill fiscal intermediaries (FI) for claims paid under the hospital inpatient prospective payment system (IPPS) or outpatient prospective payment system (OPPS)

Provider Action Needed

STOP – Impact to You

This change request and the attachments outline updates to fiscal year (FY) 2005 wage index for IPPS and OPPS hospitals. The corrected wage index tables have been published in the December 30, 2004 *Federal Register* Correction Notice to the IPPS Final Rule.

CAUTION – What You Need to Know

This update, based on a correction notice to the *Federal Register*, also updates the information published in CR 3459 and in *Medlearn Matters* article MM3459. *Medlearn Matters* article MM3459 was published in the First Quarter 2005 *Medicare A Bulletin* (pages 31-35).

GO – What You Need to Do

Please note that the corrected tables are available for download on the IPPS website at: *http://www.cms.hhs.gov/providers/hipps/ippswage.asp*.

To ensure accurate claims processing: Please review the information included here and in the corrected tables mentioned above to stay current with instructions pertaining to FY 2005 wage index.

Background

The updated wage index values for the core-based statistical area (CBSA) designations are listed in Attachment 1 of CR 3672.

Attachment 2 of CR 3672 lists changes for hospitals that require a special wage index. Attachment 2 includes blended wage indexes, hold harmless wage indexes and other special wage index exceptions that have changed since CR 3459 was released. Attachment 2 is also updated to include providers who are located in CBSAs listed in Attachment 1 where the changes to the wage data have caused their wage index values to change.

Providers that do not appear on Attachment 2 and/or Table 2 of the December 30, 2004 IPPS Correction Notice, will need to refer to the provider's CBSA wage index on Table 4A2 of the IPPS Correction Notice and the provider's MSA wage index on Table 4A1.

Providers reclassified under 1886(d)(8) or 1886(d)(10) should refer to Table 4C1 and 4C2 of the IPPS Correction Notice. If the CBSA wage index on table 4A2 is higher than the MSA wage index, the provider should receive the CBSA wage index.

For any providers that have an MSA wage index that is higher than the CBSA wage index a blended wage index is computed by taking: (.50*MSA Wage Index +.50*CBSA Wage Index).

In accordance with section 412.316, the geographic adjustment factor (GAF) under the capital PPS is based on the hospital wage index value that is applicable to the hospital under 412.63(k) (that is, the operating PPS). Therefore, if a hospital receives a "special wage index" (i.e., section 508 reclassification, 50/50 blended MSA/CBSA wage index, or the out-commuting adjustment) under the operating PPS, then its GAF is computed from that "special wage index" value. The GAF is calculated as the wage index is raised to the 0.6848 power.

Additional Information

The official instruction issued regarding this change can be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R422CP.pdf*.

Please note that the corrected tables are also available for download on the IPPS website at: *http://www.cms.hhs.gov/providers/hipps/ippswage.asp*.

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: 3672
Related CR Release Date: December 30, 2004
Related CR Transmittal Number: 422
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Source: CMS Pub. 100-4, Transmittal 422, CR 3672

CRITICAL ACCESS HOSPITAL SERVICES

Special Rules for Critical Access Hospital Outpatient Billing

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

Note: This Medlearn Matters article was revised on December 3, 2004, to make a correction to show that critical access hospital (CAH) outpatient reimbursement under the optional payment method is the sum of physician/professional services and outpatient services, including ASC type services. An article related to new requirements for CAH was published in the Second Quarter 2004 *Medicare A Bulletin* (page 57).

Provider Types Affected

Critical access hospitals (CAHs)

Provider Action Needed

CAHs need to be aware of some key changes resulting from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

STOP – Impact to You

The percentage of reasonable cost, as the basis for CAH outpatient services, has increased, while the notification time for the election of payment methodology has decreased. Additionally, a CAH may now hold more hospital beds.

CAUTION – What You Need to Know

The percentage of reasonable cost as the basis for reimbursement was raised to 101percent of reasonable cost (up from 100 percent), while the notification time for election of payment methodology (for the standard or optional payment method) was decreased from 60 days to 30 days. Additionally, the limit for CAH inpatient beds was increased from 15 to 25 beds.

GO – What You Need to Do

Note these changes. Refer to the *Additional Information* section for more information about the standard and optional payment methods and for access to the original CR.

Background

Under previous law, CAHs were paid reasonable costs for outpatient services. The MMA, section 405(e), amended that law to ensure that, if the CAH elected the standard method of payment, then payment to CAHs for outpatient services would be made at 101 percent of the reasonable costs of those services, after application of deductible and coinsurance provisions.

In addition, the CAH must choose whether they wish to be reimbursed according to the standard or optional payment methodology. If the CAH opts for the optional method, the election must be made in writing 30 days prior to the affected cost reporting period. This must be done for each cost reporting period; otherwise the standard payment method will be used.

Additional Information

The following is a brief description of the standard and optional payment methods.

Standard Payment Method

CAH outpatient services will be reimbursed at the lesser of:

1. **80 percent of 101 percent** (up from 100 percent as of January 1, 2004) of reasonable cost for CAH services,

OR

2. **101 percent** of reasonable cost for CAH services, less the applicable Part B deductible and coinsurance amounts.

Optional (Elective) Payment Method (Services Furnished On or After July 1, 2001)

CAH outpatient services' reimbursement will be the **sum** of Physician/Professional Services + Outpatient Services (including ASC type services).

1. Physician/Professional Services – 115 percent of what would be paid under the physician fee schedule (after applicable deductions) for physician outpatient services and 115 percent of 85 percent of the allowable amount for non-physician practitioner professional services,

AND

2. Outpatient Services – 101 percent of the reasonable costs of the services. The lesser of: 80 percent of **101 percent** (up from 100 percent as of Jan. 1, 2004) of reasonable cost for CAH services;

OR

3. **101 percent** of reasonable cost for CAH services, less the applicable Part B deductible and coinsurance amounts.

For a more detailed comparison of the two payment methods, please refer to Chapter 4 of the Medicare Claims Processing Manual (Pub 100-04), sections 250.1 and 250.2. The table of contents for this Manual may be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

Once at this site, scroll down to Chapter 4 and select the version of Chapter 4 that you wish to view.

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*.

Once at that Web page, look for 3051 in the CR NUM column on the right and click on the file for that CR.

Related Change Request (CR) Number: 3051
Related CR Release Date: January 16, 2004
Related CR Transmittal Number: R63CP
Effective Date: January 1, 2004
Implementation Date: January 1, 2004

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

Change to the Skilled Nursing Facility Consolidated Billing Edits for Method II Payment Option

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 under the method II payment option

Provider Action Needed

STOP – Impact to You

If method II payment option is used by the CAH, it can bill and be paid for physician services without being subject to skilled nursing facility (SNF) consolidated billing (CB).

CAUTION – What You Need to Know

Outpatient claims containing professional services are billed by CAHs on type of bill (TOB) 85x to the FI. Also, CAHs must use revenue codes 96x, 97x, or 98x to identify professional fees on the TOB 85x. Like professional services billed to the carrier, the specific line items containing revenue codes for professional services are excluded from the requirement for CB.

GO – What You Need to Do

As of July 5, 2005 use the new TOB with codes but see related instructions.

Background

Effective July 1, 2001, the Benefits Improvement and Protection Act (BIPA) established payment method II, in which CAHs can bill and be paid for physician services billed to their intermediary. Under the method II option, a CAH:

- Would bill the professional services on a TOB 85x to their Medicare intermediary; and
- Must use revenue codes 96x, 97x or 98x to identify the professional fees on the TOB 85x.

Note: Claims for CAH inpatient and swing bed services are not affected since these revenue codes, if they appeared on these claim types, do not receive separate payment.

This instruction requires the CWF to bypass SNB CB edits for line items containing revenue codes 96x, 97x, or 98x on a TOB 85x. This bypass will ensure that physicians' services billed to intermediaries by CAHs will not receive incorrect SNF CB edits. Section 1888 of the Social Security Act codifies SNF PPS and CB.

Since this change is effective for services provided on or after July 1, 2001, Medicare intermediaries will override the timely filing requirement for such claims and allow them to be processed.

Implementation Date

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

Additional Information

The Medicare Claims Processing Manual (Pub. 100-04), Chapter 6 (SNF Inpatient Part A Billing), Section 20 (Services Included in Part A PPS Payment Not Billable Separately by the SNF), has been revised. The revision is 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*.

From that Web page, look for CR 3561 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 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: 3561
Related CR Release Date: January 14, 2005
Related CR Transmittal Number: 429
Effective Date: July 1, 2001
Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 429, CR 3561

LOCAL COVERAGE DETERMINATIONS

In accordance with publications specified by CMS, Medicare contractors no longer distribute full-text local medical review policies (LMRPs)/local coverage determinations (LCDs) to providers in hardcopy format. Providers may obtain full-text LMRPs/LCDs from the provider education website *www.floridamedicare.com*. 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 Web site, *http://www.floridamedicare.com*; click on the "Join our electronic mailing list FCSO *eNews*" bar and follow the prompts.

More Information

For more information, or to obtain a hardcopy of a specific LMRP/LCD if you do not have Internet access, contact the Medical Policy department at:

Medical Policy – 19T
First Coast Service Options, Inc.
P.O. Box 2078
Jacksonville, FL 32231-0048
or call 1-904-791-8465

Local Coverage Determination Table of Contents

Additions/Revisions to Existing Local Medical Review Policies/ Local Coverage Determinations

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*.

ADDITIONS/REVISIONS TO LMRPs/LCDs

A29540: Strapping—Addition to Policy

The local coverage determination for strapping was last updated on July 22, 2004.

The following additional ICD-9-CM codes were added to the "ICD-9 Codes that Support Medical Necessity" section of the policy since they are appropriate for strapping:

- 733.93 – Stress fracture of tibia or fibula
- 733.94 – Stress fracture of the metatarsals
- 733.95 – Stress fracture of other bone

A separate coding guidelines attachment is not applicable to this policy.

Effective Date

This addition is effective for services provided **on or after October 14, 2004**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

A55873: Cryosurgical Ablation of the Prostate—Revision to Policy

The local medical review policy (LMRP) for cryosurgical ablation of the prostate was last updated on July 1, 2001

Based upon CMS Change Request 3168, dated July 30, 2004, revenue code 034x for this service has been corrected to 036x. Therefore, the LMRP has been revised accordingly. The policy has also been revised to delete type of bill code 12x (inpatient ancillary charges) and to add type of bill code 85x (critical access hospital).

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

Effective Date

These revisions are effective for claims processed **on or after January 1, 2005.** The full-text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* on or after this effective date.

A72192: Computed Tomography of the Pelvis—Revision to Policy

The local medical review policy (LMRP) for computed tomography of the pelvis was last updated on October 1, 2003.

A request was made to add additional ICD-9-CM codes to the computed tomography of the pelvis local coverage determination. The request for these additional ICD-9-CM codes was determined to be valid. Therefore, the following ICD-9-CM codes were added to the "ICD-9 Codes that Support Medical Necessity" section of the policy.

152.0-152.9	158.0-158.9	159.0-159.9	170.6	171.3
172.9	176.0-176.9	184.1-184.4	187.1-187.7	195.8
196.8	198.82	199.0-199.1	200.01-200.04	200.07
200.11-200.14	200.17	200.21-200.24	200.27	200.80-200.88
202.00-202.68	202.81-202.84	202.87	202.90-202.98	204.00-204.01
204.10-204.11	211.2	213.6	215.3	221.1-221.2
221.8-221.9	222.0-222.9	223.0-223.9	230.3	230.5
230.6	230.7	235.5	236.3	236.4
236.6	236.91	239.0	239.2	592.1
592.9	V55.3	V55.5		

ICD-9-CM codes identified as secondary diagnoses cannot be billed as primary diagnoses.

The following diagnosis codes – V42.0, V42.84, V44.3, and V44.50-V44.59, identified as secondary diagnoses, have been removed from this policy. Other ICD-9-CM codes already present in the policy were identified as replacements or additional codes were added to replace the deleted V-codes. ICD-9-CM 996.81 and 996.87 can be used in place of V42.0 and V42.84, respectively. ICD-9-CM V55.3 and V55.5 have been added to the policy to replace V44.3 and V44.50-V44.59, respectively.

In addition, type of bill codes 14x, 21x and 22x were removed from the policy.

The policy has also been converted to the local coverage decision (LCD) format.

Effective Date

These revisions are effective for services provided **on or after November 18, 2004**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

A90901: Biofeedback—Addition to Policy

The local coverage determination for biofeedback was last updated on December 6, 2004. Since that time, type of bill 74x (outpatient rehabilitation facility) has been added to the policy.

Effective Date

This addition is effective for claims processed **on or after December 6, 2004.** The full-text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* on or after this effective date.

A91110: Wireless Capsule Endoscopy—Addition to Policy

The local medical review policy for wireless capsule endoscopy was last revised on January 1, 2004.

A request was made to expand indications of the policy to include the use of wireless capsule endoscopy for the initial diagnosis of suspected Crohn's disease when there is no evidence provided by conventional diagnostic tests. After reviewing recent literature, it was determined that this was a valid request.

Coverage had been expanded to include the use of wireless capsule endoscopy for the initial diagnosis of Crohn's Disease. ICD-9-CM code 555.9 has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy. Type of bill code 12x has been added as a valid type of bill for billing this service.

The policy has also been converted to the local coverage decision (LCD) format.

Effective Date

This addition is effective for services provided **on or after January 4, 2005**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

AG0108: Diabetes Outpatient Self-Management Training—Addition to Policy

The local coverage determination (LCD) for diabetes outpatient self-management training was last updated on January 1, 2004.

CMS Change Request 3531, dated October 29, 2004, has expanded the type of bill codes for this service to include 22x (skilled nursing facility). Therefore, the LCD has been revised accordingly.

Effective Date

This addition is effective for services provided **on or after January 1, 2005.** The full-text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* on or after this effective date.

AJ1440: G-CSF (Filgrastim, Neupogen®)—Addition to Policy

The local medical review policy (LMRP) for G-CSF (Filgrastim, Neupogen®) was last updated on April 10, 2003. Since that time, ICD-9-CM diagnosis code 995.2, unspecified adverse effects of drug, medicinal and biological substance, has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy.

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

Effective Date

This addition is effective for claims processed **on or after January 20, 2005.** The full-text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* on or after this effective date.

AJ1950: Leuprolide Acetate—Revision to Policy

The local medical review policy (LMRP) for leuprolide acetate was last updated on May 22, 2003. Since that time, the following revisions have been made to the policy:

- ICD-9-CM diagnosis code range 174.0-174.9, malignant neoplasm of female breast has been added to "ICD-9 Codes that Support Medical Necessity" section of the policy for procedure code J9217.
- Clarification to the "ICD-9 Codes that Support Medical Necessity" to support the indication(s) listed for each HCPCS codes in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy.

These revisions are effective for services provided **on or after December 9, 2004.**

In addition, ICD-9-CM diagnosis code range 218.0-218.9, uterine leiomyomata, has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy for procedure code J1950.

This revision is effective for claims processed **on or after December 9, 2004.**

Also, based on the 2005 HCPCS update, procedure code C9430, was added to the "CPT/HCPCS Codes" section of the policy.

This addition is effective for services provided **on or after January 1, 2005.**

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

The full-text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* on or after these effective dates.

AJ9000: Antineoplastic Drugs—Revision to Policy

The local coverage determination for antineoplastic drugs was last updated on November 29, 2004. A revision to the policy was made to update the following drugs with the addition of the ICD-9-CM codes and descriptors and/or off-labeled indications listed below, based on the *Compendia-Based Drug Bulletin* and/or the Antineoplastic Drug Workgroup for diagnoses and/or indications and limitations of coverage.

- Carboplatin (J9045) – Added stomach carcinoma to off-labeled indications and changed diagnosis code 151.0 to include range 151.0-151.9 (malignant neoplasm of stomach).
- Irinotecan (J9206) – Added primary brain tumors to off-labeled indications and added ICD-9-CM code range 191.0-191.9 (malignant neoplasm of brain).
- Paclitaxel (J9265) – Changed one off-labeled indication to read small cell and non-small cell lung carcinoma instead of small cell lung carcinoma
- The ICD-9-CM code range of 162.2-162.9 was changed to 162.0-162.9 (malignant neoplasm of trachea, bronchus, and lung) for the following drugs:

Carboplatin (J9045)	Paclitaxel (J9265)
Docetaxel (J9170)	Mitomycin (J9280, J9290, & J9291)
Epirubicin (J9178)	Topotecan (J9350)
Etoposide (J9181 & J9182)	Vinorelbine (J9390)
Gemcitabine (J9201)	Porfimer (J9600)

- Rituximab (J9310) – Changed the ICD-9-CM code ranges of 202.00-202.08 and 202.80-202.88 to 202.00-202.98 (other malignant neoplasms of lymphoid and histiocytic tissue).
- Gemcitabine (J9201) – Added the following note under the ICD-9-CM codes "*Note-Diagnosis code 189.0 only to be used for transitional cell cancer of the bladder residing in the kidney (renal transitional cell carcinoma)."
- Oxaliplatin (J9263) – Added additional off-labeled indication to allow adjuvant FOLFOX therapy for colon cancer.

Effective Date

These revisions are effective for services provided **on or after February 1, 2005**. The revised full-text for this policy is available on the provider education website *http://www.floridamedicare.com* on or after this effective date.

2005 HCPCS Local Medical Review Policy/Local Coverage Determination Changes

Florida Medicare has revised local medical review policy (LMRP)/local coverage determinations (LCDs) impacted by the 2005 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and removed accordingly.

LMRP/LCD Title	2005 Changes
A11000 – Debridement Services	• Added procedure codes 11004, 11005, 11006, 11008, 97597, and 97598
A44388 – Diagnostic Colonoscopy	• Added procedure codes 45391 and 45392
A67221 – Ocular Photodynamic Therapy (OPT) with Verteporfin	• Deleted procedure code J3395 • Added procedure code J3396
A76070 – Bone Mineral Density Studies	• Descriptor change for procedure code 76075
A77301 – Intensity Modulated Radiation Therapy (IMRT)	• Descriptor change for procedure code 77418
A77750 – Clinical Brachytherapy	• Descriptor change for procedure code 77750
A78460 – Myocardial Perfusion Imaging	• Descriptor change for procedure codes 78464 and 78465
A93724 – Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator	• Descriptor change for procedure codes 93741 and 93742
A93886 – Transcranial Doppler Studies	• Added procedure codes 93890, 93892, and 93893
AALEFACEPT – Alefacept **(Coding Guidelines only)**	• Removed procedure code 90782
AAPBI – Accelerated Partial Breast Irradiation (APBI)	• Added procedure codes 19296 and 19297

2005 HCPCS Local Medical Review Policy/Local Coverage Determination Changes (continued)

LMRP/LCD Title	2005 Changes
ABEXXAR – Tositumomab and Iodine I 131 Tositumomab (Bexxar®) Therapy **(Coding Guidelines only)**	• Deleted procedure codes 78990 and 79900 • Deleted procedure codes 79100 and 79400 and replaced them with procedure code 79101 • Descriptor change for procedure code 77750
AJ0150 – Adenosine (Adenocard®, Adenoscan®)	• Descriptor change for procedure codes J0150 and J0152
AJ1563 – Intravenous Immune Globulin	• Descriptor change for procedure code J1564
AJ1950 – Leuprolide Acetate	• Added procedure code C9430
AJ2430 – Pamidronate (Aredia®, APD)	• Added procedure code C9411
AJ9000 – Antineoplastic Drugs	• Added procedure codes C9415, C9425, C9426, C9431, and C9432
AOOS – Outpatient Observation Services	• Descriptor change for procedure code G0244
APULMDIAGSVCS – Pulmonary Diagnostic Services	• Descriptor change for procedure codes 94060 and 94070
ASKINSUB – Skin Substitutes	• Added procedure codes J7343 and J7344
AVISCO – Viscosupplementation Therapy for Knee	• Added procedure code C9413

Final LMRP/LCDs are available on the Florida Medicare provider education website *http://www.floridamedicare.com*. ❖

ESRD SERVICES

Medicare Termination of Beneficiaries with End-Stage Renal Disease

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

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed

Physicians, suppliers, and providers should note that this instruction provides information to Medicare intermediaries, including regional home health intermediaries, on handling overpayment issues related to end-stage renal disease (ESRD) beneficiaries whose Medicare Part A coverage should have ended prior to December 1999.

It also tells contractors what to do if another third-party payer has voluntarily made or voluntarily makes a primary payment to the individual or entity when Medicare also paid for the services.

Background

Entitlement for individuals with ESRD is governed under the Social Security Act (Section 226A). In addition, under the Social Security Act (Section 226A[b][2]), Medicare Part A benefits based on ESRD will be terminated:

- **Thirty-six months** after the month the individual receives a kidney transplant; or
- **Twelve months** after the month in which the individual who has not received a kidney transplant no longer requires a regular course of dialysis.

However, when Part A entitlement is not terminated in a timely manner, the Social Security Act (Section 1837[h]) permits Part A entitlement to extend up through the month the individual is notified that Part A coverage has been terminated.

Generally, this means that no attempt will be made to recover any payments that Medicare previously made for Part A covered items and services. However, Medicare payments should be accepted in instances where another third-party payer has voluntarily made or voluntarily makes a primary payment for the items and services to the individual or other entity that Medicare paid, if the third party payer voluntarily repays Medicare its primary payment.

In November 2003 the Social Security Administration (SSA) terminated the Medicare coverage of approximately 8,000 individuals for Part A services and issued a notice to each beneficiary.

The notice provided the date(s) that Medicare coverage ends and gave the beneficiary the right to file an appeal. Also, neither beneficiaries nor providers are being held financially liable for items and services received prior to the formal notice of Medicare termination to the extent that another third party payer has not voluntarily made or does not voluntarily make a primary payment for any items and services.

Note: Medicare intermediaries have been instructed not to issue demand letters or recoup Part A payments made to fee-for-service providers who have received payments on behalf of these individuals. The period for not issuing the demand letters or recouping Part A payments is the period on or after the date of Part A termination up to the final notice of termination of coverage from the Social Security Administration, which is November 2003.

In addition, Medicare intermediaries shall not reopen any cost reports or claims paid for recouping these payments for services made to fee-for-service providers for these beneficiaries during the timeframes defined in the preceding paragraph.

This instruction relates to this subset of Medicare beneficiaries and does not revise Medicare policies.

Implementation

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

Additional Information

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

From that Web page, look for CR 2923 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: MM2923
Related CR Release Date: October 29, 2004
Related CR Transmittal Number: 13
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

Source: CMS Pub. 100-1, Transmittal 13, CR 2923

New Case-Mix Adjusted End-Stage Renal Disease Composite Payment Rates and New Composite Rate Exception Window for Pediatric ESRD Facilities

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

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates that the Centers for Medicare & Medicaid Services (CMS) use a limited number of patient characteristics in establishing a basic case-mix adjusted prospective payment system for dialysis services furnished by providers and renal dialysis facilities to individuals in a facility or in their home. 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 MMA (Section 623[d][1]), the Centers for Medicare & Medicaid Services (CMS) "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."

Use of a case-mix measure permits targeting of greater payments to facilities that treat more costly and more resource-intensive patients, and 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 the unique case-mix of their patients. The patient characteristic variables that are utilized in determining an individual patient's case-mix adjusted composite payment rate include:

- Five age groups
- A low body mass index (BMI)
- A body surface area (BSA)
- An adjustment for pediatric patients.

Note that pediatric ESRD patients (defined as under the age of 18) receive a specific case-mix adjustment factor. As a result, none of the other case-mix adjustors (i.e. the five age groups, low BMI and BSA) are applicable to pediatric ESRD patients.

Medicare has established software, known as the ESRD PRICER program, to automatically calculate the composite payment rate for a particular patient for a particular month(s). As an example, the ESRD PRICER program utilizes each patient's height and weight as reported on billing form UB-92 CMS-1450 to automatically calculate the low BMI and BSA case-mix adjustments to an ESRD facility's composite payment rate.

While payment formulas may change, Medicare is required to maintain overall budget neutrality and overall payments will 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.

Since ESRD facilities can maintain their current exception rates, CMS expects ESRD facilities to compare their exception rate to their basic case-mix adjusted composite rate to determine the best payment rate for their facility.

Each dialysis facility has the option of continuing to be paid at its exception rate or at their basic case-mix adjusted composite rate (which includes all 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. Determinations as to whether an ESRD facility's exception rate per treatment will exceed its average case-mix adjusted composite rate per treatment are left to the entities affected.

Each ESRD facility is allowed to notify its fiscal intermediary (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 intermediary's receipt of the facility's notification letter. ESRD facilities electing to retain their exceptions do not need to notify their intermediaries.

Pediatric facilities should note that the MMA requires the opening of a new pediatric facility exception request window for such facilities that **did not have an approved exception rate** as of October 1, 2004.

MMA defines a pediatric facility as a renal facility with at least 50 percent of whose patients are under 18 years of age. If a pediatric facility should project, on the basis of prior years cost and utilization trends that it will have an allowable cost per treatment higher than the prospective rate, the facility may request that CMS approve an exception to that rate and set a higher prospective payment rate. ***Pediatric facilities must submit request such requests from April 1, 2005 to September 27, 2005 in order for the request to be considered. The September 27, 2005 deadline will not be extended.***

CMS will adjudicate such exception requests in accordance with the procedure outlined in regulation at 42 CFR 413.180 and at Chapter 27 of Part I of the Provider Reimbursement Manual (PRM). Part I of the PRM can be accessed at: *http://www.cms.hhs.gov/manuals/pub151/PUB_15_1.asp*.

New Case-Mix Adjusted ESRD Composite Payment Rates and Exceptions ... (continued)

Please note that if the facility fails to adequately justify its pediatric exception request, such request would be denied.

Providers and facilities should note the following with regard to claims submissions:

- Be sure to populate value code A8 on types of bill (TOB) 72x with patient weight in kilograms or your claim will be returned.
- Be sure to populate value code A9 on TOBs 72x with patient height in centimeters or your claim will be returned.
- Because this new payment process is effective on April 1, 2005, renal dialysis facilities (RDFs) must split all ESRD claims that overlap April 1, 2005. For example, the facility should split claims where the "Through Date" is on or after April 1, 2005, and the "From Date" is prior to April 1, 2005.
- RDFs should use condition code 80 when an ESRD beneficiary receives home dialysis in nursing facilities, including skilled nursing facilities (SNFs).
- RDFs should also continue to use condition code 74 when an ESRD beneficiary receives home dialysis in nursing facilities, including SNFs.

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*.

From that Web page, look for CR 3572 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: 3572
Related CR Release Date: November 19, 2004
Related CR Transmittal Number: 370
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 370, CR 3572

CORF SERVICES

Comprehensive Outpatient Rehabilitation Facilities/Outpatient Physical Therapy Edit for Billing Inappropriate Supplies

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

Provider Types Affected

Comprehensive outpatient rehabilitation facilities (CORFs) and outpatient physical therapy (OPT) facilities

Provider Action Needed

STOP – Impact to You

A system edit is being established to return claims to CORFs/OPTs when billing for supplies with revenue code 270 without an appropriate Healthcare Common Procedure Code System (HCPCS) code.

CAUTION – What You Need to Know

Supplies furnished by CORFs/OPTs are considered part of the practice expense. CORFs/OPTs should not bill for the supplies they furnish except for the splint and cast, level II HCPCS Q-codes associated with the level I HCPCS in the 29000 series.

GO – What You Need to Do

Make sure the appropriate HCPCS code is used to avoid returned claims and delayed payment when billing for certain supplies furnished by CORFs/OPTs.

Background

This instruction requires Medicare fiscal intermediaries (FIs) to return claims to CORFs/OPTs when billing for supplies without an appropriate HCPCS. Supplies are considered part of the practice expense and are not separately payable under the Medicare physician fee schedule (MPFS) except for the splint and cast, level II HCPCS Q-codes associated with the level I HCPCS in the 29000 series.

Thus, CORFs/OPTs should not bill for the supplies they furnish except for the splint and cast, level II HCPCS Q-codes associated with the level I HCPCS in the 29000 series. The appropriate Level II HCPCS "Q" codes to be used are Q4001 thru Q4049. The appropriate Level I HCPCS codes associated with the Level II HCPCS "Q" codes are *29000* thru *29085; 29105* thru *29131;* and *29305* thru *29515*.

The splint and cast supplies are to be billed on a bill type of 74x or 75x with a supplies revenue code of 270 and the appropriate HCPCS codes.

Note that your intermediary will not search their files for claims already processed to make adjustments. However, the intermediary will adjust any claims brought to their attention.

Additional Information

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

From that Web page, look for CR 3468 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: 3468
Related CR Release Date: October 22, 2004
Related CR Transmittal Number: 319
Effective Date: July 1, 2001
Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 319, CR 3468

SKILLED NURSING FACILITY SERVICES

Service Furnished Under an "Arrangement" with an Outside Entity

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

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 delineating the "arranged-for" services for which the SNF assumes responsibility and the manner in which the SNF will pay the outside entity for those services can help the 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 bill submission to its Medicare intermediary almost all of the services a resident receives during a covered stay, excluding those services which are not covered under the SNF's global prospective payment system (PPS) per diem payment for the particular stay.

These excluded services (e.g., those provided by physicians and certain other practitioners) continue to be separately billable to Part B directly to the Medicare carrier by those "outside entities" that actually provide the service. Also, 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.

In addition, 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 Medicare-covered service that is subject to SNF consolidated billing to an SNF resident during a covered stay, the outside entity must look to the SNF for payment (rather than billing their carrier under Part B). The reason is because under an arrangement, 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 outside entities if the service provided is subject to the SNF's global 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.

  In this context, the term "supplier" can also include those 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.

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). 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 the "wait" time between billing and payment.

SNF's Responsibility

However, the absence of a valid arrangement (written or not) does not nullify the SNF's responsibility to pay suppliers for services "bundled" in the SNF PPS global per diem rate. The SNF must be considered the responsible party (even in cases where it did not specifically order the service) when beneficiaries in In this context, the term "supplier" can also include those 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.

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:

Service Furnished Under an "Arrangement" with an Outside Entity (continued)

- 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 non-payment of a supplier claim may occur. When patterns of such denials are identified, there are potentially adverse consequences to SNFs. The reason is because 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 said 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's 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.

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. If in Scenario 1 above the SNF refuses to pay the supplier even after the accuracy of its initial information is called to its attention, the SNF would risk being in violation of its provider agreement by not complying with consolidated billing requirements. As stated previously, supporting written documentation for the disputed service would provide a basis for resolving the dispute and aid in 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, periodically throughout each resident's stay, and upon the resident's temporarily leaving the facility.

Service Furnished Under an "Arrangement" with an Outside Entity (continued)

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, which 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 carrier/intermediary regarding this change. The official instruction may be found at: *http://www.cms.hhs.gov/manuals/pm_trans/R412CP.pdf*.

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: 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

Revisions and Corrections to the Medicare Claims Processing Manual, Chapter 6, Section 30 and Various Sections in Chapter 15

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

Provider Types Affected

Skilled nursing facilities (SNFs) billing Medicare fiscal intermediaries (FIs)

Provider Action Needed

This article includes information provided in Change Request (CR) 3664 which revises the Medicare Claims Processing Manual to include International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) coding guidance SNFs.

Background

CR 3664 revises the Medicare Claims Processing Manual (Pub. 100-04, Chapter 6) (SNF Inpatient Part A Billing), Section 30 (Billing SNF PPS Services), to include the following ICD-9-CM coding guidance for SNFs:

- **Principal Diagnosis Code –** SNFs should enter the ICD-9-CM code for the principal diagnosis in FL 67. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting, as required by 1) the Health Insurance Portability and Accountability Act (HIPAA), and 2) any applicable guidelines regarding the use of V codes. The code must be the full ICD-9-CM diagnosis code, including all five digits where applicable.
- **Other Diagnosis Codes Required** – SNFs should enter the full ICD-9-CM codes for up to eight additional conditions in FLs 68-75. The Centers for Medicare & Medicaid Services (CMS) does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in the ICD-9-CM guidelines.

For complete details regarding these changes, including the revised portions of the Medicare Claims Processing Manual, please see the official instruction issued to your intermediary. That instruction may be viewed by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3664 in the CR NUM column on the right, and click on the file for that CR.

Implementation

The implementation date for this instruction is February 22, 2005.

Additional Information

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: 3664
Related CR Release Date: January 21, 2005
Related CR Transmittal Number: 437
Effective Date: January 1, 2005
Implementation Date: February 22, 2005

Source: CMS Pub. 100-4, Transmittal 437, CR 3664

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: This article was revised on January 25, 2005 to include clarifying language, but no substantive changes were made. The original article was published in the First Quarter 2005 Medicare A Bulletin (pages 75-76).

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 Secretary 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, 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], Section90). 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

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 Medicare Renal Dialysis Facility Manual, Chapter II, Coverage of Services can be found at the following CMS website: *http://www.cms.hhs.gov/manuals/29_rdf/rd200.asp?#_1_17*.

You can find the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 11, End-Stage Renal Disease (ESRD), at the following CMS website: *http://www.cms.gov/manuals/102_policy/bp102index.asp*.

You can 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.gov/manuals/104_claims/clm104index.asp*.

The CMS Medlearn consolidated billing website can be found at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*.

SNF Consolidated Billing and Erythropoietin (EPO, Epoetin Alfa) and Darbepoetin Alfa (Aranesp) (continued)

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 Matters SE0434

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.

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*.

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:

April Update to 2005 HCPCS Codes Used for SNF Consolidated Billing Enforcement (continued)

- 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

Note on codes above:
***** 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.

April Update to 2005 HCPCS Codes Used for SNF Consolidated Billing Enforcement (continued)

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
- **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

Note: 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.

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*.

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

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.

Provider Types Affected

Skilled nursing facilities (SNFs), suppliers of ambulance services, and therapists

Provider Action Needed

STOP – Impact to You

Effective on or after April 1, 2005, you must not separately bill your fiscal intermediary (FI) for transporting, by ambulance, a Medicare beneficiary in a covered Part A SNF stay, to or from an independent diagnostic testing facility (IDTF). If you do submit this ambulance transport as a Part B bill, it will be denied. Also, the SNF must submit Medicare claims for all physical and occupational therapies, and speech-language pathology services its residents received under inpatient Part B.

CAUTION – What You Need to Know

Medicare considers the ambulance transport of a beneficiary in a covered Part A SNF stay, to or from an IDTF, to be part of SNF consolidated billing (CB). Therefore, this transport is to be paid in the SNF prospective payment system (PPS) rate and may **not** be paid separately as Part B services. Therefore, on or after April 1, 2005, any such Part B ambulance claims that you bill to your FI will be denied.

GO – What You Need to Do

Make sure that your billing staffs are aware that the ambulance transport of any beneficiary in a Part A covered SNF stay to or from an IDTF cannot be separately billed under Part B. Also, be sure they are aware of the requirements to bill for the therapies mentioned in the STOP section above.

Background

Section 4432(b) of the Balanced Budget Act (BBA) requires CB for SNFs. Under CB requirements, the SNF must submit under Part A, except for certain excluded services, all Medicare claims for all the services its residents receive. Also, the SNF must submit Medicare claims for all physical and occupational therapies and speech-language pathology services its residents received under inpatient Part B. In addition, all Medicare-covered Part A services that are deemed to be within an SNF's scope or capability are

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

considered paid in the SNF 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 IDTFs.

This instruction clarifies the current SNF CB rules for ambulance transports to or from IDTFs, and implements a change to the processing of institutional provider claims for ambulance transports of an SNF Part A stay beneficiary to or from an IDTF, when billed separately as a Part B service to the FI.

Specifically, change request CR 3196, which was released earlier this year, included new edits to be installed in the common working file (CWF) system to deny Part B claims billed by ambulance suppliers to their carriers (on or after October 4, 2004) for ambulance transports of SNF Part A stay beneficiaries to or from an IDTF. This instruction requires the CWF to apply the same edits to these ambulance services when billed to the FI by institutional providers.

This means that ambulance transports to or from IDTFs are considered paid in the SNF PPS rate and may **not** be billed as Part B services. More specifically, ambulance transports are included in the SNF PPS rate if:

- The first or second character (origin or destination) of any Healthcare Common Procedure Coding System (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.

Ambulance transports to or from renal dialysis facilities for the purpose of receiving dialysis and related services are excluded from SNF CB. In this case, 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.

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.

Implementation

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

Related Instructions

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*.

From that Web page, look for CR 3427 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: MM3427
Related CR Release Date: October 29, 2004
Related CR Transmittal Number: 342
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 342, CR 3427

Skilled Nursing Facility Consolidated Billing

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

Note: This article was revised on January 20, 2005 to include clarifying language, but no substantive changes were made. The original article was published in the First Quarter 2005 *Medicare A Bulletin* (pages 70-73).

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 make 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 included 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.)

Skilled Nursing Facility Consolidated Billing (continued)

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 General Accounting 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. 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 eoetin afa (EPO, trade name Epogen®) for certain dialysis patients. Note: drbepoetin afa (DPA, trade name Aranesp®) is now excluded on the same basis as EPO);

Skilled Nursing Facility Consolidated Billing (continued)

- 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; and
- 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.
- 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

Skilled Nursing Facility Consolidated Billing (continued)

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 can 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; and
- 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

Updated Skilled Nursing Facility No Pay File for April 2005

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

Provider Types Affected

Providers who bill fiscal intermediaries

Provider Action Needed

STOP – Impact to You

HCPCS codes 94760, 94761, and Q4078 are payable in an SNF setting and these three codes have been removed from the SNF no pay file retroactive to April 1, 2003.

CAUTION – What You Need to Know

Change Request 3534 discontinued the use of the SNF no pay file for SNF claims with dates of service on and after January 1, 2005, since the editing accomplished through the no pay file was determined to be duplicative of other efforts. The most current no pay file will be used for editing claims with dates of service prior to January 1, 2005, until the timely filing period expires.

GO – What You Need to Do

To ensure accurate claims processing, please note the above changes.

Additional Information

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*.

Once at that page, scroll down the CR NUM column on the right to find the link for CR 3642. 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: 3642
Related CR Release Date: January 14, 2005
Related CR Transmittal Number: 431
Effective Date: April 1, 2003
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Source: CMS Pub. 100-4, Transmittal 431, CR 3642

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

January 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 billing Medicare fiscal intermediaries (FIs) for claims paid under the OPPS

Provider Action Needed

Physicians, providers and suppliers should note that this article describes Change Request (CR) 3632 which covers changes to, and billing instructions for, various payment policies implemented by Medicare in the January 2005 OPPS update.

Background

The policies implemented in CR 3632 were discussed in the 2005 OPPS final rule, which was published in the *Federal Register* on November 15, 2004 (*Federal Register,* Volume 69, page 65682), and unless otherwise noted, all changes addressed in CR 3632 are effective for services furnished on or after January 1, 2005.

The January 2005 OPPS outpatient code editor (OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 3632.

The following includes information relevant to the January 2005 instructions:

- **Changes to the OPPS OCE data files, the OPPS PRICER logic, and payment policy for diagnostic mammography** are provided in CR 3586, "January 2005 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of OPPS Outpatient Code Editor (OCE) Data Changes and OPPS PRICER Logic Changes; Changes to Payment for Diagnostic Mammography," issued December 3, 2004. For information on this, see Medlearn Matters article MM3586, which can be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3586.pdf*.
- **Instructions for non-pass-through devices are provided in** CR 3606, "January 2005 Update of the Hospital Outpatient Prospective Payment System (OPPS): Billing for Devices that do not have Transitional Pass-Through Status and that are not Classified as New Technology APCs." A Medlearn Matters article, MM3606, is also available for that CR at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3606.pdf*.
- **Instructions for Drug administration are provided in** CR 3610, "January 2005 Update of the Hospital Outpatient Prospective Payment System (OPPS): Changes to Coding and Payment for Drug Administration." These instructions are discussed in the Medlearn Matters article at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3610.pdf*.
- **Revisions to OPPS OCE instructions and specifications are provided in** CR 3583, "January 2005 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 6.0," issued December 3, 2004. These instructions are covered in Medlearn Matters article MM3583 at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3583.pdf*.

Key changes for the January 2005 update are as follows:

1. Hyperbaric Oxygen Therapy

Hospitals providing hyperbaric oxygen (HBO) therapy should continue to report this service using the following HCPCS code:

- HCPCS Code C1300, Hyperbaric oxygen under pressure, full body chamber, per 30-minute interval.

In addition, effective January 1, 2005, the following may be included in calculating the total number of 30-minute intervals billable under HCPCS code C1300:

- Time spent by the patient under 100 percent oxygen;
- Descent;
- Airbreaks; and
- Ascent.

January 2005 Update of the Hospital OPPS: Summary of Payment Policy Changes (continued)

Note: A physician order for a 90-minute HBO treatment typically means that the physician desires that the patient be placed under 100 percent oxygen for 90 minutes. In order to safely achieve 100 percent oxygen for 90 minutes, additional time may be needed to provide for the descent, airbreaks, and ascent. Therefore, the total number of billable 30-minute intervals would not be based solely on the amount of time noted on the physician order.

In calculating how many 30-minute intervals to report, hospitals should take into consideration the time spent under pressure during descent, airbreaks, and ascent.

Additional units may be billed for sessions requiring at least 16 minutes of the next 30-minute interval. For example, two units of HCPCS code C1300 should be billed for a session in duration of between 46 and 75 minutes, while three units should be billed for a session in duration of between 76 and 105 minutes.

Further, four units of HCPCS code C1300 should be billed for a session in duration of between 106 and 135 minutes.

HBO is typically prescribed for an average of 90 minutes, which hospitals should report using appropriate units of HCPCS code C1300 in order to properly bill for full body HBO therapy. In general, the Centers for Medicare and Medicaid Services (CMS) does not expect that a physician order for 90 minutes of HBO therapy would exceed four billed units of HCPCS code C1300.

Example:

Physician orders and patient receives 90 minutes of therapeutic HBO. Patient requires and receives 10 minutes of descent time, 10 minutes of air breaks, and 10 minutes of ascent time. To bill correctly, hospital should bill 4 units of HCPCS code C1300, reflecting the sum of 90 minutes of therapeutic HBO, 10 minutes of descent time, 10 minutes for airbreaks, and 10 minutes of ascent time.

2. Payment for Brachytherapy Sources

Section 621(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established separate payment for brachytherapy devices consisting of a seed or seeds (or radioactive source), based on the hospital's charges for the source(s), adjusted to cost, effective January 1, 2004 through December 31, 2006.

CR 3154 (Transmittal 132), issued March 30, 2004, provided instructions regarding this change to billing and payment for brachytherapy sources and identified the applicable codes that became effective for this payment as of January 1, 2004.

Table 1 provides a listing of three new codes to be reported for payment of brachytherapy sources under the OPPS.

Table 1: New Brachytherapy Codes

HCPCS Code	Effective Date	SI	APC	Short Descriptor	Long Descriptor
C2634	01/01/05	H	2634	Brachytx source, HA, I-125	Brachytherapy source, high activity, iodine-125, per source
C2635	01/01/05	H	2635	Brachytx source, HA, P-103	Brachytherapy source, high activity, paladium-103, per source
C2636	01/01/05	H	2636	Brachytx linear source, P-103	Brachytherapy linear source, paladium-103, per 1 mm

3. New Services

The following new services are assigned for payment under the OPPS:

a. Kyphoplasty

Kyphoplasty is a new surgical procedure intended to treat vertebral compression fractures. The procedure involves percutaneous insertion of an inflatable balloon tamp into a vertebral body to create a void and to partially restore vertebral body height. This is followed by introduction of bone cement under low pressure to fill the cavity in the vertebral body. A single level vertebral kyphoplasty procedure may involve either unilateral or bilateral vertebral body void creation and injection of cement.

Hospitals should bill for kyphoplasty as complete procedures, coding only one unit of the appropriate C-code for each vertebral body treated. In addition to the kyphoplasty C-codes, hospitals may bill for the radiological supervision and interpretation service provided during the kyphoplasty.

Table 2 provides a listing of two new codes to be reported for kyphoplasty under the OPPS.

Table 2: New Kyphoplasty Codes

HCPCS Code	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
C9718	01/01/05	T	0051	Kyphoplasty, first vertebra	Kyphoplasty, one vertebral body, unilateral or bilateral injection	$2043.45	$408.69
C9719	01/01/05	T	0051	Kyphoplasty, each additional	Kyphoplasty, one vertebral body, unilateral or bilateral injection, each additional vertebral body	$2043.45	$408.69

January 2005 Update of the Hospital OPPS: Summary of Payment Policy Changes (continued)

b. High-Energy (> 0.22MJ/MM2) Extracorporeal Shock Wave (ESW) Treatment

The following new service is assigned to a new technology APC for payment under the OPPS.

Table 3: New Code for High-Energy ESW Treatment

HCPCS Code	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
C9720	01/01/05	T	1547	HE ESW tx, tennis elbow	High-energy (greater than 0.22MJ/MM2) extracorporeal shock wave (ESW) treatment for chronic lateral epicondylitis (tennis elbow	$850.00	$170.00
C9721	01/01/05	T	1547	HE ESW tx, plantar fasciitis	High-energy (greater than 0.22MJ/MM2) extracorporeal shock wave (ESW) treatment for chronic plantar fasciitis	$850.00	$170.00

c. Stereoscopic Kv-X-ray Imaging with Infrared Tracking for Localization of Target Volume

The following new service is assigned to a new technology APC for payment under the OPPS. **Do not report C9722 in conjunction with G0173, G0243, G0251, G0339, or G0340.**

Table 4: New Code for Stereoscopic KV X-Ray Imaging

HCPCS Code	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
C9722	01/01/05	S	1502	KV imaging w/IR tracking	Stereoscopic KV X-ray imaging with infrared tracking for localization of target volume	$75.00	$15.00

4. Billing for Observation Services (APC 0339)

In the 2005 OPPS final rule, CMS made 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.

a. 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.

b. To receive separate payment for HCPCS code G0244, hospitals are required to report a qualifying ICD-9-CM diagnosis code for 1) Congestive Heart Failure (CHF), 2) chest pain or 3) asthma as one of the following:

- 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.

c. 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.

d. Observation time ends 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 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.

5. Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. New Dosage Descriptors for Certain Drugs and Biologicals

Hospitals are strongly encouraged to report charges for all Drugs, Biologicals, and Radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used.
It is also of great importance that hospitals billing for these products make certain that the reported unit of service is consistent with the quantity of a drug, biological, or radiopharmaceutical that was actually administered to the patient.

January 2005 Update of the Hospital OPPS: Summary of Payment Policy Changes (continued)

For 2005, several HCPCS codes for drugs and biologicals have undergone changes in their HCPCS descriptors. **Hospitals should be reminded that they should bill for units of service consistent with the dosages contained in the new long descriptors.**

The affected HCPCS codes are listed in the Table 5.

Table 5: New Dosage Descriptors for Certain Drugs and Biologicals

Old HCPCS	Old Long Descriptor	New HCPCS	New Long Descriptor
C9109	Injection, tirofiban hydrochloride, **6.25 mg**	J3246	Injection, tirofiban HCL, **0.25 mg**
C9125	Injection, risperidone, per **12.5 mg**	J2794	Injection, risperidone, long acting, **0.5 mg**
C9207	Injection, bortezomib, per **3.5 mg**	J9041	Injection, bortezomib, **0.1 mg**
C9209	Injection, laronidase, per **2.9 mg**	J1931	Injection, laronidase, **0.1 mg**
C9210	Injection, palonosetron hydrochloride, per **250 mcg**	J2469	Injection, palonosetron HCL, **25 mcg**
J3245	Injection, tirofiban hydrochloride, **12.5 mg**	J3246	Injection, tirofiban HCL, **0.25 mg**
J3395	Injection, verteporfin, **15 mg**	J3396	Injection, verteporfin, **0.1 mg**

Note: Hospital should be aware that effective January 1, 2005 radiopharmaceutical agents will be treated as drugs; therefore, these agents will no longer be eligible for outlier payments under OPPS.

b. Updated Payment Rates for Certain Drugs and Biologicals, including Orphan Drugs, Reflecting Third Quarter 2004 Average Sales Price (ASP) Submissions

In the 2005 OPPS final rule (*Federal Register,* Volume 69, page 65777), it was stated that payments for drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available.

Effective January 1, 2005, payment rates for several drugs and biologicals have changed from the values published in the 2005 OPPS final rule as a result of the new ASP calculations (based on sales price submissions from the third quarter of 2004). The affected drugs and biologicals, with changes in their payment rates, are listed below in Table 6.

Table 6 - Updated Payment Rates for Certain Drugs and Biologicals

HCPCS	APC	Short Descriptor	Payment Rate	Copayment
C9123	9123	Transcyte, per 247 sq cm	$706.16	$141.23
C9205	9205	Oxaliplatin	$82.41	$16.48
C9212	9212	Inj, alefacept, IM	$399.75	$79.95
C9218	9218	Injection, azacitidine	$4.19	$0.84
C9220	9220	Sodium hyaluronate	$215.72	$43.14
J0128	9216	Abarelix injection	$68.62	$13.72
J0135	1083	Adalimumab injection	$288.78	$57.76
J0180	9208	Agalsidase beta injection	$121.12	$24.22
J0256	0901	Alpha 1 proteinase inhibitor	$3.28	$0.66
J0595	0703	Butorphanol tartrate 1 mg	$4.74	$0.95
J1457	1085	Gallium nitrate injection	$1.25	$0.25
J2185	0729	Meropenem	$3.40	$0.68
J2280	1046	Inj, moxifloxacin 100 mg	$3.77	$0.75
J2357	9300	Omalizumab injection	$15.32	$3.06
J2469	9210	Palonosetron HCl	$18.22	$3.64
J2783	0738	Rasburicase	$107.01	$21.40
J2794	9125	Risperidone, long acting	$4.60	$0.92
J3240	9108	Thyrotropin injection	$699.60	$139.92
J3411	1049	Thiamine hcl 100 mg	$0.58	$0.12
J3415	1050	Pyridoxine hcl 100 mg	$2.36	$0.47
J3465	1052	Injection, voriconazole	$4.55	$0.91
J3486	9204	Ziprasidone mesylate	$18.74	$3.75
J7308	7308	Aminolevulinic acid hcl top	$87.65	$17.53
J7518	9219	Mycophenolic acid	$2.42	$0.48
J7674	0867	Methacholine chloride, neb	$0.41	$0.08
J9035	9214	Bevacizumab injection	$57.08	$11.42
J9041	9207	Bortezomib injection	$28.38	$5.68
J9055	9215	Cetuximab injection	$49.64	$9.93
J9216	0838	Interferon gamma 1-b inj	$265.67	$53.13
J9300	9004	Gemtuzumab ozogamicin	$2,203.67	$440.73
Q4076	1070	Dopamine hcl, 40 mg	$0.72	$0.14

January 2005 Update of the Hospital OPPS: Summary of Payment Policy Changes (continued)

For claims submitted prior to implementation of the January 2005 OPPS OCE, hospitals may bill for natalizumab injections using the following HCPCS code in accordance with CR 3287:

- HCPCS Code **C9399**, Unclassified drug or biological.

For claims submitted on or after implementation of the January 2005 OPPS OCE, hospitals should bill for natalizumab injections using the following product-specific HCPCS code:

- HCPCS Code **C9126**, Injection, natalizumab.

Note: Fiscal intermediaries (FIs) will return claims for natalizumab billed with C9399 that are submitted after installation of the January 2005 OPPS update.

e. Status Indicator Assignment for Injection, azacitidine

HCPCS C9218, *Injection, azacitidine*, and its associated APC, 9218, were inadvertently:

- Assigned status indicator "G" in Addendum A and Addendum B in the 2005 OPPS final rule, and
- Included in Table 23, "List of Drugs and Biologicals with Pass-Through Status in CY 2005."

As stated in the preamble of the November 15, 2004 *Federal Register* final rule with comment period, effective January 1, 2005, HCPCS C9218:

- Is assigned status indicator K instead of status indicator G, and
- Will be paid as a single indication orphan drug rather than as a drug with pass-through status (*Federal Register,* Volume 69, page 65808).

6. Endometrial Cryoablation with Ultrasonic Guidance

For services furnished on or after January 1, 2005 to report endometrial cryoablation with ultrasonic guidance:

- Use CPT code **58356**, and
- Discontinue reporting CPT code **0009T**.

7. Determining Payment for Carrier-Priced Items and Services that are Assigned Status Indicator "A" under the OPPS (Services furnished to hospital outpatients that are paid under a fee schedule or payment system other than OPPS)

In order to ensure that services that are assigned status indicator "A" under the OPPS are being paid appropriately, your FI will follow the procedures defined in the Medicare Claims Processing Manual (Pub. 100-04), Chapter 23 (*Fee Schedule Administration and Coding Requirements),* Section 40.4.1 (*Carriers Forward HCPCS Gap Fill Amounts to Fiscal Intermediaries)*, and Section 50 (*Fee Schedules Used by All Intermediaries and Regional Home Health Intermediaries [RHHIs])*.

8. Placement of Needle for Intraosseous Infusion (36680)

In the 2005 OPPS Final Rule, CMS inadvertently mapped CPT code 36680 *Placement of Needle for Intraosseous Infusion* to APC 120, which is an infusion APC.
CPT 36680 is not a code for infusion; it is a code for placement of a needle.

Therefore, CMS has corrected the APC assignment for CPT 36680, effective January 1, 2005, to APC 0002, *Level I Fine Needle Biopsy/Aspiration*.

9. Therapeutic Apheresis

Since nonfacility practice expense relative value units (RVUs) were established for CPT codes 36515 and 36516 in the 2005 update of the Medicare Physician Fee Schedule, published in the November 15, 2004 *Federal Register*, questions have been raised regarding how hospitals should report certain therapeutic apheresis services. In every case, hospitals should report the codes that most accurately describe the service that is furnished.

When using CPT code 36515 to report *extracorporeal immunoadsorption treatment and plasma reinfusion with a protein A column* for indications such as 1) rheumatoid arthritis and 2) idiopathic thrombocytopenic purpura, hospitals may:

- Include the charge for the protein A column with the charge for CPT 36515 or
- Include the charge using an appropriate supply revenue code.

Similarly, when using CPT code 36516 to report *extracorporeal selective adsorption or selective filtration and plasma reinfusion,* for indications such as familial hypercholesterolemia, hospitals may:

- Bill supply charges with the charge for CPT code 36516 or
- Bill supply charges using an appropriate supply revenue code.

Important Reminder Regarding Coverage Determinations

The fact that a HCPCS code and payment rate under the OPPS is assigned (for a drug, device, procedure, or service) does not imply coverage by the Medicare program. It only indicates how the product, procedure, or service may be paid if covered by the program.

January 2005 Update of the Hospital OPPS: Summary of Payment Policy Changes (continued)

FIs determine whether a drug, device, procedure, or service meets all program requirements for coverage, for example, that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Implementation

The implementation date for this instruction is January 14, 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/pm_trans/R423CP.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: 3632
Related CR Release Date: January 6, 2005
Related CR Transmittal Number: 423
Effective Date: January 1, 2005
Implementation Date: January 14, 2005

Source: CMS Pub. 100-4, Transmittal 423, CR 3632, PCM #0501001

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.

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 postpayment 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.

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.

ASCA Enforcement of Mandatory Electronic Submission of Medicare Claims (continued)

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*.

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*.

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 14, 2005
Related CR Transmittal Number: 435
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 435, CR 3440

April 2005 Update of Health Care Claim Status Codes and Health Care Claim Status Category Codes

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

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

Physicians, providers, and suppliers should note that this article and related CR 3566 provide information regarding updates to the health care claim status codes and health care claim status category codes for use in requesting information about the status of claims with the health care claim status request and response ASC X12N 276/277 transactions. Effective April 1, 2005, Medicare intermediaries and carriers will use codes with the "new as of June 2004" designation and prior dates.

Background

The Health Insurance Portability and Accountability Act (HIPAA) directs that all health care plans to use national standards for the transfer of certain health care data. HIPAA requires all payers to use the applicable health care claim status category codes and health care claim status codes of the American National Standards Institute (ANSI) American Standards Committee (ASC) X12N. Medicare intermediaries and carriers must periodically update their claim system with the most current health care claim status category codes and health care claim status codes for use with the health care claim status request and response ASC X12N 276/277 transaction. These transactions are used by providers to inquire about the status of claims they have submitted and by health plans to reply to such inquiries.

Medicare contractors (carriers, durable medical equipment regional carriers, intermediaries, and regional home health intermediaries) must update their claim systems to ensure that the current version of these codes is used in their claim status responses. By April 4, 2005, Medicare contractors are to use the "new as of June 2004" or a prior date designation. These codes may be found at: *http://www.wpc-edi.com/codes/Codes.asp*.

Not all of the codes apply to Medicare. Thus, Medicare contractors are not required to accommodate codes that do not apply to Medicare in their 277 responses.

Note: Medicare contractors must comply with the requirements contained in the version 4010A1 ASC X12 276/277 IG and must use valid health care claim status category codes and health care claim status codes when sending 277 responses.

Additional Information

The Medicare Claim Processing Manual (Pub. 100-04), Chapter 31 (ANSI X12N Formats), Section 20 (ANSI X12N 276/277 Claim Status Request/Response Transaction Standard), Subsection 20.7, has been revised. The revised manual page(s) are attached to the official instruction released to your Medicare intermediary/carrier. You may view that instruction at: *http://www.cms.hhs.gov/manuals/pm_trans/R406CP.pdf*.

For additional information on claim status codes and claim status category codes, you may also refer to Medlearn Matters article MM3361, which is available at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3361.pdf*.

The code sets for use with the 276/277 are the health care claim status category codes and health care claim status codes found at: *http://www.wpc-edi.com/codes/codes.asp*.

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*.

April 2005 Update of Health Care Claim Status Codes ... (continued)

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: 3566
Related CR Release Date: December 17, 2004
Related CR Transmittal Number: 408
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 406, CR 3566

ELECTRONIC DATA INTERCHANGE

Elimination of Old Format for Standard Paper Remittance Notices and Issuance of Paper Remittance Advice Notices—Implementation Date Revision

Subsequent to the release of Joint Signature Memorandum (JSM)-412, the Centers for Medicare & Medicaid Services (CMS) was notified of complications that prevented some fiscal intermediaries (FI) from complying by January 1, 2005. This JSM supplements JSM-412 to change the effective date for FI completion of the noted changes. Information related to JSM-412 was published in the First Quarter 2005 *Medicare A Bulletin* (pages 94-95).

Elimination of Issuance of SPRs to Providers Who Receive ERAs

The effective date for FI elimination of issuance of standard paper remittance (SPR) advice notices using a pre-version 4010A1 flat file is changed to April 4, 2005. This change is being made so the data in SPRs will be consistent with the 835 version 4010A ERAs required by HIPAA.

Some changes were made in the FI SPR format to accommodate additional data elements. This updated SPR format shall be used with the version 40101A1 flat file to issue all SPRs effective April 4, 2005. The new data elements are:

- An additional field for the new technology add-on payment.
- A "PRE PAY ADJ" (presumptive payment adjustment) field in the claim detail section.
- A new field to report a provider level adjustment used to balance an "out of balance" remittance on the SPR summary page.

Elimination of Issuance of SPRs to Providers Who Receive ERAs

JSM-412 instructed FIs to terminate issuance of SPRs to those providers (or a billing agent, clearinghouse, or other entity representing a provider) currently receiving electronic remittance advices (ERAs), or who begin to receive ERAs, effective with the 31st day after initial issuance of 835s in production to the provider or an agent. The change was to be effective January 1, 2005. However, the fiscal intermediary share maintainer system has reported that a programming change is needed to accomplish this. As a result, the effective date for FI issuance of SPRs to ERA users is being changed to July 4, 2005.

Source: CMS JSM-05107

Standard Paper Remittance Advice Changes

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

Provider Types Affected

All Medicare providers that bill fiscal intermediaries (FIs)

Provider Action Needed

Be advised that the Centers for Medicare & Medicaid Services (CMS) has instructed FIs to discontinue sending SPRs to providers, billing agents, clearinghouses, or other entities representing providers, that have received electronic remittance advices (ERAs) for at least 30 days, effective July 1, 2005.

Additionally, CMS has instructed FIs to discontinue including their telephone number on their SPRs effective July 1, 2005.

Background

Publication 100-4, Chapter 22, Section 40.1 of the Medicare Claims Processing Section of the Internet Only Manual (IOM) states: "FIs allow providers to receive a hard copy remittance in addition to the 835 during the first 30 days of receiving ERAs and during other testing. After that time, FIs do not send a hard copy version of the 835, in addition to the electronic transmission, in the production mode. They should contact CMS if this requirement causes undue hardship on a particular provider." For a variety of reasons, all FIs did not discontinue mailing of SPRs following successful transmission of 835s to providers that requested transmission of 835s. CMS is now requiring that all FIs enforce this requirement effective July 1, 2005.

FI SPRs currently contain the contractor phone number, but their ERAs do not. CMS prohibits inclusion of information in an SPR that is not reported in ERA transactions to eliminate a possible incentive for receipt of an SPR in lieu of an 835. To comply with this restriction, effective July 5, 2005, all FIs must eliminate printing their telephone number in their SPRs. Contact information should continue to be included on the FI website and published in regularly scheduled newsletters. Such information, including toll-free numbers for your FI, can also be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

Implementation

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

Related Information

SE0451 titled, "Guidance Regarding Elimination of Standard Paper Remittance (SPR) Advice Notices in the Old Format." may be found at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0451.pdf*.

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*.

From that Web page, look for CR 3645 in the CR NUM column on the right, and click on the file for that CR.

Related Change Request (CR) Number: 3645
Related CR Release Date: January 21, 2005
Related CR Transmittal Number: 438
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 438, CR 3645

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

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

Provider Types Affected

All Medicare providers

Provider Action Needed

STOP – Impact to You

The July 2004 through October 2004 updates have been posted for the X12N 835 Health Care Remittance Advice Remark Codes and the X12 N 835 Health Care Claim Adjustment Reason Codes. Your Medicare carrier or fiscal intermediary must use the latest approved and valid codes in 835 transactions, corresponding standard paper remittance advice, and coordination of benefits transactions.

CAUTION – What You Need to Know

The most current and complete code list will be found online at: *http://www.wpc-edi.com/codes*.

Please note that in case of a discrepancy, the code text included on this Washington Publishing Company (WPC) website will supersede any corresponding text in a Medicare CR.

GO – What You Need to Do

The above noted codes are updated three times a year. Please advise your billing staff to stay current with the latest approved and valid codes, in accordance with effective and implementation dates, to ensure correct interpretation of the electronic or paper remittance advice notices sent by Medicare.

Remittance Advice Remark Code and Claim Adjustment Reason Code Update (continued)

Background

The Remittance Advice Remark Code list is one of the code lists mentioned in the ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG). This list is maintained by The Centers for Medicare & Medicaid Services (CMS) and is updated three times a year. The Health Care Claim Adjustment Codes are maintained by the Claim Adjustment Reason Code and Status Code Maintenance Committee. The Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and decides on any additions, modifications, or retirement of reason codes. This updated list is also posted three times a year.

The complete list of current codes is available online at the WPC website: *http://www.wpc-edi.com/codes*.

Here is a summary of the current updates.

Remark Codes

- **New**

New codes from N247 to N344 have been created to replace a number of generic remark codes, or to enable some existing codes to be split to better reflect their lowest component. This has been done to resolve some provider complaints that it is difficult for them to correlate certain remark codes with segments and data elements submitted on their corresponding claims. Codes with multiple meanings have been split, and new code(s) added to report each of the multiple bits of information previously included in a single message. For example,

- M45 (Missing/incomplete/invalid occurrence codes or dates) has been modified to mean "Missing/incomplete/invalid occurrence code(s)," and N299 (Missing/incomplete/invalid occurrence date[s]) has been added to address the date portion of the prior message.
- MA29 has been deactivated entirely and codes N256, N258, N261, N264, N266, N269, N279, N281, N285, N289, N292, N294, and N296 have been added to convey distinct types of information previously conveyed in MA29.

The following is a list showing the new codes and the source code that has been modified/split to create the new code:

New Code	Split from Existing Code
N299	M45
N300	M46
N301	M51
N302	M74
N303	MA66
N304	N57

- Modified Remark Codes

The following table reflects modified remark codes:

Code	Current Modified Narrative	Modification Date
M67	Missing/incomplete/invalid other procedure code(s).	12/2/04
M74	This service does not qualify for a HPSA/Physician Scarcity bonus payment.	12/2/04
M45	Missing/incomplete/invalid occurrence code(s).	12/2/04
M46	Missing/incomplete/invalid occurrence span code(s).	12/2/04
M51	Missing/incomplete/invalid procedure code(s).	12/2/04
MA66	Missing/incomplete/invalid principal procedure code.	12/2/04
MA121	Missing/incomplete/invalid x-ray date.	12/2/04
MA122	Missing/incomplete/invalid initial treatment date.	12/2/04
N31	Missing/incomplete/invalid prescribing provider identifier.	12/2/04
N57	Missing/incomplete/invalid prescribing date.	12/2/04

- **Deactivated Remark Codes**

Codes M57, M68, M108, M110, M120, M128, MA29, MA38, MA 52, MA82, MA105, MA127, and N145 have been deactivated.

Reason Codes

- New

Code 165 has been added as of October 2004 and its narrative is "Payment denied/reduced for absence of, or exceeded referral."

Additional Information

The most recent changes approved for the Remittance Advice Remark Codes and the Claim Adjustment Reason Codes can be found in the official instruction issued to your carrier or fiscal intermediary, including Durable Medical Equipment Regional Carriers (DMERCs). That official instruction is found in CR 3636, which is available at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

Remittance Advice Remark Code and Claim Adjustment Reason Code Update (continued)

Once at that page, scroll down the CR NUM column on the right to find the link for CR 3636. Click on the link to open and view the file for the CR. The CR attachments also include information on the process of the decision making process that updates the X12N 835 Health Care Remittance Advice Remark Codes and the X12 N 835 Health Care Claim Adjustment Reason Codes. It also includes a table of changes; however, please note that the most current and complete list is online at the WPC web site. This CR includes changes made only from July through October of 2004.

If you have questions regarding this issue, you may also contact your fiscal intermediary and carrier or at their toll free 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: 3636
Related CR Release Date: January 21, 2005
Related CR Transmittal Number: 436
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

Source: CMS Pub. 100-4, Transmittal 436, CR 3636

Inappropriate Access to or Use of Electronic Data Interchange Transaction Data by Third Party Entities

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

Provider Types Affected

All physicians, suppliers, and providers.

Provider Action Needed

STOP – Impact to You

Failure to abide by Medicare security requirements for EDI access could lead to suspension of EDI capabilities.

CAUTION – What You Need to Know

This article clarifies and reminds affected physicians, providers, and suppliers of existing Medicare requirements and prohibitions concerning use of EDI numbers and passwords.

GO – What You Need to Do

Be sure you and your third party partners are aware of and abide by these requirements to protect your EDI access and to maintain your ability to submit timely claims to Medicare.

Background

Medicare contractors (carriers and intermediaries) support electronic data interchange (EDI) to enable providers, either directly or through third party agents to:

- Verify patient eligibility to determine if a claim should be submitted to Medicare.
- Submit claims to Medicare electronically.
- Determine the status of a previously submitted claim.
- Post adjudication decisions and payments to patient accounts.

It is important to note that these functions are **the only functions** for which a provider or a third party entity is entitled to send EDI transactions directly to Medicare contractors (carriers, DMERCs, or fiscal intermediaries) or receive EDI transactions directly from Medicare contractors.

Third-party entities that request permission to access Medicare EDI records directly generally fall into one of the following categories:

1. A clearinghouse as defined by the Health Insurance Portability and Accountability Act (HIPAA) that transfers and may translate claim, eligibility, claim status, and/or payment and remittance advice data for EDI transactions being transmitted between providers and one or more Medicare contractors.
2. An agent a provider has hired to prepare claims and possibly other EDI transactions for submission to one or more Medicare contractors, and possible posting to patient records/provider accounts of eligibility, claim status, and adjudication/payment data issued by one or more Medicare contractors
3. A clearinghouse as in #1 above that also performs agent services as in #2 above.
4. A third party that does not perform clearinghouse or agent services as described in #1-3, but that may want direct access to outbound Medicare EDI transactions for alternate functions. Entities included in this category include collection agents in pursuit of delinquent beneficiary payments to providers and vendors that market payment data analysis services to providers that serve Medicare patients.

Third parties in categories 1, 2, and 3 perform functions that qualify them for direct access to Medicare contractor EDI systems. If a provider elects to use the services of a third party to perform permitted Medicare EDI functions, the provider must complete an EDI Agreement and furnish the Medicare contractor with a signed authorization specifying the EDI services each third party may perform on their behalf. The third party must comply with existing requirements to obtain their own EDI number and password from

Inappropriate Access to or Use of Electronic Data Interchange Transaction Data by Third Party Entities (continued)

the Medicare contractor that services each provider being represented.

Medicare contractors can issue EDI numbers and passwords to category 1, 2, and 3 entities and permit them to submit and/or obtain EDI data directly to/from the Medicare contractor EDI systems. Third parties in category 4 do not perform functions that qualify them for direct access to Medicare systems, and may not be issued EDI numbers or passwords.

Medicare requires that providers and third party entities to which EDI numbers and passwords are issued protect the security of those numbers and passwords to prevent use by unauthorized individuals. Furthermore, providers and third party entities of any category are prohibited from accessing Medicare systems using an EDI number or password not directly issued to them by a Medicare contractor.

This instruction is being issued to clarify and remind affected parties of existing CMS requirements and prohibitions concerning access to and use of EDI numbers and passwords.

Issues

Although they may qualify for direct access to Medicare contractor EDI systems, the read, write and use rights vary for entities in categories 1, 2, and 3. Third parties in categories 2 or 3 are allowed to review data within transactions, whereas category 1 entities are limited to review of "electronic envelope" data that contains routing information for the transactions. Some category 1 entities may be confused regarding this limitation.

The Centers for Medicare & Medicaid Services (CMS) recently discovered that at least one third-party entity in category 4 has been using EDI numbers and passwords furnished them by providers to download electronic remittance advice (ERA) transactions for those providers. The data **was not being used** to post adjudication and payment data to patient accounts, but was being used solely for automated analysis to detect information such as payment patterns and to generate reports. The providers were using the paper remittance advice notices they received, and not the ERAs, to post their accounts. CMS has been advised that other companies may also be marketing similar services and may be using EDI numbers and passwords issued to providers to obtain outbound EDI transactions from Medicare contractor systems for use in ways other than intended by Medicare.

CMS Policy

The following manual instructions contain CMS requirements that apply to these issues:

- The Medicare Claims Processing Manual (Pub. 100-04, Chapter 24) (EDI Support Requirements) contains CMS requirements for EDI access. This can be accessed at: *http://www.cms.hhs.gov/manuals/104_claims/clm104c24.pdf*.
- The Business Partners Systems Security Manual (BPSSM) (Appendix A, Section 2.9.10 of the Core Security Requirements [CSR]) contains further requirements applicable to use of passwords issued to permit system access. These can be found at: *http://www.cms.hhs.gov/manuals/117_systems_security/117_systems_security_atchA.pdf*.

  These password requirements apply to entities to which Medicare contractors issue passwords, as well as to Medicare contractors themselves.
- The Medicare Claims Processing Manual (Pub. 100-04), Chapter 24 (EDI Support Requirements), Section 90 contains instructions concerning mandatory electronic submission of claims to Medicare as required by ASCA. This information is available at: *http://www.cms.hhs.gov/manuals/104_claims/clm104c24.pdf*.
- The Medicare Claims Processing Manual (Pub.100-04), Chapter 1 (General Billing Requirements), Section 80 (Carrier and FI Claims Processing Timeliness) contains Medicare's payment floor requirements at: *http://www.cms.hhs.gov/manuals/104_claims/clm104c01.pdf*.

In regard to access policies for entities in categories 1-4:

- Category 1 third parties that transfer EDI data to and/or from providers, but do not translate that data into or from a format that complies with the HIPAA requirements are **not permitted** to:
  - Open the electronic envelope of the transmitted data; or
  - Generate reports that include data from within those transmission envelopes.
- Category 2 and 3 agents **are permitted** to:
  - Open the electronic envelopes of the transmitted data; and
  - Use the data for analysis and generation of reports for the providers they serve, in addition to use of that data to prepare beneficiary claims, determine claim status or Medicare eligibility, and/or to post adjudication and payment data to patient accounts.
- Category 4 third parties may use data prepared by Medicare, but the following requirements must be met as conditions for use:
  - The data must be forwarded to the entity by the provider;
  - A signed agreement must be in effect between the provider and the entity in which the provider authorizes the entity to use the data and specifying how the data may and may not be used;
  - The entity has furnished the provider with a signed confidentiality agreement that meets Medicare's and HIPAA's privacy and security requirements for protection of personally identifiable beneficiary health data;
  - The provider has notified the patients that their personally identifiable health data will be shared with the entity and how it will be used; and
  - The provider agrees not to furnish data to the entity for any patients who object.

Inappropriate Access to or Use of Electronic Data Interchange Transaction Data by Third Party Entities (continued)

- A category 4 entity:
  - May **not** be given an EDI number or password for direct access to Medicare data; and
  - Is never permitted to use a provider's EDI number or password for that or any other purpose.

As stated in the CSRs in BPSSM section 2.9.10, passwords (1) are "unique for specific individuals," (2) must be "controlled by the assigned user and [are] not subject to disclosure."

Contractor Actions if Improper Access is Identified

In the event a Medicare contractor becomes aware that improper access has been given, appropriate termination of EDI capabilities and notification must occur. For example:

- If an entity, previously issued an EDI number and password, falls under category 4, the Medicare contractor must immediately disable the EDI number and password of that entity, and then notify the entity and the provider why this has been done.
- If a third party entity is using a provider's EDI number and password to access Medicare systems, the Medicare contractor must immediately disable the EDI number and password, and then contact that provider by mail or phone to make them aware of Medicare's requirements and prohibitions.

During this contact, and while the EDI number and password are disabled, the Medicare contractor will remind the provider that:

- Loss of EDI privileges could result in termination of Medicare payment since the Administrative Simplification Compliance Act (ASCA) prohibits payment of claims submitted on paper that should have been submitted to Medicare electronically; and
- In those cases when ASCA permits claims to be submitted on paper, payment is delayed as result of the lengthier payment floor that applies to paper claims.

Additional Information

Providers can review appropriate requirements by checking the Web sites mentioned above.

Remember: The law requires most providers to bill Medicare electronically and EDI access is crucial to that process. Protect your access and protect your patients' confidentiality by abiding by Medicare's privacy and security requirements.

If you have any questions regarding this issue, contact the EDI department of your intermediary/carrier 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*.

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

Source: CMS Special Edition Medlearn Matters SE0461

Guidance Regarding Elimination of Standard Paper Remittance Advice Notices in the Old Format

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

Note: This article was revised on December 7, 2004 to revise the implementation date for providers billing fiscal intermediaries (FIs) and clarifies expectations for carrier changes. The original article was published in the First Quarter 2005 Medicare A Bulletin (page 95)**.**

Provider Types Affected

All Medicare physicians, providers, and suppliers

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) has issued a memorandum to all Medicare FIs and carriers, including durable medical equipment regional carriers (DMERCs), and regional home health and hospice intermediaries (RHHs) stating that, effective January 1, 2005, only the 835 version 4010A1 flat file is to be used to produce the standard paper remittance (SPR) advice notices; no other format for SPRs will be used.

Background

CMS prohibits the inclusion of data in paper remittance advice notices that is not included in the electronic remittance advice transactions. The most recent version of the SPR advice and the ERA contain the same information in the comparable fields and date elements, including the same codes. The same flat file should be used to produce both the SPR and 835 version 4010A1 ERA.

Note: **The effective date has been revised to April 4, 2005 for FIs.**

Providers billing intermediaries are also advised that they may see new data elements in their SPRs, i.e.:

- An additional field for the new technology add-on payment;
- A "PRE PAY ADJ" (presumptive payment adjustment) field in the claim detail section; and
- A new field to report a provider-level adjustment used to balance an "out of balance" remittance on the SPR summary page.

Guidance Regarding Elimination of Standard Paper Remittance Advice Notices in the Old Format (continued)

Providers billing carriers should note that not all carriers and DMERCs will be able to create SPRs directly from an 835 flat file. In such cases, carriers and DMERCs may continue to follow current practices for SPR preparation, but they must ensure that each SPR issued contains the same data elements that would be reported in the equivalent segments and data elements of an 835 version 4010A1 if produced for the same claims and provider. This applies to SPRs produced both for providers that have already transitioned to the 835 version 4010A1, and to those that received earlier versions of the 835 or the National Standard Format ERA pending transition.

Also, providers billing carriers and DMERCs should know that carriers and DMERCs have been told that SPRs may not contain data, other than the contractor's name and address and some calculated totals (as permitted in the SPR format in Chapter 22 of the Medicare Claims Processing Manual), that is not reported in the ERA.

Additional Information

Refer to Chapter 22 of the Medicare Claims Processing Manual, Publication 100-4, which can be found online at: *http://www.cms.hhs.gov/manuals/104_claims/clm104c22.pdf*.

Additional information regarding the fiscal intermediary Part A 835 flat file, including a sample of the most recent SPR format, is available in CR 3344. You may view that CR at: *http://www.cms.hhs.gov/manuals/pm_trans/R252CP.pdf*.

If you have any questions regarding receipt of or conversion to ERAs, please contact your intermediary or carrier. If you bill an intermediary, their number may be found at: *http://www.cms.hhs.gov/providers/edi/anum.asp*.

If you bill a carrier, the number may be found at: *http://www.cms.hhs.gov/providers/edi/bnum.asp*.

Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: January 1, 2005

Source: CMS Medlearn Matters Special Edition SE0451

EDUCATIONAL RESOURCES

How to Locate Specific Transmittals/Change Requests of Interest That Are Posted on Centers for Medicare & Medicaid Services Websites

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

Provider Types Affected

All Medicare physicians, providers, suppliers, and others who use the Medlearn Matters articles and related change request information

Provider Action Needed

This Special Edition article has been written to assist physicians, providers, and suppliers in locating specific change requests of interest that CMS has issued and posted on its website.

Background

CMS program transmittals/change requests (CRs) are used to communicate new or changed policies, and/or procedures that are being incorporated into a specific CMS program manual, and Medlearn Matters articles are written about selected CMS transmittals/change requests to assist providers in understanding these transmittals. Each Medlearn Matters article usually has a section included at the end of the article titled *Additional Information* that includes a variation of the following statement:

> *For complete details (regarding this Change Request XXXX), 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.*
>
> *From that Web page, look for the CR XXXX in the CR NUM column on the right, and click on the file for that CR.*

Note: The above website includes transmittals/CRs issued for the current year. Therefore, starting in January 2005, the above website includes only those transmittals/CRs with communication (comm.) release dates during calendar year 2005.

However, if you scroll down to the end of the above website page, you will find options for being redirected to websites for transmittals/CRs issued in previous years (2000 through 2004).

An abbreviated copy/view of the above CMS web site screen is shown below:

Medicare & Medicaid 2005 Program Transmittals/Program Memos Table of Contents

SIZE	FILE	COMMUNICATION (COMM) DATE	MANUAL	SUBJECT	IMPLEMENTATION DATE	CR NUM
51 kb	R425CP	1/11/2005	PUB 100-04	Section 630 of the …	4/3/2005	3521
168 kb	R423CP	1/6/2005	PUB 100-04	January 2005 Update of the …	1/14/2005	3632

The files listed above are **PDF (portable document format) files. In the past the transmittal cover page was all we were able to put on the Internet. PDF format enables us to put the entire transmittal on the Internet. You can view and print PDF files exactly as they were originally printed in paper form. To view these documents, you must have the Adobe Acrobat Reader, which can be downloaded at no cost at:
Adobe Reader – Download – *http://www.adobe.com/products/acrobat/readstep2.html*.

2004 Transmittals | 2003 Transmittals | 2002 Transmittals | 2001 Transmittals

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Accessing CRs released prior to January 1, 2005

If you want to review a transmittal/CR with a release date in a previous year, you can select the desired year, and you will be redirected to one of the following websites:

- 2004 – *http://www.cms.hhs.gov/manuals/pm_trans/2004/transmittals/comm_date_dsc.asp*
- 2003 – *http://www.cms.hhs.gov/manuals/pm_trans/2003/transmittals/comm_date_dsc.asp*
- 2002 – *http://www.cms.hhs.gov/manuals/pm_trans/2002/transmittals/comm_date_dsc.asp*
- 2001 – *http://www.cms.hhs.gov/manuals/pm_trans/2001/transmittals/comm_date_dsc.asp*
- 2000 – *http://www.cms.hhs.gov/manuals/pm_trans/2000/transmittals/comm_date_dsc.asp*

How to Locate Specific Transmittals/Change Requests of Interest That Are Posted on CMS Websites (continued)

Once you have accessed the desired Transmittal/CR website, you can **sort** the Table of Contents (example shown above) by clicking your mouse on any column heading. To reverse the order of the sort for that column, click on the sort order icon (▼ or ▲).

For some users, once you have accessed the desired transmittal/CR website, type Ctrl F (i.e., hold down the control (Ctrl) key first, then press the 'f' key), and a 'Find' box will appear. Type the desired CR number in the 'Find What?' box, press the enter key, and you will be taken directly to the CR of interest which will be highlighted.

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.

Special Edition Article Number: SE0506
Related Change Request (CR) Number: NA
Implementation Date: January 14, 2005

Source: CMS Special Edition Medlearn Matters SE0506

The Medicare Education and Training Department of First Coast Service Options, Inc.

Presents

Medifest 2005

Coming to a City Near You

The Medifest Symposium gives you an opportunity to attend various Medicare educational courses designed specifically for providers, billing/office managers and staff. You may select the courses that best meet the needs of your practice/office. New for 2005, we have added Medicare Specialty Seminars on day three (day two for Panama City). You have the following three options:

* Only attend our traditional Medifest sessions
* Attend our traditional Medifest session and a 3-hour Specialty Seminar
* Only attend a 3-hour Specialty Seminar

February 24-25, 2005
BayPoint Resort Marriott
4200 Marriott Drive, Panama City Beach, Florida 32408
Phone: (850) 236-6000

April 5-7, 2005
Coral Springs Marriott Hotel
11775 Heron Bay Blvd, Coral Springs, Florida 33076
Phone: (954) 753-5598

June 28-30, 2005
Omni Jacksonville Hotel
245 Water Street, Jacksonville, Florida 32202
Phone: (904) 355-6664

August 2-4, 2005
The Naples Beach Hotel
851 Gulf Shore Blvd North, Naples, Florida 34102
Phone: (239) 261-2222

November 1-3, 2005
Orlando Airport Marriott
7499 Augusta National Drive, Orlando, Florida 32822
Phone: (407) 851-9000

For additional information and/or registration, please visit the education section of our website at www.floridamedicare.com or call our registration hotline at (904) 791-8103

The Medicare Education and Training Department of First Coast Service Options, Inc.

Presents

Medifest 2005

Medicare Specialty Seminars

Coming to a City Near You

February 25, 2005, (8:00 am to 11:00 am)
BayPoint Marriott Resort, 4200 Marriott Drive, Panama City Beach, FL 32408

- Advanced Registered Nurse Practitioners/Physician Assistant (ARNP/PA) (B)
- Anesthesiology/Pain Management (B)
- ANSI 101 (HIPAA) (A/B)
- Evaluation and Management Documentation (B)
- Skilled Nursing Facility, Minimum Data Set Coding and Billing Efficiency (A)
- Rehabilitation Services (A/B)

April 7, 2005, (8:00 am to 11:00 am)
Coral Springs Marriott Hotel, 11775 Heron Bay Blvd, Coral Springs, FL 33076

- Oncology (B)
- Psychiatric Services (B)
- Cardiology (B)
- Evaluation and Management Documentation (B)
- Nephrology (B)
- Skilled Nursing Facilities (SNF) (A)

June 30, 2005, (8:00 am to 11:00 am)
Omni Jacksonville Hotel, 245 Water Street, Jacksonville, FL 32202

- End Stage Renal Disease (ESRD) (A)
- Psychiatric Services (B)
- Ambulatory Surgical Centers (B)
- Pathology/Clinical Lab (B)
- Skilled Nursing Facility, Minimum Data Set Coding and Billing Efficiency (A)
- Evaluation and Management Documentation (B)

August 4, 2005, (8:00 am to 11:00 am)
Naples Beach Hotel, 851 Gulf Shore Blvd North, Naples, FL 34102

- Podiatry (B)
- Urology (B)
- Rehabilitation Services (A/B)
- Chiropractic Services (B)
- Evaluation and Management Documentation (B)
- Skilled Nursing Facilities (SNF) (A)

November 3, 2005 (8:00 am to 11:00 am)
Orlando Airport Marriott, 7499 Augusta National Drive, Orlando, FL 32822

- Oncology(B)
- Ophthalmology Services(B)
- Interventional Radiology(B)
- Cardiology(B)
- Skilled Nursing Facility, Minimum Data Set Coding and Billing Efficiency (A)
- End Stage Renal Disease (ESRD) (A)

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A

C

C (continued)

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O

O (continued)

P

R

S

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Addresses

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Claim Denials (outpatient services only)
Medicare Fair Hearings (Part A)
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Medicare Secondary Payer
Hospital Review
P. O. Box 45267
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Conditional Payment
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ELECTRONIC CLAIM FILING

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Direct Data Entry (DDE)
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Jacksonville, FL 32231-4071

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Complaint Processing Unit
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Jacksonville, FL 32232-5087

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Medicare Part A Reconsiderations
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Cost Report Settlement (payments due to provider or Program)
Interim Rate Determinations
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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
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Medicare Registration – ADA
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1-800-633-4227
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Medicare Websites

PROVIDERS

Florida Medicare Contractor
www.floridamedicare.com
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

Other Important Addresses

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Hospice Claims
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