

# Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers



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

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

#### Routing Suggestions:

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



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

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## A PHYSICIAN'S FOCUS

### Medical Record Review Request—From Whom and Why

We have received questions from physicians regarding medical record review or, more specifically, requests from Medicare for medical records. A standard statement in the medical policies notes that medical record documentation maintained by the performing physician or allied provider must clearly indicate the medical necessity of the service being billed. In addition, documentation that the service was performed must be included in the patient's medical record. This information is normally found in the history and physical examination notes, office/progress notes, hospital notes, and/or procedure report.



There are currently medical record reviews conducted by different entities contracted by the Centers for Medicare & Medicaid Services (CMS) and other government offices, and each has distinct program goals. Under the Medicare Integrity Program enacted by Congress, entities such as FCSO, a carrier (pays Part B provider claims in Florida and Connecticut) and a fiscal intermediary (pays Part A provider claims in Florida), are known as the affiliated contractor (AC) as distinct from a program safeguards contractor (PSC). As a general rule, PSC is accountable for reducing fraud and abuse in the Medicare program, and AC is responsible for reducing the Medicare fee-for-service claim payment error rate. Of course, there may be overlap in responsibilities and programs. Other Medicare contractors that pay claims and may request records for medical review include the durable medical equipment regional carrier (DMERC) and the regional home health intermediary (RHHI). Though they do not pay claims directly, the quality improvement organizations (QIO) in each state have inpatient acute care hospital claim review responsibility, as well as other initiatives that may entail medical review. Two special PSC contractors administer the Comprehensive Error-Rate Testing (CERT) program, and systematically request records for medical review. Also, the Office of the Inspector General (OIG), in the Department of Health & Human Services (which governs the Medicare program), conducts surveys or assessments that involve the claim payment process and necessitates medical review. Medical records for these reviews, and subsequent follow-up reviews, will be requested by the entity contracted by the OIG for this purpose.

The following is a brief outline of medical record review with the caveat that each program has a limited impact on the number of providers and/or number of claims reviewed.

**Medical review of initial claims** – The AC requests records in the prepayment development of a claim

- Claims may have been submitted with procedure code(s) that require additional information for coverage and/or payment (e.g., an unlisted code).
- One of the services on the claim is under formal review based on utilization or other audits (these are usually outlined in a national or local policy or may be a PSC request).

**Progressive correction action (PCA) process medical review** – The AC process to lower the claim payment error rate. This is data driven with a provider education and/or policy development focus.

- Post payment request for the documentation of claims.
- In some instances, may be prepayment development of a claim for certain codes submitted by a provider.

**CERT program** – The CERT documentation contractor will request records for review by the CERT review contractor, AdvanceMed of Richmond, Virginia. The CERT program randomly samples 200 claims per month per contractor nationally.

- Post payment request for the documentation of claims, usually from prior year

**PSC and OIG** – Programs to prevent fraud and abuse.

- Post payment request for the documentation of claims.
- Prepayment medical review related to a program safeguards initiative – request comes from the AC (such as FCSO) since these are new claims, although the documentation will be reviewed by the PSC.

Finally, although limited to three states, a new medical review initiative has generated national provider interest. The Medicare Modernization Act directs the secretary of the Department of Health & Human Services to demonstrate the use of recovery audit contractors (RACs) under the Medicare Integrity Program in identifying underpayments and overpayments, and recouping overpayments under the Medicare program. As the states with the largest Medicare expenditure amounts, California, Florida, and New York have been selected for pilot RACs that began in May 2005 and last for three years. Public Consulting Group (Medicare secondary payer [MSP] claim reviews) and Health Data Insight (non-MSP claim reviews) were awarded the Florida contracts.

*Medical Record Review Request—From Whom and Why (continued)*

**RAC pilot program**

- RACs will perform data analysis to identify areas of investigation.
- 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. All reviews are post payment.
- RACs will apply national coverage policies and local coverage determinations (LCDs) that have been published by the Medicare contractors.
- 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.
- If underpayments are determined, the information will be forwarded to the ACs for processing and payment. Providers will be permitted to appeal any negative determinations to their contractor.

FCSO paid over 90 million claims in fiscal year 2005 for Part A and B providers in FL and CT. Fortunately, only a small percentage of these claims require the submission of medical records for review. If you receive a request for medical records on a Medicare beneficiary and are not sure of your responsibilities, please contact provider customer service at 1-877-602-8816 for clarification or call the number on the requesting letter for more details. Your prompt response to a legitimate request will benefit you and the Medicare program.

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**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 2006	Mid-November 2005	January 1, 2006
Second Quarter 2006	Mid-February 2006	April 1, 2006
Third Quarter 2006	Mid-May 2006	July 1, 2006
Fourth Quarter 2006	Mid August 2006	October 1, 2006

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

**Who Receives the Bulletin?**

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

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

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

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

**What Is in the Bulletin?**

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

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

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

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

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

**Do You Have Comments?**

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

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 Medicare Communication & Education  
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# GENERAL INFORMATION

## Requirements for Voided, Canceled, and Deleted Claims

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

### Provider Types Affected

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

### Provider Action Needed

This Medlearn Matters article is based on information contained in Change Request (CR) 3627, which describes the new Centers for Medicare & Medicaid Services (CMS) procedures and specific instructions to Medicare contractors (Medicare carriers, intermediaries, and DMERCs) for voiding, canceling, and deleting claims.

As a result of these changes, providers should note that some claims they were able to delete in the past will no longer be deleted from Medicare’s systems, but will instead become denied claims.

### Background

The Department of Health & Human Services (DHHS) Office of the Inspector General (OIG) has verified instances in which Medicare claims have been voided, cancelled, or deleted by Medicare carriers, DMERCs, and FIs. Further, the Medicare contractors have not traditionally maintained an audit trail for the voided, cancelled, or deleted claims. The OIG has indicated that Medicare must maintain an audit trail for voided, cancelled, and deleted claims.

CMS is therefore implementing requirements for Medicare contractors (carriers/FIs, including DMERCs and regional home health intermediaries (RHHIs)) to:

- Deny or reject claims that do not meet CMS requirements for payment for unacceptable reasons
- Cancel, void, or delete claims that are unprocessable for acceptable reasons
- Return as unprocessable claims that meet conditions mentioned below for the return of unprocessable claims.
- Maintain an audit trail for all cancelled, voided, or deleted claims that Medicare systems have processed far enough to have assigned a claim control number (CCN) or document control number (DCN).

**Note:** CR3627 requires that Medicare carriers, intermediaries, and DMERCs keep an audit trail on these claims once a CCN or DCN has been assigned to the claim.

### Acceptable Claims Deletions

Below is a list of acceptable reasons a Medicare contractor may cancel, delete, or void a claim:

1. The current CMS 1500 form or the current CMS 1450 form is not used.
2. The front and back of the CMS 1500 (12/90) claim form are required on the same sheet and are not (claims submitted to carriers only).

3. A breakdown of charges is not provided, i.e., an itemized receipt is missing.
4. Only six line items have been submitted on each CMS 1500 claim form (Part B only).
5. The patient’s address is missing.
6. An internal clerical error was made.
7. The certificate of medical necessity (CMN) was not with the claim (Part B only).
8. The CMN form is incomplete or invalid (Part B only).
9. The name of the store is not on the receipt that includes the price of the item (Part B only).

**Note:** The Medicare contractor must keep an audit trail for all claims in the above “Acceptable Claims Deletions” category if a CCN or a DCN was assigned to the claim.

### Unacceptable Claims Deletions

The following are unacceptable reasons for Medicare contractors to void, cancel, or delete claims:

1. A provider notifies the Medicare contractor that claim(s) were billed in error and requests the claim be deleted (carrier claims only).
2. The provider goes into the claims processing system and deletes a claim via any mechanism other than submission of a cancel claim (type of bill xx8). Providers may only cancel claims that are not suspended for medical review or have not been subject to previous medical review. (FI claims only)
3. The patient’s name does not match any health insurance claim number (HICN).
4. A claim meets the criteria to be returned as unprocessable under the incomplete or invalid claims instructions in the *Medicare Claims Processing Manual*, Chapter 1, Section 80.3.2.ff, which is available on the CMS website at [http://www.cms.hhs.gov/manuals/104\\_claims/cim104index.asp](http://www.cms.hhs.gov/manuals/104_claims/cim104index.asp).

Medicare contractors must deny or reject claims in the above “Unacceptable Claims Deletions” category.

### Return as Unprocessable Claims

Medicare contractors may return a claim as unprocessable for the following reasons:

1. Valid procedure codes were not used and/or services are not described (e.g., block 24D of the CMS 1500) (Part B only).
2. The patient’s HICN is missing, incomplete, or invalid (e.g., block 1A of the CMS 1500).
3. The provider number is missing or incomplete.

*Requirements for Voided, Canceled, and Deleted Claims (continued)*

4. No services are identified on the claim.
5. Block 11 (insured policy group or FECA Number) of the CMS 1500 is not completed to indicate whether an insurer primary to Medicare exists (Part B only).
6. The beneficiary's signature information is missing (Part B only).
7. The ordering physician's name and/or UPIN is missing/invalid (blocks 17 and 17A of the CMS 1500).
8. The place of service code is missing or invalid (block 24B of the CMS 1500 – Part B only).
9. A charge for each listed service is missing (e.g., block 24F of the CMS 1500).
10. The days or units are missing (e.g., block 24G of the CMS 1500).
11. The signature is missing from block 31 of the CMS 1500 (Part B only).
12. Dates of service are missing or incomplete (block 24A of the CMS 1500).
13. A valid HICN is on the claim, but the patient's name does not match the name of the person assigned that HICN.

**Summary**

In summary, CMS believes the following:

- The problems listed under the "Acceptable Claims Deletions" heading are valid reasons to void/delete/cancel a claim if the Medicare contractor maintains an audit trail.
- Claims with problems listed under the "Unacceptable Claims Deletions" heading should be denied or rejected by Medicare, and the decision to deny/reject the claim should be recorded in the Medicare contractor's claims processing system history file.

If a Medicare contractor determines that a claim is unprocessable before the claim enters that contractor's claims processing system (i.e., the claim processing system **did not assign a CCN or DCN** to the claim):

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

- The claim may be denied
- The contractor does not have to keep a record of the claim or the deletion.

If a Medicare contractor determines that a claim is unprocessable after the claim enters their claims processing system (i.e., the claim processing system **did assign a CCN or DCN** to the claim):

The denied or rejected claim will not be totally deleted from Medicare's claims processing system. The Medicare contractor must maintain an audit trail for all deleted claims that have entered the claims processing system (i.e., the system assigned a CCN or DCN to the claim).

**Implementation**

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

**Additional Information**

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

From that Web page, look for CR 3627 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 on the CMS website at <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3627

Related CR Release Date: June 17, 2005

Related CR Transmittal Number: 159

Effective Date: October 1, 2005

Implementation Date: October 3, 2005

Source: CMS Pub. 100-20, Transmittal 159, CR 3627

## The Centers for Medicare & Medicaid Services (CMS) 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 were selected for pilot RACs that began earlier this year and that will last for three years. Contractors selected for this pilot program will identify and collect Medicare claims 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).

## *The Centers for Medicare & Medicaid Services (CMS) Recovery Audit Contract Initiative (continued)*

### 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 identifying underpayments and overpayments and 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).

### Update

On January 11, 2005, CMS announced the recovery audit contractor demonstration project. (See MedLearn Matters article SE0469 which is available on the CMS website at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0469.pdf>.)

The demonstration, mandated by the MMA, will evaluate the use of recovery audit contractors in identifying Medicare underpayments and overpayments and recouping overpayments.

On March 28, 2005, CMS awarded five RACs and officially announced the beginning of the recovery audit contractor demonstration. Three of the five recovery audit contractors will perform post-payment medical review in the states of California, Florida, and New York. Those firms and the state they are responsible for are as follows:

- Connolly Consulting will perform claim reviews for providers who are serviced by an FI or carrier in New York. Connolly Consulting will also perform reviews for durable medical equipment claims for Medicare beneficiaries who reside in New York.
- PRG Schultz and its subcontractor, Concentra Preferred Systems, will perform claim reviews for providers who are serviced by an FI or carrier in California. PRG Schultz will also perform reviews for durable medical equipment claims for beneficiaries who reside in California.
- HealthData Insights will perform claim reviews for providers who are serviced by an FI or carrier in Florida. Connolly Consulting will also perform reviews for durable medical equipment claims for beneficiaries who reside in Florida.

CMS is committed to alerting the provider community regarding the focus of the recovery audit contractor demonstration. The recovery auditors have at least three years of claims they may review.

### Three-Tiered Review Process

The recovery audit contractors have a three-tiered process that is explained below:

- The first level involves Part A diagnosis related group (DRG) reviews. These reviews normally involve making a request for medical records. Providers located in Florida began seeing medical record requests in August. Providers located in New York began seeing medical record requests in September. California providers will see medical record requests some time after October.
- The second level involves overpayments determined by the recovery audit contractor's proprietary data mining systems. These are overpayments that clearly do not meet the requirements of Medicare policies. These overpayments do not require a medical record request because it is very clear that an overpayment has occurred. These overpayments may be for a Part A or Part B service. However, CMS is approving a sample of these overpayments before the demand letters are released. In October 2005, physicians and/or providers in Florida may receive overpayment demand letters resulting from these automated reviews. Beginning in October, physicians and/or providers in California and New York may also see overpayment demand letters resulting from these reviews.
- The last level involves the actual request of medical records for Part B services. All of the recovery companies have indicated that physicians may see medical record requests for Part B services in October or November of 2005. In a future Medlearn Matters article, CMS will update the provider community when medical record requests could be made.

**Note:** Questions concerning the recovery audit contractor demonstration may be directed to an email address CMS has established for the demonstration. That email address is [cms.recoveryauditdemo@cms.hhs.gov](mailto:cms.recoveryauditdemo@cms.hhs.gov).

### Additional Information

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

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

Find out more about the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) on the CMS website at <http://www.cms.hhs.gov/medicarereform/>.

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Source: Special Edition Medlearn Matters Article SE0565

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## New Fiscal Intermediary Edit to Identify Potentially Excessive Medicare Payments

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

### Provider Types Affected

All hospitals, skilled nursing facilities, home health agencies, religious nonmedical health care institutions, rural health clinics, renal dialysis facilities, federally qualified health centers, outpatient rehabilitation facilities, comprehensive outpatient rehabilitation facilities, community mental health centers, hospice providers, and non-OPPS hospitals ambulatory surgery centers, who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for outpatient and inpatient Part B claims

### Provider Action Needed STOP – Impact to You

Providers must be certain to bill types of bills (TOB) 12x, 13x, 14x, 22x, 23x, 32x, 33x, 34x, 43x, 71x, 72x, 73x, 74x, 75x, 76x, 81x, 82x, 83x, or 85x **correctly as clerical errors resulting in excessive overpayments have been found in some of these claims.**

### CAUTION – What You Need to Know

The TOBs listed will be monitored and threshold edits installed to alert FIs and RHHIs of claims that meet or exceed a reimbursement amount of \$50,000 **on Part B claims.** Claims that reach the \$50,000 threshold will be suspended and intermediaries will contact providers to determine the legitimacy of the claim.

### GO – What You Need to Do

Make certain that billing is accurate and when the FI determines that the threshold is reached legitimately the FI can override the edit and submit the claim for processing and payment.

### Background

The Centers for Medicare & Medicaid Services (CMS), in an effort to protect the Medicare trust, shore up the billing system, and reduce overpayment reporting burdens on providers and beneficiaries, is taking a proactive stand to catch and identify clerical errors and eliminate overpayments before they occur. It was determined that most errors resulting in excessive overpayments are a result of simple clerical provider billing errors. For example, analysis shows that some providers inadvertently placed the date of service in the SERVICE UNITS field of a claim, thereby causing sizeable overpayments. Thus, Medicare will implement this edit so Part B inpatient and outpatient claims meeting or exceeding \$50,000 can be verified for accuracy.

If an intermediary does suspend a claim because it has reached the threshold edit of \$50,000 the intermediary will contact the provider and together the FI and provider can work to resolve the claim. If the intermediary determines

that the reimbursement is excessive and claim corrections are needed the claim will be returned to the provider. If the intermediary determines that the billing is accurate the edit will be overridden and the claim will be processed.

Listed below are the provider types and TOBs that are referenced in this article and whose claims are affected by the new edit.

Provider Type	Types of Bills
Hospitals	12x, 13x, 14x
Skilled Nursing Facilities	22x, 23x
Home Health Agencies	32x, 33x, 34x
Religious Nonmedical Health Care Institutions	43x
Rural Health Clinics	71x
Renal Dialysis Facilities	72x
Federally Qualified Health Centers	73x
Outpatient Rehabilitation Facilities	74x
Comprehensive Outpatient Rehabilitation Facilities	75x
Community Mental Health Centers	76x
Hospice Providers	81x, 82x
Non-OPPS Hospitals	83x
Ambulatory Surgery	
Critical Access Hospitals	85x

### Implementation

The implementation date for CR 3925 is January 3, 2006

### Additional Information

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

From that Web page, look for CR 3925 in the CR NUM column on the right, and click on the file for the desired CR.

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

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

Related Change Request (CR) Number: 3925

Related CR Release Date: July 29, 2005

Related CR Transmittal Number: 620

Effective Date: Claims received on or after January 3, 2006

Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 620, CR 3925

## Services not Provided within the United States

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

### Provider Types Affected

Physicians and providers billing Medicare carriers and intermediaries

### Provider Action Needed

#### STOP – Impact to You

Physicians, providers, and suppliers should note that this article is based on information contained in Change Request (CR) 3781, which informs Medicare carriers and fiscal intermediaries (FIs) to permit payment to be made to a foreign hospital for emergency inpatient services in certain circumstances.

#### CAUTION – What You Need to Know

CR 3781 instructs Medicare carriers and FIs to permit payment to be made to a foreign hospital for emergency inpatient services provided to a beneficiary where 1) the beneficiary was present in the United States at the time the emergency occurred which necessitated the inpatient hospital services, and 2) the hospital outside the U.S. that provided the emergency inpatient services was closer to the place where the emergency arose (or substantially more accessible) than the nearest adequately equipped hospital within the United States.

#### GO – What You Need to Do

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

#### Background

Although the typical exceptions to Medicare’s “foreign exclusion” involve services that are furnished in Canada and Mexico, it is possible for Medicare to make payment to foreign hospitals besides those located in Canada and Mexico.

For example, if an emergency necessitated that inpatient hospital services be furnished to a Medicare beneficiary who is living in Guam and the nearest adequately equipped hospital to treat that beneficiary was located in the Philippines, Medicare payment would not be prohibited under Medicare’s “foreign exclusion” because Medicare payment may be permitted for the services under the Social Security Act (Section 1814(f); 42 U.S.C. 1395f(f)) in such instances.

Therefore, CR 3781 directs Medicare carriers and FIs to permit payment to be made to a foreign hospital for emergency inpatient services provided to a beneficiary where:

- The beneficiary was present in the United States at the time the emergency occurred that necessitated the inpatient hospital services.
- The hospital outside the United States that provided the emergency inpatient services was closer to the place where the emergency arose (or substantially more accessible) than the nearest adequately equipped hospital within the United States.

### Definition of “United States”

For purposes of the Social Security Act (Section 1814(f)), the term “United States” means:

- The 50 States
- The District of Columbia
- The Commonwealth of Puerto Rico
- The Virgin Islands
- Guam
- American Samoa
- The Northern Mariana Islands
- The territorial waters adjoining the land areas of the United States (for purposes of services rendered on board a ship).

### Implementation

The implementation date for the instruction is November 17, 2005.

### Additional Information

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

From that Web page, look for CR 3781 in the CR NUM column on the right, and click on the file(s) for that CR. You will note two CRs with 3781, one with a transmittal number of 38 (*Medicare Benefit Policy Manual* changes) and the other with a transmittal number of 654 (*Medicare Claims Processing Manual* changes). If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3781

Related CR Release Date: August 19, 2005

Related CR Transmittal Number: 38 and 654

Effective Date: November 17, 2005

Implementation Date: November 17, 2005

Source: CMS Pub. 100-4, Transmittal 654, CR 3781

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## 2006 Annual Update for the Health Professional Shortage Area Bonus Payments

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

### Provider Types Affected

Physicians who provide services in designated health professional shortage areas (HPSAs)

### Provider Action Needed

#### STOP – Impact to You

New information on the new automated HPSA bonus payments for 2006 is posted on the Centers for Medicare & Medicaid Services (CMS) website.

#### CAUTION – What You Need to Know

Section 413(b) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 mandated an annual update to the automated HPSA bonus payment files. This CR provides those files for claims with dates of service on or after January 1, 2006, through December 31, 2006.

#### GO – What You Need to Do

You should review the information on the CMS website to determine if you qualify for the HPSA bonus payment for 2006.

### Background

Section 1833(m) of the Social Security Act provides a ten percent bonus payment for physicians who furnish medical care services in geographic areas that the Health Resources and Services Administration (HRSA) designates as primary medical care HPSAs. MMA Section 413(b) required CMS to annually update the bonus payment files, and CR4113 provides the names of those updated files for 2006. To find details regarding the HPSA bonus payments, please visit CMS website at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0449.pdf>.

The updated list of HPSA ZIP codes for calendar year (CY) 2006 may be found on the CMS website at <http://www.cms.hhs.gov/providers/bonuspayment>.

### Additional Information

You can find more information about the HPSA bonus payment by going to the CMS website at

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## Unsolicited/ Voluntary Refunds

All Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open accounts receivable). Intermediaries generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds. The Centers for Medicare & Medicaid Services reminds providers that:

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

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

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

From that Web page, look for CR 4113 in the CR NUM column on the right, and click on the file for that CR.

You can also go to the Medlearn Matters Provider Education Web page at

<http://www.cms.hhs.gov/medlearn/matters/> to find other Medlearn Matters articles that address the bonus payments.

Special Edition articles SE0449, SE0453, and SE0450 and Medlearn Matters articles MM3108, MM3827, MM3822, MM3336, and MM3800 all address HPSA issues. From this website, you can also look at the CRs from which the articles were derived by clicking on the respective CR number.

You might also want to look at the *Medicare Claims Processing Manual* (Publication 100.04), Chapter 12 (Physician/Practitioner Billing), Section 90.4 (Billing and Payment in Health Professional Shortage Areas (HPSAs)). You can find this manual on the CMS website at [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c12.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c12.pdf).

Finally, if you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found on the CMS website at

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

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

Medlearn Matters Number: MM4113  
Related Change Request (CR) Number: 4113  
Related CR Release Date: October 14, 2005  
Related CR Transmittal Number: 722  
Effective Date: January 1, 2006  
Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 722, CR 4113

## Fiscal Year 2006 Payment for Services Furnished in Ambulatory Surgical Centers

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

### Provider Types Affected

Ambulatory surgical centers (ASCs) billing Medicare carriers or intermediaries

### Provider Action Needed

This instruction advises that the **current** ACS payment rates and wage index values **remain** in effect for fiscal year (FY) 2006.

### Background

Section 626(a) of the Medicare Modernization Act (MMA) mandates, for ASC payment rates, a zero percent increase for inflation in FY 2005, the last quarter of calendar year (CY) 2005, and each calendar year from CY 2006 through CY 2009.

### Wage Index Values

The implementation of new wage index values for FY 2006 is deferred until the Centers for Medicare & Medicaid Services (CMS) has had an opportunity to determine the impact of changes in the FY 2006 inpatient hospital wage index on payment amounts for individual ASCs. Therefore, **payments to ASCs for services furnished on or after October 1, 2005, will not change.**

Until further notice, Medicare carriers will continue to use the FY 2004 wage index to calculate payments to ASCs and continue to use the payment rates that were effective for services furnished on or after April 1, 2004.

The labor-related portion of ASC payment rates is defined currently as 34.45 percent of the payment rate. Carriers are currently using the FY 2004 hospital inpatient wage index to calculate payments for ASC services.

Transmittal AB-03-116 (CR 2871), issued August 8, 2003, updated ASC facility payment rates for inflation and updated the wage index values used to adjust ASC payments for geographic wage differences effective for services furnished on or after October 1, 2003. CR 2871 may be found on the CMS website at [http://www.cms.hhs.gov/manuals/pm\\_trans/AB03116.pdf](http://www.cms.hhs.gov/manuals/pm_trans/AB03116.pdf).

Transmittal 51 (CR 3082), issued February 4, 2004, notified contractors about a change in ASC payment rates effective April 1, 2004, resulting from enactment of Section

626(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). CR 3082 may be found on the CMS website at [http://www.cms.hhs.gov/manuals/pm\\_trans/R51OTN.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R51OTN.pdf).

### ASC Payment Group Rates

The ASC payment group rates will remain as follows:

- Group 1 \$333
- Group 2 \$446
- Group 3 \$510
- Group 4 \$630
- Group 5 \$717
- Group 6 \$826 (\$676 + \$150 for intraocular lenses (IOLs))
- Group 7 \$995
- Group 8 \$973 (\$823 + \$150 for IOLs)
- Group 9 \$1339

### Additional Information

The CMS website for ASC information may be found on the CMS website at <http://www.cms.hhs.gov/suppliers/asc>.

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

From that Web page, look for CR4075 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 4075  
 Related CR Release Date: September 30, 2005  
 Related CR Transmittal Number: 690  
 Effective Date: October 1, 2005  
 Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 690, CR 4075

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## Smoking and Tobacco-Use Cessation Counseling Services: Common Working File Inquiry for Providers

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

### Provider Affected

Providers billing Medicare carriers or fiscal intermediaries (FIs) for smoking and tobacco-use cessation counseling

### Provider Action Needed

Change request (CR) 4104 announces the implementation of the capability for providers to access the CWF (part of Medicare's claims processing systems) for viewing the number of smoking and tobacco-use cessation counseling sessions a beneficiary has received.

### Background

CR3929, issued July 15, 2005, implements a frequency of service limitations edit in the CWF for smoking and tobacco-use cessation counseling, for dates of service on or after October 1, 2005. The implementation date for this CWF edit is October 3, 2005.

Effective April, 1, 2006, Medicare providers will be given the capability to view the number of smoking and tobacco-use cessation counseling sessions provided to a beneficiary. Providers will be able to access this file through the CWF, by entering the beneficiary's health insurance claim number (HICN).

Ultimately, the capability to view the number of smoking and tobacco-use cessation counseling sessions provided to a beneficiary gives providers the ability to determine a beneficiary's available coverage for this service.

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### Additional Information

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

From that Web page, look for CR 4104 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 on the CMS website at <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Medlearn Matters Number: MM4104  
Related Change Request (CR) #: 4104  
Related CR Release Date: October 21, 2005  
Related CR Transmittal #: 726  
Effective Date: April 1, 2006  
Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 726, CR 4104

## October 2005 Medicare Physician Fee Schedule Database Update

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

### Provider Types Affected

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

### Provider Action Needed

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

### Background

CR4031 amends payment files issued to Medicare carriers and intermediaries based upon the November 15, 2004, final rules for the 2005 Medicare physician fee schedule database.

### Additional Information

The changes to the fee schedule involve numerous CPT/HCPCS codes. While many of these changes are effective retroactive to January 1, 2005, please note that your carrier/FI will not reprocess claims already processed, unless you request them to do so.

The complete details of these changes to the October

update to the 2005 Medicare fee schedule database are described in an attachment to CR 4031, which is the official instruction issued to your carrier/intermediary. That instruction may be viewed by going to the CMS website at [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 4031 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 4031  
Related CR Release Date: September 9, 2005  
Related CR Transmittal Number: 672  
Effective Date: January 1, 2005  
Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 672, CR 4031

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## October 2005 Update and Revision to April and July 2005 Quarterly Average Sale Price Medicare Part B Drug Pricing File

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

### Provider Types Affected

All Medicare providers who bill Medicare contractors: carriers, including durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs)

### Provider Action Needed

#### STOP – Impact to You

CR 3992 provides the payment allowance limits in the April 2005, July 2005, and October 2005 drug pricing files. The revised payment limits for the codes listed within this article supersede the payment limits for these codes in any publication published prior to this document.

#### CAUTION – What You Need to Know

Be aware that certain Medicare Part B drug payment limits were revised for dates of service on or after April 1, 2005; on or before June 30, 2005; on or after July 1, 2005, and on or before September 30, 2005.

#### GO – What You Need to Do

Make certain your billing staff is aware of these changes. The downloads for the on the April 1, 2005; July 2005, and October 2005 average sale price (ASP) drug pricing files are available after September 19, 2005. See the Additional Information section in this article for the website address.

### Background

According to Section 303 (c) of the Medicare Modernization Act (MMA) the Centers for Medicare & Medicaid Services (CMS) will update the payment allowances for Medicare Part B drugs on a quarterly basis. Beginning January 1, 2005, Part B drugs (that are not paid on a cost or prospective payment basis) are paid based on 106 percent of the ASP.

The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis and each quarter, CMS will update your carrier/FI payment allowance limits with the ASP files.

### Exception

There are, however, exceptions to the general rule and they were summarized in MM3846, effective April 1, 2005.

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## Claim Decision Appeals—Modification to Medicare Fiscal Intermediary Shared System

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

### Provider Types Affected

Providers who submit appeals of claim decisions of Medicare fiscal intermediaries (FIs)

### Provider Action Needed

#### STOP – Impact to You

To enable providers and suppliers to verify that their redetermination request has been received, the FI will create

This article may be found on the CMS website at

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3846.pdf>.

The **one new exception** listed in this CR states that the payment allowance limits for radiopharmaceuticals are not subject to ASP. Medicare contractors (carriers, DMERCs, FIs, and RHHIs) will determine payment limits for radiopharmaceuticals based on invoice pricing or the methodology in place on November 2003.

### Implementation

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

### Additional Information

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

From that Web page, look for CR 3992 in the CR NUM column on the right and click on the file for that CR. CMS will also update the Microsoft Excel files on the CMS website to reflect these revised payment limits. Those files may be found on the CMS website at <http://www.cms.hhs.gov/providers/drugs/asp.asp>.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found on the CMS website at

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

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

Related Change Request (CR) Number: 3992

Related CR Release Date: August 19, 2005

Related CR Transmittal Number: 653

Effective Date: April 1, 2005, July 1, 2005, and October 1, 2005, respectively

Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 653, CR 3992

an automated correspondence system (ACS) master record to input the beneficiary HIC number, document control number (DCN), date(s) of service, type of bill, and the correspondence control number (CCN) within FISS when they receive a redetermination request.

#### CAUTION – What You Need to Know

The FI is not required to send the appellant a letter

**Claim Decision Appeals—Modification to Medicare Fiscal Intermediary Shared System (continued)**

acknowledging the receipt of a redetermination request. The entries into the ACS master record will remain for 90 days before they are automatically removed by the FISS system.

**GO – What You Need to Do**

Providers and suppliers will be able to view these CCNs within the direct data entry (DDE) system and verify that their appeal requests were received. This will allow providers to view which appeals were received by the FI and which appeals need to be resubmitted.

**Background**

At the redetermination level of appeal, the FI is not required to send the appellant a letter acknowledging the receipt of a redetermination request.

The purpose of Change Request (CR) 3970 is to add a master record for appeals that incorporates the following within FISS:

- Beneficiary HIC number
- Document control number (DCN)
- Date(s) of service
- Type of bill
- Correspondence control number (CCN).

Providers can thus view reports within the direct data entry (DDE) system to verify that their redetermination request(s) were received. The FI will accomplish this by creating an automated correspondence system (ACS) master

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record to input these numbers into the system when they receive a redetermination request.

FISS will be able to run a report on the master record and provide that report to providers through the DDE. The entries into the ACS master record will remain for 90 days before they are automatically removed by the FISS system.

**Additional Information**

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

From that Web page, look for CR 3970 in the CR NUM column on the right, and click on the file for that CR.

Please refer to your local FI for more information about this issue. To find the toll free phone number, go to CMS website <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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: 3970

Related CR Release Date: August 19, 2005

Related CR Transmittal Number: 174

Effective Date: January 1, 2006

Implementation Date: January 3, 2006

Source: CMS Pub. 100-20, Transmittal 174, CR 3970

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## Billing and Claims Processing Instructions for Claims Subject to Expedited Determinations

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

**Provider Types Affected**

Hospitals, skilled nursing facilities (SNFS), home health agencies (HHAS), hospices, and comprehensive outpatient rehabilitation facilities (CORFS) billing services to Medicare intermediaries, including regional home health intermediaries (RHHIs)

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

This article is based on Change Request (CR) 3949 which provides billing instructions needed for the full implementation of the expedited determinations process.

**CAUTION – What You Need to Know**

Since the expedited determinations process expands quality improvement organization (QIO) review to claim types other than inpatient hospital claims, the Medicare Claims Processing Manual (Pub. 100-04) is being revised to include a new section in Chapter 1 that incorporates inpatient claim instructions formerly in Chapter 3 and adds new instructions pertinent to expedited determinations.

**GO – What You Need to Do**

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

**Background**

The Benefits Improvement and Protection Act (BIPA, Section 521), as amended by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), required an expedited determinations process. In response, the Centers for Medicare & Medicaid Services (CMS) published preliminary instructions regarding the expedited determinations process in Change Request (CR) 3903 (Transmittal 594, dated June 24, 2005) for discharges from SNF, HHA, hospice and CORF services.

Those preliminary instructions (in CR3903) provided only the billing changes to reflect the outcomes of expedited review, which could be accepted without changes to current Medicare systems. CR 3903 may be reviewed on the CMS website at [http://www.cms.hhs.gov/manuals/pm\\_trans/R594CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R594CP.pdf).

A Medlearn Matters article related to the same subject may be found on the CMS website at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0538.pdf>.

CR 3949 completes the preliminary instructions in CR 3903 and provides:

- Billing instructions to accommodate full reporting of expedited review outcomes on claims; and

## Billing and Claims Processing Instructions for Claims Subject to Expedited Determinations (continued)

- Requirements for systems changes to accept the indicators that reflect those outcomes.

**Note:** CR 3949 is effective for claims submitted on or after January 3, 2006 with dates of service on or after July 1, 2005.

### Claims Indicators

The use of claims indicators regarding expedited review outcomes will enable intermediaries to be aware of QIO/qualified independent contractor (QIC) determinations when developing claims for medical review and other reasons. These claims indicators include the following:

- **Condition Code C3:** Partial approval – The claim was reviewed by the QIO, and some days of the stay or services were denied; the occurrence span code M0 indicates the dates of service for the stay that were approved.
- **Condition Code C4:** Services denied – The claim was reviewed by the QIO, and all services beyond the intended discharge date were denied.
- **Condition Code C7:** Extended authorization – QIO authorization for services extended.
- **Occurrence Span Code M0:** QIO/UR approved stay dates.

### Claims Submitted On or After January 3, 2006

With regard to these indicators, hospitals, SNFs, HHAs, CORFs, and hospice facilities should note the following billing requirements for claims **submitted on or after January 3, 2006:**

- Reflect QIO/QIC determinations upholding discharge by reporting condition code C4 on original claims and provider submitted adjustments with dates of service on or after July 1, 2005.
- Report condition code C4 on original claims and adjustments with types of bill 18x, 21x, 22x, 32x, 33x, 34x, 75x, 81x, or 82x.
- In cases where the beneficiary may be liable for payment and where condition code C4 applies, also report occurrence span code 76, denoting “patient liability period.”
- The Medicare intermediary will return your claim or adjustment containing condition code C4 if the patient status code is 30 unless condition code 20 or occurrence code 31 or 32 is also present on the claim.
- To reflect QIO/QIC determinations reversing a discharge, report condition codes C3 or C7, but note the following:

- Report condition codes C3 or C7 on original claims and provider submitted adjustments with dates of service on or after July 1, 2005.
- When appropriate, report condition codes C3 or C7 on original claims adjustments with types of bill 18x, 21x, 22x, 32x, 33x, 34x, 75x, 81x, or 82x.
- The Medicare intermediary will return your claims or adjustments that report condition code C3 if occurrence span code M0 is not also present.

**Note:** CMS has issued change request (CR) 4116 on October 14, 2005, to add type of bill 23x to the CMS manual system Pub. 100-04 (Medicare Claim Processing Manual), Chapter 1 (General Billing Requirements), Section 150.3.3. (Billing and Claim Processing Requirements Related to Expedited Determinations).

### Implementation

The implementation date for this instruction is January 3, 2006.

### Additional Information

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

From that Web page, look for CR 3949 in the CR NUM column on the right, and click on the file for that CR.

Please note that the new section 150 of Chapter 1 of the Medicare Claims Processing Manual is attached to CR 3949 and you may wish to review that section as it relates to provider and beneficiary payment liability issues.

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

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

Related Change Request (CR) Number: 3949

Related CR Release Date: July 29, 2005

Related CR Transmittal Number: 632

Effective Date: Applies to claims submitted on or after January 3, 2006 with dates of service on or after July 1, 2005

Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 632, CR 3949



**Claim Decision Appeals: Redeterminations and Reconsiderations  
(Implementation Date May 1, 2005)—Changes to Chapter 29**

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

**Provider Types Affected**

Physicians, providers, and suppliers who submit claims to Medicare for services

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

The new second level in the administrative appeals process is called **“reconsideration.”** It is different from the previous first level of appeal for Part A claims performed by Medicare fiscal intermediaries (FIs). Reconsiderations will be processed by qualified independent contractors (QICs).

**CAUTION – What You Need to Know**

Medicare contractors (FIs, including regional home health intermediaries [RHHIs], or carriers, including durable medical equipment regional carriers [DMERCs]) may consider as **good cause for late filing**, written redetermination requests that are:

- Mailed or personally delivered to CMS, SSA, RRB office or another Government agency; and
- Mailed in good faith and within the time limit, **but**
- Do not reach the appropriate Medicare contractor until after the time period to file a request expired.

In this case, the Medicare contractor may extend the period for filing.

**GO – What You Need to Do**

Please refer to the *Background* section of this article for additional new policy information about the time limit for filing a request for redetermination.

**Background**

The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, now requires a new second level in the administrative appeals process called a reconsideration.

Requests for redeterminations of appeal decisions (determinations) should go either to the qualified independent contractor (QIC), the administrative law judge (ALJ), or the hearing officer (HO), depending on whether the claim is a Part A or Part B claim; whether the Medicare contractor who issued the initial claim decision is an FI or a carrier; and the date the claim was issued.

**Time Limit for Filing a Request for Redetermination**

A request for redetermination must be filed within 120 days of the date of receipt of the notice of initial determination (either the Medicare summary notice (MSN) supplied to the beneficiary or the remittance advice (RA) supplied to the provider).

- For requests filed in writing – the date received is defined as the date received by the Medicare contractor in the corporate mailroom.
- For requests filed in person – the date received is defined as the date of the office’s date stamp on the request.

Please refer to the following table for clarification.

**Appeal Rights for Requests for Redeterminations  
The First Level of Appeal**

Medicare Claims	Medicare Contractor Issuing Redetermination	Date Redetermination Issued and Mailed	Where to Appeal the Redetermination*
Part A/Part B	FI	On or after May 1, 2005	Qualified Independent Contractor
Part B	Carrier	On or after January 1, 2006	Qualified Independent Contractor
Part A	FI	Before May 1, 2005	Administrative Law Judge
Part B	FI	Before May 1, 2005	Hearing Officer
Part B	Carrier	Before January 1, 2006	Hearing Officer

**Additional Information**

*Medicare Claims Processing Manual*, Chapter 29 - Appeals of Claims Decisions, 310.2, 310.3 may be found on the CMS website at [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c29.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c29.pdf).

Medlearn Matters article MM3530 – “MMA - Revisions to Medicare Appeals Process for Fiscal Intermediaries” (CR Title – Appeals Transition - BIPA 521 Appeals), **revised: 4/12/2005** may be found on the CMS website at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3530.pdf>.

Change Request CR 3530 “Revisions to Medicare Appeals Process for Fiscal Intermediaries” (CR Title- Appeals Transition – BIPA 521 Appeals), **revised: 4/12/2005** may be found on the CMS website at [http://www.cms.hhs.gov/manuals/pm\\_trans/R146OTN.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R146OTN.pdf).

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

From that Web page, look for CR 3942 in the CR NUM column on the right, and click on the file for that CR. The new sections of Chapter 29 of the *Medicare Claims Processing Manual* are attached to CR3942.

### *Appeals of Claims Decisions: Redeterminations and Reconsiderations (Implementation Date May 1, 2005) (continued)*

Please refer to your local carrier/DMERC/FI for more information about this issue. To find the toll free phone number, go to the CMS website at <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3942

Related CR Release Date: October 7, 2005

Related CR Transmittal Number: 697

Effective Date: May 1, 2005

Implementation Date: January 9, 2006

Source: CMS Pub. 100-4, Transmittal 697, CR 3942

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## General Appeals Process in Initial Determinations

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

### Provider Types Affected

Physicians, providers, and suppliers who submit Part A or Part B fee-for-service claims to Medicare

### Background

The Medicare claim appeals process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a reconsideration. It is different from the previous first level of appeal for Part A claims performed by fiscal intermediaries (FIs). Reconsiderations will be processed by qualified independent contractors (QICs).

CR 4019 focuses on the general appeals process in initial determinations. CR 4019 contains a considerable amount of information that is pertinent to the entire process of Medicare claims appeals, and focuses specifically on the additions of sections 200 to 260 to chapter 29 of the *Medicare Claims Processing Manual*.

### Key Points

#### Centers for Medicare & Medicaid Services (CMS) Decisions Subject to the Administrative Appeals Process

The Social Security Administration (SSA) makes initial Part A and Part B entitlement determinations and initial determinations on applications for entitlement. These decisions are subject to appeal with the SSA.

#### Minor Errors and Omissions

Providers should be aware that there is no need to appeal a claim if the provider has made a minor error or omission in filing the claim, which, in turn, caused the claim to be denied. In the case where a minor error or omission is involved, the provider can request that the Medicare contractor reopen the claim so the error or omission can be corrected, rather than having to go through the appeals process.

#### Who May Appeal

CR 4019 (Additions to Chapter 29) defines and describes the individuals and entities who have the right to appeal a Medicare contractor's initial determination. (Medicare contractors are carriers, including durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs).) An individual who has a right to appeal is referred to as a "party."

#### Provider or Supplier Appeals When the Beneficiary Is Deceased

When a provider or supplier appeals on behalf of a deceased beneficiary, and the provider or supplier otherwise does not have the right to appeal, it is the contractor's responsibility to determine whether another party is available to appeal. CR 4019 describes what must be done in this situation.

#### Parties to an Appeal

Any of the persons/entities who may appeal Medicare's decision to deny or reduce payment are parties to an appeal of a claim for items or services payable under Part A or Part B.

#### Steps in the Appeals Process: Overview

The process of appeal described in CR 4019 is effective for all redeterminations issued on or after May 1, 2005, by Medicare FIs and all redeterminations issued on or after January 1, 2006, by carriers. The appeals process consists of five levels. Each level must be completed for each claim at issue prior to proceeding to the next level of appeal. No appeal can be accepted until an initial determination has been made for the claim. The following chart outlines the steps in the Medicare appeal process:

*General Appeals Process in Initial Determinations (continued)*

**The Medicare Fee-for-Service Appeals Process**

<b>Appeal Level</b>	<b>Time Limit for Filing Request</b>	<b>Where to Appeal*</b>	<b>Monetary Threshold To Be Met or Amount in Controversy</b>
<b>1. Redetermination</b>			
<ul style="list-style-type: none"> <li>Performed by the Medicare Contractor</li> </ul>	120 days from date of receipt of the notice initial determination (MSN or RA). (The notice of initial determination is presumed to be received five days from the date of the notice unless there is evidence to the contrary.)	<b>Part A – FI (MAC)</b>  <b>Part B – Carrier (MAC)</b>	None
<b>2. Reconsideration</b>			
<ul style="list-style-type: none"> <li>Performed by QIC</li> <li>Case file prepared by the Medicare contractor and forwarded to the QIC.**</li> <li>Medicare contractor may have effectuation responsibilities for decisions made by the QIC.</li> </ul>	180 days from date of receipt of the redetermination	Part A and B – QIC	None
<b>3. Administrative Law Judge (ALJ) Hearing</b>			
<ul style="list-style-type: none"> <li>Case file prepared by the QIC and forwarded to the HHS Office of Medicare Hearings and Appeals (OMHA).</li> <li>Medicare contractor may have effectuation responsibilities for decisions made at the ALJ level.</li> </ul>	60 days from the date of receipt of the reconsideration notice	Part A and B – HHS OMHA Field Office	At least \$100 remains in controversy***  <i>For requests made on or after January 1, 2006, at least \$110 remains in controversy</i>
<b>4. Departmental Appeals Board (DAB) Review</b>			
<ul style="list-style-type: none"> <li>Contractor may have effectuation responsibilities for decisions made at the DAB level.</li> </ul>	60 days from the date of receipt of the ALJ hearing decision/dismissal	Part A and B – DAB or ALJ Hearing Office	None
<b>5. Federal Court (Judicial) Review</b>			
<ul style="list-style-type: none"> <li>Medicare contractor may have effectuation responsibilities for decisions made at the Federal Court level.</li> </ul>	60 days from date of receipt of DAB decision or declination of review by DAB		At least \$1,050 remains in controversy*** <i>For requests made on or after January 1, 2006, at least \$1,090 remains in controversy</i>

\*Where to Appeal – Part A includes Part B claims filed with the FI.

\*\* In accordance with the appropriate manual section and the Joint Operating Agreement (JOA).

\*\*\*Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar amount in controversy (AIC) requirement will increase by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of \$10 will be rounded to the nearest multiple of \$10.

**Where to Appeal**

Where a party must file an appeal depends on the level of appeal. The above chart indicates where appellants should file appeal requests for each level of appeal.

**When to Appeal – Time Limits for Filing Appeals and Good Cause for Extension of the Time Limit for Filing Appeals**

The time limits for filing appeals vary according to the type of appeal. The table above indicates the time limits for filing appeal requests for each level of appeal. These time limits may be extended if good cause for late filing is shown.

## General Appeals Process in Initial Determinations (continued)

### Good Cause – General Procedure to Establish Good Cause for Late Filing

Procedures to establish good cause are effective for all requests for redeterminations received by FIs on or after May 1, 2005, and all requests for redeterminations received by the carrier on or after January 1, 2006. The new Section 240 of Chapter 29 of the *Medicare Claims Processing Manual* lists the general procedure for establishing good cause for late filing; when a favorable decision for good cause is made; and when an unfavorable decision for good cause is made. A listing of conditions and examples that may establish good cause for late filing by beneficiaries, or by providers, physicians, and suppliers, can be found in Section 240, which is attached to CR 4019.

### Amount in Controversy Requirements

The amount in controversy requirements apply only to the ALJ and federal court levels. The chart above indicates the amount in controversy (AIC) as well as the method of calculating the AIC, for the Medicare appeals process.

### Additional Information

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

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From that Web page, look for CR 4019 in the CR NUM column on the right, and click on the file for that CR. All of the new sections of Chapter 29 of the *Medicare Claims Processing Manual* are attached to CR4019. These sections provide excellent detail that explains the revised appeals process.

Please refer to your local FI or carrier for more information about this issue. To find their toll-free phone number, go to the CMS website <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: 4019

Related CR Release Date: October 7, 2005

Related CR Transmittal Number: 695

Effective Date: May 1, 2005

Implementation Date: January 9, 2006

Source: CMS Pub. 100-4, Transmittal 695, CR 4019

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## The Comprehensive Error Rate Testing Process for Handling a Provider's Allegation of Medical Record Destruction

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

SE0547 outlines the process Medicare providers should follow when medical records requested by Medicare's comprehensive error rate testing (CERT) documentation contractor (CDC) and/or Medicare's CERT review contractor (CRC) are destroyed by disaster.

### CAUTION – What You Need to Know

For CERT purposes, a "disaster" is defined as any natural or man-made catastrophe that causes damages of sufficient severity and magnitude to partially or completely destroy or delay access to medical records and associated documentation.

- Natural disasters would include hurricanes, tornadoes, earthquakes, volcanic eruptions, fires, mudslides, snowstorms, and tsunamis.
- Man-made disasters would include terrorist attacks, bombings, floods caused by manmade actions, civil disorders, and explosions. A disaster may be widespread or impact multiple structures or be isolated and impact a single site only.

### GO – What You Need to Do

If you cannot submit the requested medical records

because they were destroyed by a disaster, the CDC/CRC will ask you to attest, under penalty of perjury, to the destruction of the medical records. The **attestation form** is available to providers at <http://www.certprovider.org>.

Providers who need to use this form can print and fax the form to the CDC who will either retain the form or send it to the CRC depending on which contractor sent the initial request letter for medical record documentation to the provider.

### Background

The Centers for Medicare & Medicaid Services (CMS) recognizes that there are circumstances in which destruction of medical record documentation because of unforeseen events should not count as a "no documentation error." Therefore, CMS has established the following process and procedures to corroborate allegations that CERT-requested medical records were destroyed by a disaster.

The **corroboration process is comprised of two steps: 1) qualification and 2) accuracy**. In the first step, the CDC/CRC will review the attestation statement to determine if the event qualifies as a disaster. Provider induced disasters and disasters caused by negligence on the part of providers will be counted as "no documentation errors."

The following are examples of provider induced disasters and **disasters caused by negligence** on the part of providers that **would NOT qualify** as a natural or man-made disaster:

*CERT Process for Handling a Provider's Allegation of Medical Record Destruction (continued)*

- My dog ate the medical record
- My computer lost or destroyed the medical record

If the event does not qualify as a natural or man-made disaster defined in the Provider Action Needed section of this article, the claim associated with that medical record is documented as a “no documentation error.”

The following are examples of events that **WOULD qualify** as a natural or man-made disaster:

- The medical record was destroyed by a flood.
- Office fire consumed the medical record.

If the event does qualify as a natural or man-made disaster, the CDC/CRC will move to the **second step in the corroboration** process: confirming the accuracy of the attestation. The CDC will confirm the attestation statement through any or all of the following means:

- The CDC **checks the following database records for evidence** of natural, man-made, and/or provider induced disasters: Pacer (civil and criminal searches), <http://www.crimetime.com>, news searches, Internet search, HHS OIG sanctioned providers, Merlin, state record searches (courthouse records, insurance carriers or <http://www.insurancefraud.org>/Choicepoint / Autotrak, Argyli, Tracer, and the National Crime Insurance Bureau).
- The CDC **interviews the provider** who reported the destruction of medical records. The CDC determines the events leading up to the destruction of medical records, such as: what caused the destruction (weather, fire, etc.), were back-up records maintained (electronic or otherwise), what else might have been destroyed, were fire, police, insurance adjusters called to review the damage? The CDC will identify the magnitude of the destruction to medical records, determine if the Medicare Carrier/DMERC/FI has copies, interview other third parties as necessary, and determine if medical records were retained elsewhere and how were they maintained.
- The CDC **validates additional supporting evidence** for the event, which may include but not be limited to the following sources:
  - ♦ Weather related events, such as, rain, floods, hurricanes, tornadoes, etc., that can be confirmed by NOAA on a state and county geographical basis.
  - ♦ Fire that can be confirmed by checking with the local fire marshall.
  - ♦ Explosions, such as, natural gas that can be confirmed by the local Fire Marshal or local gas company.

- ♦ Explosions, such as, chemical explosions that can be confirmed by the local fire marshall and the Bureau of Alcohol, Tobacco, and Firearms.
- ♦ Local, state, and federal investigative officials can confirm explosions.
- ♦ State insurance officials can confirm whether doctors, hospitals, and DME suppliers applied for insurance coverage under their insurance policies.
- ♦ FEMA can confirm if doctors, hospitals, and DME suppliers applied for disaster recovery loans.
- ♦ Local and state investigative agencies may be able to confirm events leading to the destruction of medical records.
- ♦ Employees or non-employees of doctors, hospitals, and DME suppliers may have contributed to the destruction of medical records and there should be records disclosing charges against that individual(s).

Where the CDC is unable to verify the accuracy of the explanation provided in the attestation statement, the claim will be counted as a “no documentation error.” Please note that this could eventually lead to a determination that an overpayment has occurred and overpayment recovery action could result.

### Additional Information

Medlearn Matters article MM2976 describes the CERT program and MM3812 provides additional information on CERT. Those articles may be viewed, respectively on the CMS website at:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM2976.pdf> and

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3812.pdf>.

To review copies of the letters CERT contractors use to request medical record documentation from Medicare physicians/providers go to the CMS website at <http://www.cms.hhs.gov/CERT/letters.asp>.

Also on this site are CERT Newsletters that provide information about the entire CERT process. If you have questions, please contact your carrier or intermediary at their toll free number, which is available on the CMS website at <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Source: Special Edition Medlearn Matters Article SE0547

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## Medical Review Additional Documentation Requests

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

### Provider Types Affected

All Medicare providers and suppliers

### Provider Action Needed

#### STOP – Impact to You

Through the use of the additional documentation request (ADR), your carrier, including durable medical equipment regional carriers (DMERCs), or intermediary may ask you for additional documentation regarding a particular Medicare claim.

#### CAUTION – What You Need to Know

To get a more complete picture of a patient’s clinical condition, CR 4022 allows carriers, DMERCs, and intermediaries to request additional documentation about the patient’s condition before and after a specific service to gain a more complete picture of the patient’s clinical condition.

#### GO – What You Need to Do

Your staffs should be aware of ADRs and should be prepared to respond to them within 30 days.

### Background

When a carrier, DMERC, or intermediary (also referred to as Medicare contractor(s)), cannot make coverage or coding determination from the information that has been provided on a claim and its attachments, they may ask for additional documentation by issuing an additional documentation request (ADR). The Medicare contractor must request records related to the claim(s) being reviewed. The Medicare contractor may collect documentation related to the patient’s condition before and after a service in order to get a more complete picture of the patient’s clinical condition. Your Medicare contractor will not deny other claims

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related to the documentation of the patient’s condition before and after the claim in question unless they review and give appropriate consideration to the actual additional claims and associated documentation.

### Additional Information

For more information about ADRs during prepayment or postpayment medical review, go to the CMS website [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 4022 in the CR NUM column on the right and click on the file for that CR.

Also useful is the *Medicare Program Integrity Manual*, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 3.4.1.2 (Additional Documentation Requests (ADR) During Prepayment or Postpayment MR), which is an attachment to CR 4022.

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

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

Related Change Request (CR) Number: 4022

Related CR Release Date: September 30, 2005

Related CR Transmittal Number: 125

Effective Date: December 30, 2005

Implementation Date: December 30, 2005

Source: CMS Pub. 100-8, Transmittal 128, CR 4022

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

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

### Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services paid under the DMEPOS fee schedule

### Provider Action Needed

This article is based on Change Request (CR) 4026 and provides specific information regarding the October quarterly update of the 2005 durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule.

### Background

The DMEPOS fee schedules are updated on a quarterly basis in order to:

- Implement fee schedule amounts for new codes; and

- Revise any fee schedule amounts for existing codes that were calculated in error.

Payment on a fee schedule basis is required for:

- Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a)(h)(i)); and
- Parenteral and Enteral Nutrition (PEN) by regulations contained in the Code of Federal Regulations (42 CFR 414.102).

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

The following codes are being added to the Healthcare Common Procedure Coding System (HCPCS) on October 1, 2005, and are effective for claims with dates of service on or after October 1, 2005:

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

<b>Code</b>	<b>Description</b>	<b>Code</b>	<b>Description</b>
Q0480	Driver for use with pneumatic ventricular assist device, replacement only	Q0495	Battery/power pack charger for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0481	Microprocessor control unit for use with electric ventricular assist device, replacement only	Q0496	Battery for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0482	Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only	Q0497	Battery clips for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0483	Monitor/display module for use with electric ventricular assist device, replacement only	Q0498	Holster for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0484	Monitor/display module for use with electric or electric/pneumatic ventricular assist device, replacement only	Q0499	Belt/vest for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0485	Monitor control cable for use with electric ventricular assist device, replacement only	Q0500*	Filters for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0486	Monitor control cable for use with electric/pneumatic ventricular assist device, replacement only	Q0501	Shower covers for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0487	Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device, replacement only	Q0502	Mobility cart for pneumatic ventricular assist device, replacement only
Q0488	Power pack base for use with electric ventricular assist device, replacement only	Q0503	Battery for pneumatic ventricular assist device, replacement only, each
Q0489	Power pack base for use with electric/pneumatic ventricular assist device, replacement only	Q0504	Power adapter for pneumatic ventricular assist device, replacement only, vehicle type
Q0490	Emergency power source for use with electric ventricular assist device, replacement only	Q0505	Miscellaneous supply or accessory for use with ventricular assist device
Q0491	Emergency power source for use with electric/pneumatic ventricular assist device, replacement only		
Q0492	Emergency power supply cable for use with electric ventricular assist device, replacement only		<b>* Replacement filters</b> described by code Q0500 are furnished in boxes of varying quantities by different manufacturers. Therefore, the base unit for code Q0500 for billing purposes is per each filter.
Q0493	Emergency power supply cable for use with electric/pneumatic ventricular assist device, replacement only		<b>Note:</b> Instructions regarding the implementation of the above codes were furnished in CR 3931.
Q0494	Emergency hand pump for use with electric or electric/pneumatic ventricular assist device, replacement only		The following table describes upcoming changes in certain HCPCS codes for wheelchairs beginning October 1, 2005.

<b>HCPCS Code</b>	<b>New Information</b>
E0971 (anti-tipping device for wheelchairs)	The fee schedule amount for code E0971 is being revised to reflect a base billing unit of "EACH." Up to this point E0971 represented "each" or a "pair" of devices. In October the fee schedule will be standardized to represent fees per each unit.
E1038 & E1039 (transport chairs)	The fee schedule amounts for E1038 are being revised to correct errors in the fee calculations and reflect changes in billing for items under these codes. The fees erroneously included elevating leg rests and those should be billed separately using code K0195. The updated schedule will no longer include prices for the leg rests.
K0195 (elevating leg rests)	Suppliers should be billing these leg rests under this code.
E1039 (transport chairs with patient weight capacity over 300 pounds)	Claims dated on/after October 1, 2005 should contain E1039 for chairs with weight capacity OVER 300 pounds.
E1038 (transport chairs with patient weight capacity under 300 pounds)	Claims dated on/after October 1, 2005 should contain E1038 for chairs with weight capacity of 300 pounds or less.
E1238 (Pediatric size, folding, adjustable wheelchair without seating system)	The fee schedule is being revised for E1238 to correct fee schedule calculation errors.

HCPCS codes L3000 through L3649 were added to the fee schedule file effective July 1, 2005, for use in paying claims for shoes that are an integral part of an orthoses.  
 L5685 was added to the HCPCS effective January 1, 2005. The fee schedules are being established as part of this report.

## October 2005 Quarterly Fee Schedule Update for DMEPOS (continued)

### Implementation

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

### Additional Information

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

From that Web page, look for CR4026 in the CR NUM column on the right, and click on the file for that CR.

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

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

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

Related Change Request (CR) Number: 4026

Related CR Release Date: September 2, 2005

Related CR Transmittal Number: 665

Effective Date: January 1, 2005 for implementation of revised fee schedule amounts for codes in effect on January 1, 2005; October 1, 2005 for all other changes

Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 665, CR 4026

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## New G Code for Power Mobility Devices

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

### Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for services related to power mobility devices (PMDs).

### Provider Action Needed

#### STOP – Impact to You

This article is based on change request (CR) 4121, which announces that a new G Code (G0372) has been established to recognize the additional physician service and resources required to establish and document the need for PMDs.

### CAUTION – What You Need to Know

The new G code is only payable if all of the information necessary to document the PMD prescription is included in the medical record after a face-to-face examination of the beneficiary, and the prescription is received by the PMD supplier within 30 days after the face-to-face examination.

### GO – What You Need to Do

Please see the *Background* section of this article for further details.

### Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 302(a)(2)(E)(iv)) details the revised conditions for Medicare payment of PMDs. It states that payment for motorized or power wheelchairs may not be made unless a face-to-face examination of the beneficiary has been conducted, and a written prescription (order) for the PMD has been provided by one of the following providers:

- Physician (as defined in Section 1861(r)(1) of the Social Security Act)
- Physician assistant
- Nurse practitioner

- Clinical nurse specialist (as those terms are defined in Section 1861(aa)(5) of the Social Security Act).

**Note:** Payment for the history and physical examination will be made through the appropriate evaluation and management (E&M) code corresponding to the history and physical examination of the patient.

### New G Code

Due to the MMA requirement that the physician or treating practitioner create a written prescription and a regulatory requirement that the physician or treating practitioner prepare pertinent parts of the medical record for submission to the durable medical equipment supplier, the Centers for Medicare & Medicaid Services (CMS) has established the new G Code (G0372), to recognize additional physician services and resources required to establish and document the need for a PMD.

CMS believes that the typical amount of additional physician services and resources involved is equivalent to the physician fee schedule relative values established for a level 1 office visit for an established patient (*Current Procedural Terminology (CPT) code 99211*).

The payment amount for such a visit is \$21.60; therefore, the payment amount for G0372 for 2005 will be \$21.60, adjusted by the geographic area where the services is provided, and based on the physician fee schedule values for a level 1 established patient office visit (CPT 99211).

Code G0372 indicates that:

- All of the information necessary to document the PMD prescription is included in the medical record.
- The prescription, along with the supporting documentation, has been received by the PMD supplier within 30 days after the face-to-face examination.

Effective October 25, 2005, G0372 will be used to recognize additional physician services and resources



*New G Code for Power Mobility Devices (continued)*

required to establish and document the need for the PMD, and it will be added to the Medicare physician fee schedule.

**G0372** Physician service required to establish and document the need for a power mobility device

**Short Descriptor:** MD service required for PMD

**Reimbursement**

The following fee schedules are effective for G0372 for services provided **on or after October 25, 2005**.

Code	Loc 01/02	Loc 03	\$Loc 04
G00372	\$20.82	\$21.91	\$22.86

**Implementation**

The implementation date for the instruction is October 25, 2005.

**Additional Information**

For full details regarding wheelchair coverage, visit the CMS page for wheelchairs on the CMS website at <https://www.cms.hhs.gov/coverage/wheelchairs.asp>.

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

From that Web page, look for CR4121 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 on the CMS website at <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 4121

Related CR Release Date: October 18, 2005

Related CR Transmittal Number: 713

Effective Date: October 25, 2005

Implementation Date: October 25, 2005

Source: CMS Pub. 100-4, Transmittal 713, CR 4121

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**Mobility Assistive Equipment Web Page now Available**

The Centers for Medicare & Medicaid Services (CSM) announces the publication of its new regulation, CMS-3017-IFC, Power Mobility Devices (PMD).

This regulation includes new conditions of payment that will affect how DME (durable medical equipment) suppliers dispense and submit claims for PMDs, how physicians and treating practitioners will evaluate beneficiaries for PMDs, and new requirements for PMD prescriptions and the submission of supporting medical record documentation.

CMS has developed several materials for your reference, including a fact sheet and frequently asked questions. To view these items—as well as a full copy of the regulations—please visit the “mobility Assistive Equipment” page on the Medicare Coverage website at <http://www.cms.hhs.gov/coverage/wheelchairs.asp>.

To view the press release, go to CMS website at <http://www.cms.hhs.gov/media/press/release.asp?Counter=1540>. ❖

Source: Provider Education Resources Listserv, Message 200508-11

**Financial Liability for Services Subject to Home Health Consolidated Billing**

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

**Provider Types Affected**

Home health agencies (HHAs) and providers and suppliers of services to Medicare patients in a home health episode of care

**Provider Action Needed**

This instruction is intended mostly as an informational refresher. However, the article and CR 3948 clarify guidance regarding home health services (HHS) consolidated billing, particularly the guidance that addresses potential provider and beneficiary liability for payment. **Providers/suppliers treating Medicare patients in an episode of home health care are encouraged to review the entire CR 3948.** Instructions for accessing CR 3948 are provided at the end of this article.

The Centers for Medicare & Medicaid Services (CMS) is providing this information because questions about payment liability have persisted since the home health prospective payment system (HH PPS) was implemented in

October 2000. CMS believes that providing clear answers in the *Medicare Claims Processing Manual* will help you better understand HH PPS.

**Background**

Section 1842 (b)(6)(F) of the Social Security Act requires consolidated billing for all home health services that are included under a physician-authorized home health care plan. Earlier guidance and information about HH PPS consolidated billing was primarily published in articles attached to Program Memoranda. CR 3948 (from which this article is taken) improves the organization of and clarifies instructions about HH PPS. In particular, it identifies circumstances in which providers or beneficiaries may be liable for payment for services subject to HH PPS consolidated billing.

**A Short Summary of the Guidance**

Under HHS consolidated billing, only the primary HHA can bill for services included in a beneficiary’s home health

### *Financial Liability for Services Subject to Home Health Consolidated Billing (continued)*

benefit during the beneficiary's HHA episode of care. With the exception of durable medical equipment (DME) and physician-provided therapy services (discussed below), Medicare will not separately pay other providers or suppliers for any home health services that they render. Therefore, providers and suppliers of home health services should be aware that, under certain circumstances, they, or the beneficiary, could potentially bear the cost of these services.

#### **The Guidance in More Detail**

HH PPS consolidated billing provides that the Medicare payment for all of a beneficiary's home health items and services is to be made to a single (known as "primary") HHA that oversees that beneficiary's physician-authorized home health plan. This primary HHA is the **only** agency that may bill Medicare for home care for a given homebound beneficiary at a specific time. Further, the payment Medicare makes is to the primary HHA, regardless of who actually furnishes the service (including services furnished by others under arrangement to the primary HHA, by any other contracting or consulting arrangements existing with the primary HHA, or by any other mechanism).

However, while the primary HHA is responsible for providing all of a patient's home health services, they would not be responsible for payment to another provider if they were unaware of the physician's orders for that service. Therefore, if an independent provider/supplier were to provide the beneficiary a home health service that was already consolidated into the HHA's payment, Medicare would deny their claim and they would not receive payment.

#### **Types of Services Subject to Home Health Billing**

The following types of services are subject to this home health consolidated billing provision, and are included in the primary HHA's payment:

- Skilled nursing care
- Home health aide services
- Physical therapy
- Speech-language pathology
- Occupational therapy
- Medical social services
- Routine and non-routine medical supplies
- Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of a HHA that is affiliated or under common control with that hospital.
- Care for homebound patients involving equipment too cumbersome to take to the home.

Two types of services, however, are an exception to this guidance, and are therefore not subject to the home health consolidated billing methodology. These services are:

- Physician-performed therapy services (which means that although the procedure code would be subject to HH consolidated billing, the specialty code which indicates that it was provided by a physician removes it).
- Durable medical equipment (DME).

#### **Billing of Durable Medical Equipment**

DME warrants some further discussion. DME may be billed by a supplier to a durable medical equipment regional carrier (DMERC) or billed by an HHA (including HHAs other than the primary HHA) to a regional home health intermediary (RHHI). To prevent duplicate RHHI and DMERC billing (the same dates of service for the same beneficiary), Medicare system edits ensure that all DME items billed by HHAs have a line-item date of service and HCPCS code, even though, by law, HH consolidated billing does not apply to DME. If the RHHI and the DMERC receive duplicate bills (for either purchase or rental), the first claim received will be processed and paid, and the subsequent duplicate claims will be denied.

#### **How Do You Protect Yourself and the Beneficiaries?**

In general, all providers and suppliers serving a home health patient should attempt to protect the beneficiary from unexpected liability by notifying them of the possibility that they can be responsible for payment.

#### **Primary HHAs**

Let's first discuss your responsibilities if you are the primary HHA. When a homebound beneficiary seeks care from you, you need to determine if they are already being served by a primary HHA. You can ask the beneficiary or his/her representative, if they are already being served by an HHA. Or, you can send an inquiry to your RHHI.

If the response indicates that the beneficiary is not already under the care of another HHA, you may admit them and you will become primary. The HHA that submits a successfully processed request for anticipated payment (RAP) or no-RAP low utilization payment adjustment (LUPA) will be recorded as the primary HHA for a given episode in the common working file (CWF).

You may also admit them, even if an episode is already open at another HHA, if the patient has chosen to transfer. If a beneficiary transfers during a 60-day episode, then the transfer HHA that establishes the new plan of care assumes responsibility for that patient's consolidating billing.

At the time of their initial home health care admission, you, as the primary HHA, must advise the patient that you will be providing all of their home health services, including therapies and supplies. You must also explain the disciplines (e.g., skilled nursing, physical therapy, home health aide, etc.) that will be furnishing their care, and the proposed visit frequency.

In addition, you must advise the patient, in advance (both orally and in writing), about possible payment sources, including what Medicare is expected to cover, as well as other payment sources, including payment from the patient. This discussion should help alert the beneficiary to the possibility of payment liability if they were to obtain services from anyone other than their primary HHA.

#### **Independent Providers/Suppliers**

Since Medicare payment for services that fall under home health consolidated billing is made to the primary HHA, independent providers or suppliers of these services need to understand that Medicare will not pay you separately. Therefore, before you provide a homebound beneficiary any services, you need to first determine if they are being served by a primary HHA.

**Financial Liability for Services Subject to Home Health Consolidated Billing (continued)**

To get this information you can, first, ask the beneficiary (or their authorized representative) if they are currently receiving home health services under a home health plan of care. In fact, beneficiaries and their representatives should have the most complete information as to whether or not they are receiving home health care. But, beneficiary-derived HH information, in and of itself, does not shift liability to either the beneficiary or to Medicare. Additionally, you can ask your intermediary or carrier.

**Note:** Institutional providers who bill fiscal intermediaries (FIs) can access this information electronically through the home health CWF inquiry process. (See Chapter 10, Section 30.1, Health Insurance Eligibility Query to Determine Episode Status attached to CR 3948.) Independent therapists who bill carriers or suppliers who bill DMERCs can call the provider toll free line to request home health eligibility information available on the CWF. (Those toll free numbers are available on the CMS website at <http://www.cms.hhs.gov/medlearn/tollnums.asp>.)

But remember that the carrier's or DMERC's information is based only on claims Medicare has received from HHAs by the day of the contact.

If you are concerned about the reliability of any of this information, you should advise the HH beneficiary that if they decide to accept your services rather than those provided by the primary HHA, they can be liable for the payment.

Finally, if you learn of a home health episode and contact the primary HHA, you might inquire about the possibility of making a payment arrangement with them for the service. Such contacts may foster relationships between therapy providers, suppliers and HHAs that are beneficial both to the providers involved and to Medicare beneficiaries.

**Hospitals**

Hospitals are responsible for making Medicare beneficiaries and caregivers aware of Medicare home health coverage policies in order to:

- Help ensure that those services are provided appropriately.
- Alert the beneficiary to their potential liability under home health consolidated billing.

Under the Medicare Conditions of Participation (COP) for Hospitals: Discharge planning, (42 CFR, §482.43 (b) (3) and (6)), your discharge planning process must include an evaluation of the likelihood that a patient will require post-hospital services and an evaluation of their availability. Hospitals need to counsel those beneficiaries who are to receive HH services after discharge that their primary HHA will provide all of their home health services. You should also provide them with a list of HHAs from which to choose, and notify the agency that you are referring the patient to and provide the agency with any counseling notes. This should serve as a reminder to the HHA to notify the beneficiary that they will be providing all of their HH services.

**Other Important Information  
Institutionalizing an HH patient**

Under HH PPS, claims for inpatient hospital and skilled nursing facility (SNF) services have priority over claims for home health services. Because institutionalized beneficiaries cannot receive home care, if Medicare detects dates of service on an HH PPS claim that fall within the dates of an inpatient or SNF claim (not including the dates of admission and discharge), the RHHI will reject the HH claim. This will be the outcome even if the HH PPS claim were received first and the SNF or inpatient hospital claims came in later.

**Edits and Denials**

Claims subject to consolidated billing may be identified either pre-payment or post payment. HH consolidated billing editing is applied when Medicare has received and processed the episode claim. Any line item services within the episode start, and end, or last billable service dates, will be edited.

Medicare sends information to the FIs and carriers that enable them to reject or deny line items on claims subject to consolidated billing. This rejection or denial may take place either prior to, or after, payment. If it occurs after payment, Medicare notifies the FI or carrier to make a post-payment rejection or denial. FI post-payment recoveries will be made automatically in the claims process, and carriers follow their routine overpayment identification and recovery procedures.

Important editing issues include the following:

- If Medicare receives only a request for anticipated payment (RAP) from an HHA for an episode and an incoming claim from another provider contains dates of service within the 60-day home health episode period, Medicare alerts the FI or carrier that the incoming claim may be subject to consolidated billing. The FI or carrier will process the claim for payment, but also alerts the provider on the remittance advice with remark code N88: *"This payment is being made conditionally. An HHA episode of care notice has been filed for this patient...This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care."*
- If an independent provider/supplier submits a claim for services (subject to home health consolidated billing) for a beneficiary under a home health care plan (place of service on the claim is "12 home"), but Medicare does not yet have a record of either a RAP or a home health claim for the episode of care, your carrier will alert you on the remittance advice with remark code N116: *"This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care...This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care."*
- In HH PPS consolidated billing, non-routine medical supplies are identified as a list of discrete items by HCPCS code. Medicare periodically publishes Routine Update Notifications that contain updated lists of non-

## Financial Liability for Services Subject to Home Health Consolidated Billing (continued)

routine supply codes and therapy codes that must be included in home health consolidated billing. The lists are updated annually, effective January 1, as a result of the annual changes in HCPCS codes, and also as frequently as quarterly if required by the creation of new, mid-year HCPCS codes. (Medlearn Matters articles are prepared to inform providers of these periodic updates.)

- ♦ Any claim submitted to a DMERC, with dates of service that overlap the dates of an open HH PPS episode and containing a non-routine supply HCPCS code, will be denied.
- ♦ Non-routine supply HCPCS codes, which may be claimed as part of providing certain emergency, surgical, diagnostic, and end-stage renal disease (ESRD) services, are either bundled into the rate paid for the primary service, or are otherwise incident to the primary service(s) being rendered. They do not fall within the bundling provisions of HH PPS, and are not subject to CWF consolidated billing edits.

- Medicare enforces consolidated billing for outpatient therapies on claims submitted to FIs, recognizing as therapies all services billed under revenue codes 042x, 043x, 044x. These revenue codes have been cross-referenced to a list of HCPCS codes that represent the same services for use in editing against carrier claims. This list will also be updated periodically by routine update notification.
- Remember, however, as mentioned earlier, physician-performed therapy services are not subject to home health consolidated billing.

- **Osteoporosis drugs** are subject to home health consolidated billing, even though they continue to be paid on a cost basis. Only a primary HHA can bill for their use by Medicare patients in an episode of care. For more detailed information, refer to Section 90.1 of Chapter 10 of the *Medicare Claims Processing Manual*, which is available on the CMS website at [http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp).

### Additional Information

This article summarizes the information made available in CR3948. Providers treating Medicare patients in a home health episode of care are encouraged to be familiar with all the details of CR3948. You may find CR 3948 on the CMS website at [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3948 in the CR NUM column on the right, and click on the file for that CR. CR 3948 includes revised portions of the *Medicare Claims Processing Manual* related to the HH PPS. Finally, if you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3948  
Related CR Release Date: August 5, 2005  
Related CR Transmittal Number: 635  
Effective Date: October 1, 2000  
Implementation Date: November 3, 2005

Source: CMS Pub. 100-4, Transmittal 635, CR 3948

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## National Modifier and Condition Code To Be Used To Identify Disaster Related Claims

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

### Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries) for services rendered to beneficiaries affected by hurricane Katrina.

### Provider Action Needed

#### STOP – Impact to You

This article is based on change request (CR) 4106, which establishes a new condition code and modifier for providers to use to indicate claims for hurricanes Katrina and Rita, and other disasters.

#### CAUTION – What You Need to Know

To accommodate the emergency health care needs of Medicare beneficiaries and providers affected by hurricane

Katrina and Rita, and any future disasters, the Centers for Medicare & Medicaid Services (CMS) has created the following new condition code and modifier, effective for dates of service on and after August 21, 2005. The new condition code is "DR – Disaster related" and the new modifier is "CR – Catastrophe/Disaster Related."

### GO – What You Need to Do

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

### Background

CMS has acted to ensure that the Medicare program will be flexible enough to accommodate the emergency health care needs of beneficiaries and medical providers in the states devastated by hurricanes Katrina and Rita. Many of the programs' normal operating procedures have been relaxed to speed the provision of health care services to the

*National Modifier and Condition Code To Be Used To Identify Disaster Related Claims (continued)*

elderly and persons with disabilities who depend on Medicare services.

Because of hurricane damage to local health care facilities, many Medicare beneficiaries have been evacuated to neighboring states where receiving hospitals and nursing homes have no access to patients':

- Health care records
- Current health status
- Verification of status as Medicare beneficiaries.

**Note:** CMS is assuring facilities and medical providers receiving Medicare beneficiaries affected by hurricanes Katrina and Rita that *the normal requirements for documentation will be waived and the presumption of eligibility should be made.*

Health care providers that furnish medical services in good faith, but who cannot comply with normal program requirements because of hurricanes Katrina and Rita, will be:

- Paid for services provided.
- Exempt from sanctions for noncompliance (unless it is discovered that fraud or abuse occurred).

**New Condition Code and Modifier**

To facilitate claim processing and track services and items provided to victims of hurricanes Katrina and Rita, and any future disasters, CMS has established a new condition code and modifier for providers to use on disaster related claims. The new condition code and modifier are for use by providers submitting claims for Medicare beneficiaries who are Katrina disaster patients in any part of the country and are effective for dates of service on and after August 21, 2005. The new codes are the following:

- The new condition code is **DR – Disaster Related**
- The new modifier is **CR – Catastrophe/Disaster Related**

For physicians or suppliers billing their local carrier or DMERC, only the modifier CR should be reported and not the condition code. A condition code is used in FI billing.

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For institutional billing, either the condition code or modifier may be reported. The condition code would identify claims that are impacted or may be impacted by specific payer policies related to a national or regional disaster. The modifier would indicate a specific Part B service that may be impacted by policy related to the disaster.

CR 4106 instructs Medicare contractors to recognize the new condition code and modifier on October 3, 2005, if possible, but no later than October 31, 2005.

In addition to this Medlearn Matters Article, CMS regional offices will help facilitate contractor outreach regarding provider education on the use of the new modifier and condition code.

**Implementation**

The targeted implementation date is October 3, 2005, but no later than October 31, 2005.

**Additional Information**

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

From that Web page, look for CR 4106 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 4106

Related CR Release Date: October 14, 2005

Related CR Transmittal Number: 184

Effective Date: August 21, 2005

Implementation Date: October 3, 2005, but no later than October 31, 2005

Source: CMS Pub. 100-20, Transmittal 184, CR 4106

## FCSO Offers Help to Address Potential Medicare Billing and Payment Impacts Due to a Natural Disaster

The 2004 hurricane season severely impacted many of First Coast Service Options' (FCSO) Medicare customers. In response to the devastating impacts and potential damage, and in keeping our promise to provide superior customer service, FCSO has established a team to proactively assist providers. Here are some helpful tips related to communication, benefit payments and operational processes that may warrant special consideration:

1. First, we encourage impacted health care providers and suppliers to communicate billing and payment concerns by calling our Medicare Part A Customer Service Center

at 1-877-602-8816 or our Medicare Part B Customer Service Center at 1-866-454-9007.

2. Health care facilities whose cash flow may be adversely impacted by a natural disaster may be granted an accelerated payment. FCSO and the Centers for Medicare & Medicaid Services (CMS) have implemented a process to expedite these requests. Medicare Part A impacted providers who need to pursue an accelerated payment should contact Provider Audit and Reimbursement specialist, Jeff Guy at 1-904-791-6695.

## *FCSO Offers Help to Address Potential Medicare Billing and Payment Impacts Due to a Natural Disaster (continued)*

3. Part B providers whose cash flow may be adversely impacted by a natural disaster may fax a request including the reason for the advance payment and an authorization to offset the advance payment from pending claims. Information may be faxed to the attention of "Customer Service Operations" at 1-904-791-8316.
4. In filing an appeal request, natural disaster is an example of "good cause" in asking for a time extension.
5. If you cannot receive mail at your present location and you have a CMS-855 on file, you may set up a temporary "pay to" address, practice location and/or telephone number. Submit the request to the specially designated natural disaster fax line at 1-904-301-1827. The fax request should include the following:
  - The provider's legal business name
  - Tax identification number/social security number
  - Signature of either the provider or the authorized representative/designated officialIf you don't have a CMS-855 on file and for more information, refer to the article titled "Temporary Provider Enrollment Procedures due to Hurricanes" posted on the Florida Medicare website.

**Note:** Telephone requests will not be allowed.
6. Impacted providers and suppliers may use another provider's computer to transmit claims; however, someone from FCSO Medicare Electronic Data Interchange (EDI) must be involved in order to maintain the security of the records. If you are an impacted provider who needs to explore the feasibility of this option, please contact Medicare EDI Manager, Shelly March at 1-904-791-8240
7. If you were under a mandatory evacuation notice and had to transport patients by ambulance, Medicare will consider payment under certain conditions. Additional information will be made available as needed.
8. For guidelines regarding CMS' instructions for hospital dialysis due to natural disasters, see Change Request 2503, transmittal A-02-129. For complete details, please see the official instruction issued by going to CMS website at [http://www.cms.hhs.gov/manuals/pm\\_trans/A02129.pdf](http://www.cms.hhs.gov/manuals/pm_trans/A02129.pdf). Information related to this change request was also published in the [January 2003 Medicare A Bulletin – Special Issue](#) (page 31).
9. Points of interest for additional documentation requests:
  - In the event your records are destroyed due to a natural disaster, it is imperative that you clearly document "patients' files/records destroyed due to disaster" (or similar phraseology) and include the date(s) of the occurrence.
  - Clearly indicate when the patient was "transported/relocated due to mandatory evacuation." Additional information will be posted to <http://www.floridamedicare.com> as it becomes available.If you have additional questions, please contact our Medicare Part A Customer Service Center at 1-877- 602-8816 or our Medicare Part B Customer Service Center at 1-866-454-9007, as we have designated points-of-contact for various types of issues related to natural disasters. ❖

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## Temporary Provider Enrollment Procedures due to Hurricanes

Hurricane Katrina has severely impacted the states of Louisiana, Mississippi, Alabama, and Florida. Therefore, the Centers for Medicare & Medicaid Services (CMS) requests that carriers in these states develop an easier process for providers/suppliers to change their pay-to-address, practice location, and/or telephone information.

### Pay-to-Address, Practice Location, Telephone Number Requests

Any provider that requests a change to a pay-to-address, practice location and/or telephone number may do so by submitting the request to the specially designated natural disaster fax line at (904) 301-1827. **Note:** This instruction and fax number is designated **ONLY** for those providers whose practice is located in a disaster area.

**Note:** Telephone requests will not be allowed.

For those providers who already have a CMS-855 on file, the fax request should include the following:

- The provider's legal business name
- Tax identification number/social security number
- Signature of either the provider or the authorized representative/designated official.

**Note:** The faxed signature will be compared to the signature on file through the CMS-855 enrollment form.

For those providers that do not have a CMS-855 on file, additional identifying information must be submitted with the provider's faxed request:

- Legal business name
- Tax identification number/social security number
- Previous practice and pay-to-address Information
- Previous telephone number
- Signatures
- Any other identifying data the contractor deems necessary.

For those providers that are unable to reach their authorized representative or delegated official to sign the change request, contractors shall treat the request as being from a provider that does not have a CMS-855 on file; the additional identifying data outlined above shall be requested. If for any reason we are unable to verify/validate this information, the request shall be denied.

**Temporary Provider Enrollment Procedures due to Hurricanes (continued)**

Once the situation in the affected states has stabilized, contractors shall contact those providers that did not have an authorized representative/delegated official on file and ask them to resubmit their requests using the CMS-855 application.

**Initial Enrollments**

Contractors that have initial enrollment applications in-house that show practice locations that are located in disaster areas (identified by ZIP codes for the affected counties), will contact applicants in an attempt to obtain additional information.

In situations where the contractor can process the application, we will continue to do so.

In situations where the area will remain unstable, the

contractor will request the applicant to resubmit his/her application at a later date. This notification will be made via U.S. mail if the applicant cannot be reached by phone.

**Independent Diagnostic Testing Facility**

If an independent diagnostic testing facility (IDTF) is temporarily relocating due to this emergency, and it has an active provider identification number (PIN), the site visit requirement may be waived provided there is no change in modality. After this emergency has ended, if a provider decides to make this a permanent location, a site visit will be required. ❖

Source: CMS Joint Signature Memorandum 05504, September 6, 2005

**Hurricanes Katrina and Rita—Frequently Asked Questions: Medicare Issues**

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

**Provider Types Affected**

All providers who are affected by hurricanes Katrina and Rita or serving Medicare patients affected by those hurricanes

**Key Points**

This article contains important information about Medicare issues resulting from hurricanes Katrina and Rita. The Centers for Medicare & Medicaid Services (CMS) has posted pertinent information on its website at <http://www.cms.hhs.gov/hki>.

This website is updated on a daily basis. The information on this site includes the following:

**A Question and Answer Document**

This document was created to answer frequently asked questions about Medicare issues resulting from hurricanes Katrina and Rita. Please review each question and answer and take appropriate action to implement them into your claim process. Account and document all activities associated with implementing these instructions. (To view this information, scroll down to the *Question and Answer* section on the page (<http://www.cms.hhs.gov/hki>) and select the category desired (e.g., Section 1135, General, Ambulance, etc.).

**Hurricane Katrina Electronic Mailing List**

This is an electronic mailing list service for those interested in receiving news automatically via e-mail from the CMS.

**Hurricane Katrina: What Government Is Doing**

This Department of Homeland Security website focuses on the government’s response to hurricane Katrina – including links to:

- How to Get Help
- Donations and Volunteering
- Finding Friends and Information
- Health and Safety
- A link to hurricane Katrina-related information in Spanish.

**Fact Sheet: CMS Actions to Help Beneficiaries, Providers in Katrina Stricken Areas**

This link leads to specific Medicare-related hurricane relief information for healthcare providers who furnish medical services related to hurricane Katrina.

**Phone Numbers for State Medical Assistance Offices**

This Web page contains contact information for all states; related websites; and resources (a download of the Helpful Contacts tool).

**State Health Officials Letter and 1115 Model Waiver Template**

This links to state Medicaid directors’ information, including:

- A Letter to State Medicaid Directors and State Children’s Health Insurance Program Directors
- An Application Template – Medicaid and SCHIP Coverage for Evacuees of Hurricane Katrina
- Information on Evacuee Eligibility Simplification Based on Home State Eligibility Rules
- Medicaid Eligibility Groups – Income and Resource Limits.

**Approved Katrina 1115 Waiver Information**

This Web page contains approved Katrina 1115 waiver documents for the states of Alabama, Arkansas, District of Columbia, Florida, Georgia, Idaho, Mississippi, and Texas, including an approval letter, the terms and conditions, and the attachments for each of the states.

**Hurricane Information from the Department of Health and Human Services**

Topics on this page include:

- What HHS is Doing
- Health and Safety
- How to Get Help
- Donate and Volunteer
- Finding Friends and Information
- What Other Federal Agencies are Doing

**Hurricanes Katrina and Rita—Frequently Asked Questions: Medicare Issues (continued)**

- Key State Government Agencies in the Region.

**Hurricane Katrina Medicare Contractor and CMS Regional Office Contacts**

This Web page informs Medicare providers about relevant contact points for those in the affected areas; and notifies providers about a list of questions and answers available online in the “Spotlight” section of CMS website <http://www.cms.hhs.gov>.

**Signed Waiver Under Section 1135 of the Social Security Act 9/4/2005**

Section 1135 of the Social Security Act allows the Secretary of Health & Human Services to waive or modify certain Medicare, Medicaid, or State Children’s Health Insurance Program requirements in order to protect the public health and welfare in times of national crisis. On Wednesday August 31, 2005, Secretary Michael Leavitt notified the Congress that he was invoking this authority, as a consequence of hurricane Katrina, in order to protect the health and welfare of the public in areas impacted by this crisis. CMS is taking action consistent with this authority to ensure that the people in these areas receive all necessary health care services.

**Hurricane Katrina Recovery Information from FirstGov.gov**

Links on this page include:

- Find Family and Friends
- How to Get Help
- Shelter and Housing for Survivors
- Donate and Volunteer
- Health and Safety
- What Government is Doing
- Frequently Asked Questions.

**Katrina Information Resources**

Links on this page include:

- National Voluntary Organizations Active in Disaster (NVOAD) Resources
- CCD information related to Tetanus Prevention, non-01 and non-0139 Vibro cholerae
- Cancer Patient Resources for Hurricane Katrina.

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Article SE0563

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**Medicare Care Management for High Cost Beneficiary Demonstration**

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

**Provider Types Affected**

Provider types affected by CR 4100 include physicians and providers who bill any Medicare contractor (carrier, durable medical equipment regional carrier (DMERC), fiscal intermediary (FI), or regional home health intermediary (RHHI)) for services provided to Medicare fee-for-service (FFS) beneficiaries (i.e., those in the traditional FFS Medicare program) who reside in any one of the geographic areas described below and who have enrolled in a CMHCB program.

The CMHCB programs in these geographic areas are operated by one of six organizations, known as Care Management Organizations (CMOs), that will deliver provider-based intensive care management services to certain FFS Medicare beneficiaries with one or more chronic conditions. Beneficiaries eligible for participation in the demonstration will be designated by the Centers for Medicare & Medicaid Services (CMS). If you submit claims to the Medicare contractors listed in the following charts, for Medicare patients who reside in the geographic areas shown in the charts, this article is of special interest to you:

<b>Carrier, FI, DMERC, RHHI</b>	<b>Geographic Areas To Be Served</b>
1. Anthem Health Plans of Maine, Inc.	Massachusetts
2. Blue Cross and Blue Shield of South Carolina, also known as Palmetto GBA	Florida, Texas
3. Connecticut General Life Insurance Company	California, Nevada, Oregon, Washington
4. Empire HealthChoice Assurance, Inc.	New York
5. First Coast Service Options, Inc.	Florida
6. Group Health Incorporated	New York
7. HealthNow New York, Inc.	Massachusetts, New York
8. National Heritage Insurance Company	California, Massachusetts
9. Noridian Mutual Insurance Company	Nevada, Oregon, Washington
10. Regence BlueCross BlueShield of Oregon	Oregon
11. Trailblazer Health Enterprises, LLC	Texas
12. United Government Services, LLC	Nevada, Oregon, Washington, California, New York



*Medicare Care Management for High Cost Beneficiary Demonstration (continued)***Provider Action Needed****STOP – Impact to You**

This article contains information from CR4100 that describes the CMS CMHCB Demonstration project and the associated Care Management Organizations (CMOs') programs. These programs are being implemented under the demonstration project to test whether supplemental care management services can improve quality of care and health results, and reduce unnecessary hospital stays and emergency room visits for Fee-for-Service (FFS) beneficiaries who have one or more chronic diseases. Care management services provided by the CMOs may include facilitating collaboration among beneficiaries' primary and specialist providers, and enhanced communication of relevant clinical information to providers for the beneficiaries enrolled in a CMHCB program.

**CAUTION – What You Need to Know**

**A beneficiary's participation in this demonstration program will not change his or her FFS Medicare benefits.** The beneficiary is **not** enrolled in an HMO, Medicare Advantage plan, or other non-FFS plan. The beneficiary remains entitled to all FFS benefits. You may be contacted by one of the CMOs in your geographic area.

**GO – What You Need to Do**

Make sure that your office and billing staffs are aware that these beneficiaries remain eligible for FFS services. **There are no changes to Medicare FFS billing instructions or claims processing as a result of this CMHCB program.** Provider participation in care plans developed by, and other collaboration with, the CMO is voluntary and at provider discretion.

**Background**

This article provides information on CMS's implementation of the CMHCB project to conduct a three-year study of various care management models for certain beneficiaries in the traditional Medicare FFS program. These programs will be administered by the CMOs.

The CMO programs will support collaboration among demonstration participants' primary and specialist providers and enhance communication of relevant clinical information. The programs are intended to:

- Help increase adherence to evidence-based care;
- Reduce unnecessary hospital stays and emergency room visits; and
- Help participants avoid costly and debilitating complications.

FFS Medicare benefits will continue to be covered, administered, and paid under the traditional FFS Medicare program. Demonstration programs will be offered at no additional charge to the participating beneficiaries beyond their normal original Medicare plan premiums, co-payments, and/or deductibles. The CMOs will not be able to restrict beneficiary access to care, or restrict beneficiary provider choice.

Since the CMO services may include collaboration with the physician on the beneficiary's plan of care, you may be contacted by the CMO regarding any of your patients who enroll in the CMHCB demonstration. It is up to each physician to determine whether he or she wishes to collaborate with the CMO.

**Note:** Beneficiaries enrolled in these demonstrations remain eligible for FFS services, and physicians and providers of those services should continue to bill as they normally would. There are no changes to Medicare FFS billing instructions or claims processing as a result of this demonstration.

**CMO Program Features and Geographic Areas**

The following table describes the name, target population, special features, scheduled launch date, and designated geographical areas of each program.

<b>Name of Program</b>	<b>Health Buddy Program</b>
<b>Geographic Area</b>	<b>Oregon:</b> Deschutes, Jefferson, Crook, Lake, Malheur and Harney <b>Washington:</b> Chelan, Grant, Okanogan and Douglas <b>Nevada:</b> Clark and Nye

**Population Focus and Program Features**

- Serves beneficiaries with congestive heart failure, diabetes, and or chronic obstructive pulmonary disease.
- Uses a technology platform. Patients receive a Health Buddy appliance that coaches them about their health, collects vital signs and symptoms, and transmits results back to multi-specialty medical groups.
- Physicians and nurses will use information provided through the Health Buddy program to spot problems early and ensure patients stay healthy.
- **Launch date:** Early calendar year (CY) 2006

<b>Name of Program</b>	<b>Care Level Management</b>
<b>Geographic Area</b>	<b>California:</b> Alameda, San Francisco, Marin, San Mateo, Contra Costa, Sacramento, Santa Clara, Sonoma, Solano, San Joaquin, Fresno, Stanislaus, Monterey, Tulare, Madera, Merced, Santa Cruz, San Benito, Los Angeles, Ventura, Santa Barbara, San Luis Obispo, Riverside, San Bernardino, Kern, Kings, Orange and San Diego <b>Texas:</b> Bexar, Atascosa, Bandera, Comal, Guadalupe, Kendall, Medina and Wilson <b>Florida:</b> Brevard, Indian River, Osceola, Seminole and Orange

**Population Focus and Program Features**

- Serves beneficiaries who are seniors suffering from advanced, progressive chronic disease(s) and comorbidities with two or more condition-related hospital admissions in the past year.
- Care management via a distributed network of Personal Visiting Physicians (PVPs) who see patients in their homes and nursing facilities and who are available 24 hours a day, 7 days a week.
- PVPs are supported by Personal Care Advocate.
- Nurses who are based in nearby regional offices and who provide care coordination and maintain regular phone contact with beneficiaries.
- Utilizes a Web-based electronic medical record.

## Medicare Care Management for High Cost Beneficiaries Demonstration (continued)

- **Launch date:** October 1, 2005

**Name of Program** Mass General Care Management  
**Geographic Area** Massachusetts: Norfolk, Suffolk, Middlesex, Essex, and Plymouth

### Population Focus and Program Features

- Serves beneficiaries who seek care from Massachusetts General healthcare system.
- Comprehensive care management by a dedicated team of doctors and nurses.
- Specialized programs for patients with chronic conditions.
- Home visits and home telemonitoring as needed.
- Electronic medical record system assures coordination, continuity, and adherence to physician-approved care management plan.
- **Launch date:** Early CY 2006

**Name of Program** Montefiore Care Guidance  
**Geographic Area** New York: Bronx  
**Population Focus and Program Features**

- Serves beneficiaries with multiple chronic conditions, residing in naturally occurring retirement communities regardless of where they currently receive care, and FFS beneficiaries cared for within the Montefiore health care network.
- Offers enhanced home-based services to participants using telemonitoring equipment and home visit programs.
- Also offers medication management, falls prevention, palliative care, and disease management programs.
- **Launch date:** Early CY 2006

**Name of Program** RMS KEY to Better Health  
**Geographic Area** New York: Nassau, Suffolk, and Queens

### Population Focus and Program Features

- Serves beneficiaries with chronic kidney disease.
- Provides intensive disease management directed by nephrologists in supplementary clinics to identify potential problems and avoid complications, coordinate early intervention plans and prevent acute hospitalization.
- **Launch date:** November 1, 2005

**Name of Program**  
**Geographic Area**

**Texas Senior Trails**  
**Texas:** Armstrong, Bailey, Borden, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Cottle, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Floyd, Gaines, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, Kent, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Scurry, Sherman, Stonewall, Swisher, Terry, Wheeler, and Yoakum

### Population Focus and Program Features

- Serves beneficiaries who receive care from the Texas Tech Physician Associates primary care and specialist physicians and who are at greatest risk for readmission and adverse events in largely underserved, rural areas.
- Team coordinates a home and office based program.
- **Launch date:** Early CY 2006

### Additional Information

Additional information on the demonstration project may be found on the CMS website at <http://www.cms.hhs.gov/researchers/demos/cmhcb.asp>.

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

From that Web page, look for CR 4100 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 contractor at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 4100  
 Related CR Release Date: September 23, 2005  
 Related CR Transmittal Number: 28  
 Effective Date: October 1, 2005  
 Implementation Date: October 3, 2005

Source: CMS Pub. 100-19, Transmittal 28, CR 4100

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**Medicare Care Management for High Cost Beneficiary Demonstration**

Effective October 1, 2005, for claims processed on or after October 3, 2005, the Centers for Medicare & Medicaid Services (CMS) has entered into demonstration agreements with six organizations, known as “Care Management Organizations (CMOs)”. The CMOs will deliver provider-based intensive care management services to certain Medicare fee-for-service (FSS) beneficiaries with one or more chronic conditions.

The three-year demonstration will test the ability of each CMO program to improve quality of care and reduce costs. The CMO programs will support collaboration among demonstration participants’ primary and specialist provider and enhance communication of relevant clinical information.

- The purpose of this demonstration project is to improve quality of care and reduce costs.
- Each CMO will have a demonstration program – Florida’s program is called the Care Level Management program.

- Beneficiaries that are eligible to participate in this project will be identified by CMS and will have to meet the criteria outlined by each CMO program.
- Beneficiary participation is voluntary and does not affect their Medicare fee-for-service benefits.
- There will be no charge for the services provided to the eligible beneficiaries.
- Beneficiaries will still be responsible for their premiums, co-payments and deductibles.

For additional information, please reference the Medlearn Matters article MM4100 at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM4100.pdf>.

Additional information on the demonstration project may be found on the CMS website at <http://www.cms.hhs.gov/researchers/demos/cmhcb.asp>. ❖

Source: CMS Pub. 100-19, Transmittal 28, CR 4100

**Medicare Health Support Programs (Formerly Known as Medicare Chronic Care Improvement Programs)**

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this article on August 23, 2005, due to a revision to CR3953. The changes to the article are the new CR release date and transmittal number shown above, and updates to the information below. *Also, please note that the implementation date of CR3953 is not tied to the implementation dates for Medicare Health Support Organizations (MHSOs).* This article was published in the Fourth Quarter 2005 Medicare A Bulletin (pages 22-26).

**Provider Types Affected**

Physicians and providers in any one of the nine geographic area described below.

<b>Organization Selected by CMS to Provide Program</b>	<b>Geographic Areas to Be Served</b>
1. Aetna Life Insurance Company, LLC	Chicago, Illinois counties
2. American Healthways	Maryland and the District of Columbia
3. CIGNA Health Support	Northwest Georgia
4. Health Dialog Services Corporation	Western Pennsylvania
5. Humana, Inc.	Central and South Florida
6. LifeMasters Supported SelfCare, Inc.	Oklahoma
7. McKesson Health Solutions	Mississippi
8. Visiting Nurse Service of New York/EverCare	Brooklyn and Queens boroughs, New York City
9. XLHealth Corporation	Selected counties in Tennessee

**Provider Action Needed**

**STOP – Impact to You**

This article includes information from change request (CR) 3953 that describes the new Medicare Health Support programs (MHSPs), formally known as Chronic Care Improvement programs, and identifies the nine organizations selected by the Centers for Medicare & Medicaid Services (CMS) to provide MHSPs to certain beneficiaries enrolled in the traditional fee-for-service (FFS) Medicare program.

**CAUTION – What You Need to Know**

CMS is implementing phase I: Developmental of the Medicare health support initiative. The nine MHSOs selected by CMS will serve approximately 180,000 Medicare beneficiaries who have congestive heart failure and/or diabetes among their chronic conditions. Eligible beneficiaries do not have to change plans or providers to participate, and participation is totally voluntary. Participation in an MHSP does not restrict access to other Medicare services and will be provided at no extra cost to beneficiaries.

**GO – What You Need to Do**

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

*Medicare Health Support Programs (Formerly Known as Medicare Chronic Care Improvement Programs (continued))*

**Background**

This article provides information on the CMS’ implementation of the Medicare Health Support program, formally known as Chronic Care Improvement program. Section 721 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) adds a new section 1807, “Voluntary Chronic Care Improvement Under Traditional Fee-for-Service (FFS) Medicare” to the Social Security Act. This requires Medicare to provide for the phased-in development, testing, evaluation, and implementation of chronic care improvement programs (now known as MHSPs) and to proceed with expansion regionally or possibly nationwide if the pilot programs (or program components) are successful.

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

Some key points about of MHS initiative are as follows:

- The MHSPs will test whether or not providing additional health education and support services for targeted chronically ill Medicare beneficiaries who are in traditional FFS Medicare will lead to improved clinical quality and satisfaction and lower costs to Medicare.
- CMS has entered into agreements with selected organizations (MHSOs) to provide MHSPs to targeted Medicare FFS beneficiaries (about 20,000 beneficiaries serviced by each MHSO) who have congestive heart failure and/or diabetes.
- The first MHSPs will be phased in during 2005, operate for three years, and be tested through comparative analysis to beneficiaries randomly assigned to regional control groups. The statute provides for expansion of the MHS initiative if the pilot programs or program components are successful.
- The programs will offer support services—such as self-care guidance and answers to questions about medications—for chronically ill beneficiaries who are invited by CMS to participate. The goal is to help them adhere to their prescribed treatment plans and ensure that they seek the medical care they need to reduce their health risks. Coordination and collaboration with participants’ healthcare providers to enhance communication of relevant clinical information are also key components of the MHSPs.
- Participation in MHSPs will not restrict access to care and will be provided at no cost to eligible beneficiaries. Such beneficiaries do not have to change from their existing plans, nor do they have to change physicians or providers in order to participate. Further, they may stop participating at any time.
- MHSOs will be paid by CMS, outside of the Medicare FFS claims payment system, a fixed administrative fee per participant per month.
- The MHSOs will not focus on any single disease, but will help participants manage their health holistically.
- The MHSOs will *not* pay any claims on behalf of enrolled beneficiaries and a beneficiary’s participation will not affect how claims from their physicians/providers are processed by Medicare.

The following chart identifies the MHSO, provides information about selected program features of the MHSPs to be offered, and delineates the geographic areas served by the MHSOs:

MHSO	Selected Program Features	Geographic Area
<b>Aetna, Life Insurance Company, LLC</b>	<ul style="list-style-type: none"> <li>• Advance practice nursing program for home health and nursing homes</li> <li>• Customized care plans</li> <li>• Caregiver education</li> <li>• Blood pressure monitors and weight scales provided based on participant need</li> <li>• Physician communication</li> <li>• Physician Web access to clinical information</li> <li>• 24-hour nurse line</li> </ul>	Chicago Illinois counties
<b>American Healthways</b>	<ul style="list-style-type: none"> <li>• Personalized care plans</li> <li>• Direct-mail and telephonic messaging</li> <li>• Supplemental telephonic coaching</li> <li>• Gaps in care generate physician prompts</li> <li>• Intensive case management services as necessary</li> <li>• Remote monitoring devices (weight, blood pressure, and pulse) based on participant need</li> <li>• Physician Web access to clinical information</li> <li>• Physician communication</li> <li>• 24-hour nurse line</li> </ul>	Maryland and the District of Columbia

*Medicare Health Support Programs (Formerly Known as Medicare Chronic Care Improvement Programs (continued))*

<b>MHSO</b>	<b>Selected Program Features</b>	<b>Geographic Area</b>
<b>CIGNA Health Support, LLC</b>	<ul style="list-style-type: none"> <li>• Personalized plan of care</li> <li>• Telephonic nurse interventions</li> <li>• Oral and written communication in addition to telephonic coaching</li> <li>• Home monitoring equipment (weight, blood pressure and glucometers) based on participant need</li> <li>• Intensive case management for frail elderly and institutionalized participants, as required</li> <li>• Data exchange with physicians</li> <li>• 24-hour nurse line</li> </ul>	Northwest Georgia
<b>Health Dialog Services Corporation</b>	<ul style="list-style-type: none"> <li>• Personal health coaches develop individual care management plans</li> <li>• Health education materials (Web-based, faxed or mailed)</li> <li>• In-home biometric monitoring</li> <li>• Behavioral health case management and intensive case management as needed</li> <li>• Data exchange with physicians</li> <li>• Active involvement of other community agencies</li> <li>• 24-hour nurse line</li> </ul>	Western Pennsylvania
<b>Humana, Inc.</b>	<ul style="list-style-type: none"> <li>• Trademarked Personal Nurse program model</li> <li>• Group education and support sessions</li> <li>• Biometric monitoring equipment, including glucometers and weight scales as necessary</li> <li>• Core telephonic support supplemented with RNs, social workers and pharmacists in the field interacting with providers and beneficiaries with complex needs</li> <li>• Data exchange with physicians</li> <li>• On-site meetings with physicians and CME (continuing medical education) programs</li> <li>• Physician Web access to clinical information</li> <li>• Electronic medical record keeping systems will be piloted in five small physician-group practices</li> <li>• Active involvement of other community agencies</li> <li>• 24-hour nurse line</li> </ul>	Central and South Florida
<b>Lifemasters Supported SelfCare</b>	<ul style="list-style-type: none"> <li>• Single nurse as primary contact for beneficiary</li> <li>• Supported self-care model including education, medication compliance, behavior change</li> <li>• Home visits as appropriate</li> <li>• Team of local and call center-based nurses, physicians, pharmacists, and health educators</li> <li>• Digital weight scale and blood pressure monitors</li> <li>• Physician communication including customized care plans, alerts, decision support applications; access to patient care record and biometric monitoring data</li> <li>• Physician outreach includes in-person orientation for high volume physician practices</li> <li>• Physician Web access to clinical information</li> <li>• Active involvement of other community agencies</li> <li>• 24-hour nurse line</li> </ul>	Oklahoma

## GENERAL INFORMATION

### Medicare Health Support Programs (Formerly Known as Medicare Chronic Care Improvement Programs (continued))

MHSO	Selected Program Features	Geographic Area
<b>McKesson Health Solutions</b>	<ul style="list-style-type: none"> <li>• Extensive physician involvement, including on-site staff support</li> <li>• Data exchange with physicians,</li> <li>• Physician Web access to clinical information</li> <li>• Telephonic outreach</li> <li>• Mail, fax, workbooks</li> <li>• Remote monitoring and biometric equipment for selected high-risk participants</li> <li>• Pharmacist review of medications and collaboration with physicians</li> <li>• Management of long-term care residents and intensive case management, including end-of-life</li> <li>• 24-hour nurse line</li> </ul>	Mississippi
<b>Visiting Nurse Service of New York/ Evercare</b>	<ul style="list-style-type: none"> <li>• Home health agency leading outreach in community</li> <li>• Management of high-risk participants who require extensive in home management</li> <li>• Telephonic outreach and health risk assessments</li> <li>• Use of Smart Cards to use at physician visits and hospital admissions to track service use and convey embedded information to providers</li> <li>• Physician Web access to clinical information</li> <li>• Active involvement of other community agencies</li> <li>• 24-hour nurse line</li> </ul>	Brooklyn and Queens boroughs of New York
<b>XL Health Corporation</b>	<ul style="list-style-type: none"> <li>• Biometric monitoring including glucometers and weight scales as necessary</li> <li>• RNs, social workers, and pharmacists in the field, interacting with providers and beneficiaries with complex needs</li> <li>• Medication counseling sessions by pharmacists at retail pharmacies</li> <li>• Specialized program for higher risk patients</li> <li>• Medication management and compliance</li> <li>• Data exchange with physicians,</li> <li>• Physician Web access to clinical information</li> <li>• 24-hour nurse line</li> </ul>	Selected counties in Tennessee

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

<p><b>Aetna:</b> Kathleen Giblin Aetna Health Management, LLC 151 Farmington Avenue, RT11 Hartford, CT 06156 <b>Or call 888-713-2836 or visit <a href="http://www.aetna.com">http://www.aetna.com</a></b></p>	<p><b>LifeMasters Supported SelfCare:</b> Ron Lau, c/o Mel Lewis LifeMasters Supported SelfCare 5000 Shoreline Court S#300 South San Francisco, CA 94080 <b>Or call 888-713-2837 or visit <a href="http://www.lifemasters.com">http://www.lifemasters.com</a></b></p>
<p><b>American Healthways:</b> Michael Montijo, M.D., American Healthways American Healthways, Inc. 3841 Green Hills Village Drive Nashville, TN 37215 <b>Or call 866-807-4486 or visit <a href="http://www.medicarehealthsupport.com">http://www.medicarehealthsupport.com</a></b></p>	<p><b>McKesson Health Solutions:</b> Sandeep Wadhwa McKesson Health Solutions 335 Interlocken Parkway Broomfield, CO 80021 <b>Or call 800-919-9110 or visit <a href="http://www.mckesson.com">http://www.mckesson.com</a></b></p>
<p><b>Health Dialog Services Corporation:</b> Molly Doyle Health Dialog Services Corporation 60 State Street, Suite 1100 Boston, MA 02109 <b>Or call 800-574-8475 or visit <a href="http://www.myhealthsupport.com">http://www.myhealthsupport.com</a> (available August 2005)</b></p>	<p><b>XL Health Corporation:</b> Paul Serini XLHealth Corporation 351 West Camden Street, Suite 100 Baltimore, Maryland 21201 <b>Or call 877-717-2247</b></p>

*Medicare Health Support Programs (Formerly Known as Medicare Chronic Care Improvement Programs (continued))*

<p><b>Humana, Inc.:</b>                  Heidi Margulis                  Humana, Inc.                  500 West Main Street, 6<sup>th</sup> Floor                  Louisville, KY 40202  <b>Or call 800-372-8931 or visit</b>  <a href="http://www.greenribbonhealth.com">http://www.greenribbonhealth.com</a></p>	<p><b>Visiting Nurse Service of New York/Evercare:</b>                  Paul Roth                  VNS CHOICE                  5 Penn Plaza, 19<sup>th</sup> Floor                  New York, NY 10001-1810</p>
<p>CIGNA HealthSupport:                  David Post                  CIGNA                  900 Cottage Grove, B227                  Bloomfield, CT 06002  <b>Or call 866-563-4551 or visit</b>  <a href="http://www.mhsgeorgia.com">http://www.mhsgeorgia.com</a> (available August 2005)</p>	

**Implementation**

The implementation date for this instruction is August 23, 2005.

**Additional Information**

For complete details of CR 3953, please see the official instruction issued by going to CMS website:

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

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

The Medicare fact sheet that describes the Medicare Health Support programs may be found on the CMS website at:

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

This document is an excellent overview of the program.

Medlearn Matters Article MM3410 provides some background information on the “Use of Group Health Plan Payment System to Pay Capitated Payments to Chronic Care Improvement Organizations Serving Medicare Fee-For-Service Beneficiaries Under Section 721 of the MMA” and may be viewed by going to CMS website:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3410.pdf>.

Related Change Request (CR) Number: 3953

Related CR Release Date: August 12, 2005

Related CR Transmittal Number: 27

Effective Date: October 20, 2005

Implementation Date: October 20, 2005

Source: CMS Pub. 100-19, Transmittal 27, CR 3953

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**NATIONAL PROVIDER IDENTIFIER**

**CMS National Provider Identifier Web Page now Available**

The Centers for Medicare & Medicaid Services is pleased to announce the new CMS Web page dedicated to providing all the latest National Provider Identifier (NPI) news for fee-for-service (FFS) Medicare providers. Visit the CMS website at <http://www.cms.hhs.gov/providers/npi/default.asp>.

As a reminder, all health care providers are required by law to apply for an NPI. To apply online, visit <https://nppes.cms.hhs.gov>. ❖

Source: Provider Education Resources Listserv, Message 200510-07

## Implementation of the National Provider Identifier

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

*The Second in the Series of Special Edition Medlearn Matters Articles on National Provider Identifier-Related Activities*

### Provider Types Affected

Providers and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries. In addition, organizations or associations that represent providers and plan to obtain national provider identifiers (NPIs) for those providers should take note of this article.

### Part 1: Information That Applies to All Providers

#### Background

All health care providers are eligible to receive NPIs. All HIPAA covered health care providers, whether they are **individuals** (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or **organizations** (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, health maintenance organizations, suppliers of durable medical equipment, pharmacies, etc.) must obtain an NPI for use to identify themselves in HIPAA standard transactions. Once enumerated, a provider’s NPI will not change. The NPI remains with the provider regardless of job or location changes.

**Note:** HIPAA covered entities such as providers completing electronic transactions, health care clearing-houses, and large health plans, must use only the NPI to identify covered health care providers in standard transactions by May 23, 2007. Small health plans must use only the NPI by May 23, 2008.

#### Obtaining and Sharing Your NPI

Providers and suppliers may now apply for their NPI on the National Plan and Provider Enumeration System (NPPES) website, <https://nppes.cms.hhs.gov>.

The NPPES is the only source for NPI assignment.

The NPI will replace health care provider identifiers in use today in standard health care transactions by the above dates. The application and request for an NPI does not replace the enrollment process for health plans. Enrolling in health plans authorizes you to bill and be paid for services.

Health care providers should apply for their NPIs as soon as it is practicable for them to do so. This will facilitate the testing and transition processes and will also decrease the possibility of any interruption in claims payment. Providers may apply for an NPI in one of three ways:

- An easy Web-based application process is available at <https://nppes.cms.hhs.gov>.
- A paper application may be submitted to an entity that assigns the NPI (the enumerator). A copy of the application, including the enumerator’s mailing address, is available at <https://nppes.cms.hhs.gov>.

A copy of the paper application may also be obtained by calling the enumerator at 1-800-465-3203 or TTY 1-800-692-2326.

- With provider permission, an organization may submit a request for an NPI on behalf of a provider via an electronic file.

#### Knowing the NPI Schedule of Your Health Plans and Practice Management System Companies

Providers should be aware of the NPI readiness schedule for each of the health plans with which they do business, as well as any practice management system companies or billing companies (if used). They should determine when each health plan intends to implement the NPI in standard transactions and keep in mind that each health plan will have its own schedule for this implementation. Your other health plans may provide guidance to you regarding the need to submit both legacy numbers and NPIs.

Providers should submit their NPI(s) on standard transactions only when the health plan has indicated that the plan is ready to accept the NPI. Providers should also ensure that any vendors they use will be able to implement the NPI in time to meet the compliance date.

#### Sharing Your NPI

Once providers have their NPI(s), they should protect them. Covered providers must share their NPI with any entity that would need it to identify the provider in a standard transaction. For example, a referring physician must share their NPI with the provider that is billing for the service. Other entities the provider should consider sharing their NPI with are:

- Any provider with which they do business (e.g., pharmacies)
- Health plans with which they conduct business
- Organizations where they have staff privileges.

We understand that providers have many questions related to EFI or bulk enumeration, NPPES data dissemination, and the Medicare subparts policy. We have included information currently available on these key topics in this article and will continue to provide updates, as more information becomes available.

#### Electronic File Interchange (EFI) - Formerly Known as Bulk Enumeration

The Centers for Medicare & Medicaid Services (CMS) is in the process of establishing a mechanism that will allow for bulk processing of NPI applications. EFI allows an organization to send NPI applications for many health care providers, with provider approval, to the NPPES within a single electronic file. For example, a large group practice may want to have its staff handle the NPI applications for all its members. If an organization/provider employs all or a majority of its physicians and is willing to be considered an EFI submitter, EFI enumeration may be a good solution for that group of providers.

#### The EFI Steps

Once EFI is available, concerned entities will follow these steps:

- An organization that is interested in being an EFI organization will log on to an EFI home page (currently under construction) on the NPPES website (<https://nppes.cms.hhs.gov>) and download a certification form.



**Implementation of the National Provider Identifier (continued)**

- The organization will send the completed certification form to the enumerator to be considered for approval as an EFIO organization (EFIO).
- Once notified of approval as an EFIO, the entity will send files in a specified format, containing NPI application data, to the NPPES.
- Providers who wish to apply for their NPI(s) through EFIO must give the EFIO permission to submit their data for purposes of applying for an NPI.
- Files containing NPI application data, sent to NPPES by the EFIO, will be processed. NPI(s) will be assigned and the newly assigned NPI(s) will be added to the files submitted by the EFIO.
- The EFIO will then download the files containing the NPI(s) and will notify the providers of their NPI(s).

An EFIO may also be used for updates and deactivations, if the providers agree to do so.

**National Plan and Provider Enrollment System (NPPES) Data Dissemination Policy**

CMS expects to publish a notice regarding its approach to NPI data dissemination in the coming months.

The notice will propose the data dissemination strategy and processes. The approach will describe the data that CMS expects to be available from the NPPES, in compliance with the provisions of the Privacy Act, the Freedom of Information Act, the Electronic FOIA Amendments of 1996, the NPPES System of Records Notice, and other applicable regulations and authorities.

**Crosswalks**

Each health plan may create its own crosswalk, to cross check NPI and legacy identifiers. To that end, CMS stresses the importance of health care providers entering all of their current identification numbers onto their NPI application to facilitate the building of the crosswalks.

**Subparts of a Covered Organization**

Covered-organization health care providers (e.g., hospitals, suppliers of durable medical equipment, pharmacies, etc.) may be made up of components (e.g., an acute care hospital with an ESRD program) or have separate physical locations (e.g., chain pharmacies) that furnish health care, but are not themselves legal entities. The Final NPI rule calls these entities “*subparts*” to avoid confusion with the term health care “*components*” used in HIPAA privacy and security rules. Subparts cannot be individuals such as physicians, e.g., group practices may have more than one NPI, but individual members of that group practice by definition are not and cannot be “*subparts*.”

The NPI was mandated to identify each health care provider, not each service address at which health care is furnished. Covered organization providers must designate as subparts (according to the guidance given in the NPI *Final Rule*) any component(s) of themselves or separate physical locations that are not legal entities and that conduct their own standard transactions. Covered organizations/providers must obtain NPI(s) for their subparts, or instruct the subparts to obtain their own NPIs. The subparts would use their NPIs to identify themselves in the standard transactions they conduct.

The NPI Final Rule also gives covered organizations/providers the ability to designate subparts should there be other reasons for doing so. Federal regulations or statutes may require health care providers to have unique billing numbers in order to be identified in claims sent to federal health programs, such as Medicare.

In some cases, health care providers who need billing numbers for federal health programs are actually components of covered health care providers. They may be located at the same address as the covered organization provider or they may have a different address.

In situations where such federal regulations or statutes are applicable, the covered organization providers would designate the components as subparts and ensure that they obtain NPI(s) in order to use them in standard transactions. The NPI will eventually replace the billing numbers in use today.

**What Providers Can Do to Prepare for NPI Implementation**

- Watch for information from the health plans with which you do business on the implementation/testing of NPIs in claims, and, eventually, in other standard transactions.
- Check with your billing services, vendors, and clearinghouses about NPI compliance and what you need to do to facilitate the process.
- Review laws in your state to determine any conflicts or supplements to the NPI. For example, some states require the NPI to be used on paper claims.
- Check in your area for collaborative organizations working to address NPI implementation issues on a regional basis among the physicians, hospitals, laboratories, pharmacies, health plans, and other impacted parties.

**Part 2: Information that Applies to Medicare Fee-For-Service (FFS) Providers Only**

All Medicare providers are reminded that they will be required to use the NPI *in Medicare claims transactions*.

**NPI Transition Plans for Medicare FFS Providers**

Medicare implementation involving acceptance and processing of transactions with the NPI will occur in separate stages, as shown below:

**May 23, 2005 – January 2, 2006:**

Providers should submit Medicare claims using only their existing Medicare numbers. They should not use their NPI numbers during this time period. CMS claims processing systems will reject, as unprocessable, any claim that includes an NPI during this phase.

**January 3, 2006 – October 1, 2006:**

Medicare systems will accept claims with an NPI, but an existing legacy Medicare number **must also be on the claim**. Note that CMS claims processing systems will reject, as unprocessable, any claim that includes **only** an NPI.

Medicare will be capable of sending the NPI as primary provider identifier **and** legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.

### Implementation of the National Provider Identifier (continued)

#### October 2, 2006 – May 22, 2007:

CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim.

*Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.*

Medicare will be capable of sending the NPI as primary provider identifier **and** legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.

#### May 23, 2007 – Forward:

CMS systems will only accept NPI numbers. Small health plans have an additional year to be NPI compliant.

#### Crosswalk

The Medicare health plan is preparing a crosswalk to link NPI and Medicare legacy identifiers exclusively for Medicare business, which should enable Medicare to continue claims processing activities without interruption. NPI(s) will be verified to make sure that they were actually issued to the providers for which reported. Medicare will use the check digit to ensure the NPI(s) are valid.

#### Subparts Policy

CMS is currently developing policy on how Medicare providers should identify Medicare subparts. Further details will be provided when this policy is finalized.

#### Resources for Additional Information

**Coming Soon** – CMS is developing a Medlearn Web page on NPI for Medicare FFS providers, which will house all

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Medicare fee-for-service educational resources on NPI, including links to all Medlearn Matters articles, frequently-asked questions, and other information. CMS will widely publicize the launch of this Web page in the coming weeks.

You may wish to visit

<http://www.cms.hhs.gov/hipaa/hipaa2/> regularly for the latest information about the NPI, including frequently asked questions, announcements of roundtables, conferences, and guidance documents regarding the NPI.

Go to

<http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/CoveredEntityFlowcharts.pdf>

to access a tool to help establish whether one is a covered entity under the administrative simplifications of HIPAA.

A helpful tool that provides an overview of the NPI and the application process for obtaining an NPI is available at <http://www.cms.hhs.gov/medlearn/npi/npiviewlet.asp>.

The *Federal Register* notice containing the NPI Final Rule is available at

<http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2004/pdf/04-1149.pdf>.

There are some non-CMS websites that have information on NPI-related issues. While CMS does not necessarily endorse those materials, there may be information and tools available that might be of value to you.

You may also find some industry implementation recommendations and white papers on the NPI at <http://www.wedi.org>, which is the site of the Workgroup for Electronic Data Interchange (WEDI).

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Article SE0555

## MEDICARE SECONDARY PAYER

### Modification to the Online Medicare Secondary Payer Questionnaire—Full Replacement of Change Request 3504

The Centers for Medicare & Medicaid Services (CMS) has rescinded change request (CR) 3504, which was to have made several changes to the "Medicare Secondary Payer Questionnaire." However, only one of the changes was specifically mentioned in CR 3504. In addition, none of the changes were incorporated in the CMS Internet Only Manual (IOM). CR 4098 will identify all *changes* that were made as part of CR 3504 and will make additional changes to the model questionnaire. These additional changes will assist providers in identifying other payers that may be primary to Medicare. Instruction related to CR 3504 were published in the Second Quarter 2005 *Medicare A Bulletin* (pages 18-21)

Modification to Online Medicare Secondary Payer Questionnaire may be found on the CMS Internet Only Manual, Pub. 100-05, Medicare Secondary Payer, Chapter 3 – MSP Provider, Physician, and Other Supplier Billing Requirements, Section 20.2.1. – Admission Questions to Ask Medicare Beneficiaries.

*Modification to the Online Medicare Secondary Payer Questionnaire—Full Replacement of CR 3504 (continued)*

**Implementation Date**

The effective and implementation date for this modification is for services provider January 21, 2006.

**Admission Questions to Ask Medicare Beneficiaries**

The following *questionnaire contains* lists questions *that can be used* to ask Medicare beneficiaries upon each inpatient and outpatient admission. Providers *may use this* as a guide to help identify other payers that may be primary to Medicare. *This questionnaire is a model of the type of questions that may be asked to help identify Medicare Secondary Payer (MSP) situations. 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 the patient to the next appropriate question to determine MSP situations.*

**Part I**

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

**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: *MM/DD/CCYY*  
 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: *MM/DD/CCYY*  
 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: \_\_\_\_\_

## GENERAL INFORMATION

*Modification to the Online Medicare Secondary Payer Questionnaire—Full Replacement of CR 3504 (continued)*

**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: *MM/DD/CCYY*

No. *Never Employed*

2. Is your spouse currently employed?

Yes.

Name and address of spouse's employer:

\_\_\_\_\_

\_\_\_\_\_

No. Date of retirement: *MM/DD/CCYY*

No. *Never Employed*

**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. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

\_\_\_\_\_

\_\_\_\_\_

Policy identification number (*this number is sometimes referred to as the health insurance benefit package number*):

Group identification number: \_\_\_\_\_

*Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient):*

\_\_\_\_\_

Name of policyholder/named insured: \_\_\_\_\_

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: *MM/DD/CCYY*

No. *Never employed.*

*Modification to the Online Medicare Secondary Payer Questionnaire—Full Replacement of CR 3504 (continued)*

2. *If married, is your spouse currently employed?*

Yes.

Name and address of your employer:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

No. *Date of retirement: MM/DD/CCYY*

No. *Never employed.*

**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. *Are you covered under the group health plan of a family member other than your spouse?*

Yes

Name and address of your family member’s employer:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

No

5. 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 (*this number is sometimes referred to as the health insurance benefit package number*):

Group identification number: \_\_\_\_\_

*Membership number (prior to HIPAA, this number was frequently the individual’s SSN; it is the unique identifier assigned to the policyholder/patient):* \_\_\_\_\_

Name of policyholder/named insured: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

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

**Part VI - ESRD**

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

*If yes, name and address of GHP:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Policy identification number (*this number is sometimes referred to as the health insurance benefit package number*):

Group identification number: \_\_\_\_\_

*Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual’s Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient):*

Name of policyholder/named insured: \_\_\_\_\_

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: *MM/DD/CCYY*

No.

3. Have you received maintenance dialysis treatments?

## GENERAL INFORMATION

### *Modification to the Online Medicare Secondary Payer Questionnaire—Full Replacement of CR 3504 (continued)*

Yes. Date dialysis began: MM/DD/CCYY

If you participated in a self-dialysis training program, provide date training started:

MM/DD/CCYY

No

4. Are you within the 30-month coordination period *that starts MM/DD/CCYY? (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis. If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)*

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 or dual 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 the *Common Working File (CWF)* for the beneficiary, the provider still asks the *types of* questions *above* 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 41 CR 4098

# GENERAL COVERAGE

## October 2005 Changes to the Laboratory National Coverage Determination Edit Software

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

### Provider Types Affected

Laboratories billing Medicare carriers or intermediaries for clinical diagnostic laboratory services

### Provider Action Needed

CR4005 announces changes to the list of codes included in the October 2005 release of the Medicare Laboratory National Coverage Determination (NCD) edit module for clinical diagnostic laboratory services.

These changes are a result of new ICD-9-CM code changes that become effective October 1, 2005.

### Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published as final rule, 66 FR, 58788, on November 23, 2001. Nationally uniform software was developed by Computer Sciences Corporation and incorporated into the Medicare claim processing systems so that laboratory claims subject to any of the 23 NCDs are processed uniformly throughout the nation, effective January 1, 2003.

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

CR4005 announces the changes that will be included in the October 2005 release of the edit module for clinical diagnostic laboratory services. Those changes, which become effective October 1, 2005, include the following:

### Urine Culture

In accordance with the coding analysis, CMS is adding new ICD-9-CM code **585.6 – End-stage renal disease**, to the list of ICD-9-CM Codes Covered by Medicare for Urine Culture. CMS is deleting ICD-9-CM code **585 – Chronic renal failure**, from the same list for this NCD.

### Immunodeficiency Virus (HIV) Testing (Diagnosis)

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM codes covered by Medicare for human immunodeficiency virus (HIV) testing (diagnosis). Those codes are as follows:

- 287.30 Primary thrombocytopenia, unspecified
- 31.31 Immune thrombocytopenic purpura
- 31.32 Evans' syndrome
- 287.33 Congenital and hereditary thrombocytopenic purpura
- 287.39 Other primary thrombocytopenia

CMS is deleting ICD-9-CM code **287.3 – Primary thrombocytopenia**, from the same list for this NCD.

### Blood Counts

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM codes that do not support medical necessity for Medicare for blood counts. Those codes are as follows:

- 443.82 Erythromelalgia
- 525.40 Complete edentulism, unspecified
- 525.41 Complete edentulism, class I
- 525.42 Complete edentulism, class II
- 525.43 Complete edentulism, class III
- 525.44 Complete edentulism, class IV
- 525.50 Partial edentulism, unspecified
- 525.51 Partial edentulism, class I
- 525.52 Partial edentulism, class II
- 525.53 Partial edentulism, class III
- 525.54 Partial edentulism, class IV
- V26.31 Testing for genetic disease carrier status
- V26.32 Other genetic testing
- V26.33 Genetic counseling
- V49.84 Bed confinement status
- V59.70 Egg (oocyte) (ovum) donor, unspecified
- V59.71 Egg (oocyte) (ovum) donor, under age 35, anonymous recipient
- V59.72 Egg (oocyte) (ovum) donor, under age 35, designated recipient
- V59.73 Egg (oocyte) (ovum) donor, age 35 and over, anonymous recipient
- V59.74 Egg (oocyte) (ovum) donor, age 35 and over, designated recipient
- V62.84 Suicidal ideation

CMS is deleting ICD-9-CM code **V26.3 – Genetic counseling and testing**, from the same list for this NCD.

### Partial Thromboplastin Time (PTT)

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM Codes Covered by Medicare for Partial Thromboplastin Time (PTT). Those codes are as follows:

- 287.30 Primary thrombocytopenia, unspecified
- 287.31 Immune thrombocytopenic purpura V
- 287.32 Evans' syndrome
- 287.33 Congenital and hereditary thrombocytopenic purpura
- 287.39 Other primary thrombocytopenia
- 585.4 Chronic kidney disease, stage IV (severe)
- 585.5 Chronic kidney disease, stage
- 585.6 End stage renal disease
- 585.9 Chronic kidney disease, unspecified

CMS is deleting ICD-9-CM codes, **287.3 – Primary thrombocytopenia**, and **585 – Chronic renal failure**, from the same list for this NCD.

### Prothrombin Time (PT)

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM codes covered by Medicare for prothrombin time

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

(PT). Those codes are as follows:

- 287.30 – 287.39 as defined in the section on partial thromboplastin time (PTT) above
- 585.4 – 585.9 as defined in the section on partial thromboplastin time (PTT) above.
- 443.82 – Erythromelalgia

CMS is deleting ICD-9-CM code, **287.3 – Primary thrombocytopenia**, and **585 – Chronic renal failure**, from the same list for this NCD.

**Serum Iron Studies**

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM codes covered by Medicare for serum iron studies. Those codes are as follows:

- 287.30 – 287.39 as defined in the section on partial thromboplastin time (PTT) above.
- 585.4 – 585.9 as defined in the section on partial thromboplastin time (PTT) above.

CMS is deleting ICD-9-CM codes **287.3 – Primary thrombocytopenia**, and **585 – Chronic renal failure**, from the same list for this NCD.

**Blood Glucose Testing**

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM codes covered by Medicare for blood glucose testing. Those codes are as follows:

- 276.50 Volume depletion, unspecified
- 276.51 Dehydration
- 276.52 Hypovolemia

CMS is deleting ICD-9-CM code **276.5 – Volume depletion**, from the same list for this NCD.

**Thyroid Testing**

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM codes covered by Medicare for thyroid testing. Those codes are as follows:

- 327.00 Organic insomnia, unspecified
- 327.01 Insomnia due to medical condition classified elsewhere
- 327.09 Other organic insomnia
- 327.29 Other organic sleep apnea
- 327.29 Other organic sleep apnea
- 327.52 Sleep related leg cramp
- 327.8 Other organic sleep disorders

**Lipid Testing**

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM codes covered by Medicare for lipid testing. Those codes are as follows:

**278.02 Overweight.**

- 585.4 – 585.9 as defined in partial thromboplastin time (PTT) above

CMS is deleting ICD-9-CM code **585 – Chronic renal failure**, from the same list for this NCD.

**Digoxin Therapeutic Drug Assay**

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM codes covered by Medicare for digoxin therapeutic drug assay. Those codes are as follows:

- 276.50 Volume depletion, unspecified)

- 276.51 Dehydration
- 276.52 Hypovolemia
- 426.82 Long QT syndrome
- 585.1 Chronic kidney disease, stage I
- 585.2 Chronic kidney disease, stage II (mild)
- 585.3 Chronic kidney disease, stage III (moderate)
- 585.4 Chronic kidney disease, stage IV (severe)
- 585.5 Chronic kidney disease, stage V
- 585.6 End stage renal disease
- 585.9 Chronic kidney disease, unspecified

CMS is deleting ICD-9-CM codes **276.5 – Volume depletion**, and **585 – Chronic renal failure**, from the same list for this NCD.

**Prostate Specific Antigen Testing**

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM codes covered by Medicare for prostate specific antigen testing. Those codes are as follows:

- 599.60 Urinary obstruction, unspecified
- 599.69 Urinary obstruction, not elsewhere classified

CMS is deleting ICD-9-CM codes, **599.6 – Urinary Obstruction**, from the same list for this NCD.

**Gamma Glutamyl Transferase Testing**

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM codes covered by Medicare for gamma glutamyl transferase testing. Those codes are as follows:

- 291.82 Alcohol induced sleep disorders
- 567.21 Peritonitis (acute) generalized
- 567.22 Peritoneal abscess
- 567.23 Spontaneous bacterial peritonitis
- 567.29 Other suppurative peritonitis
- 567.38 Other retroperitoneal abscess
- 567.39 Other retroperitoneal infections
- 567.81 Choleperitonitis
- 567.82 Sclerosing mesenteritis
- 567.89 Other specified peritonitis
- 585.6 End stage renal disease

CMS is deleting ICD-9-CM codes, **567.2 – Suppurative peritonitis NEC**, **567.8 – Peritonitis NEC**, and **585 – Chronic renal failure**, from the same list for this NCD.

**Fecal Occult Blood Testing**

CMS is adding ICD-9-CM codes **287.30 – 287.39 (as defined in partial thromboplastin time (PTT) above)** to the list of ICD-9-CM codes covered by Medicare for fecal occult blood testing. CMS is deleting ICD-9-CM code, **287.3 – Primary thrombocytopenia**, from the same list for this NCD.

**Negotiated Laboratory NCDs**

In accordance with the coding analysis, CMS is adding new ICD-9-CM codes to the list of ICD-9-CM codes not covered by Medicare for the negotiated laboratory NCDs. Those codes are as follows:

- V17.81 Family history, osteoporosis
- V17.89 Family history, other musculoskeletal diseases
- V18.9 Family history, genetic disease carrier

CMS is deleting ICD-9-CM code, **V17.8 – Family history of certain chronic disabling diseases**, from the same list.



*October 2005 Changes to the Laboratory National Coverage Determination Edit Software (continued)***Implementation Date**

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

**Additional Information**

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

From that Web page, look for CR 4005 in the CR NUM column on the right, and then click on the file for that CR.

If you have questions regarding this issue, contact your carrier/intermediary on their toll free number, which is

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available on the CMS website at

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

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

Related Change Request (CR) Number: 4005

Related CR Release Date: August 19, 2005

Related CR Transmittal Number: 651

Effective Date: October 1, 2005

Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 651, CR 4005

**Implementation of Presbyopia-Correcting Intraocular Lenses**

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

**Provider Types Affected**

Physicians, providers, and suppliers billing Medicare carriers or fiscal intermediaries (FIs) for intraocular lenses (IOLs)

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

In a recent ruling, the Centers for Medicare & Medicaid Services (CMS) clarified payment rules that enable Medicare beneficiaries to have the choice of receiving presbyopia-correcting intraocular lenses (IOLs). A beneficiary may request insertion of a presbyopia-correcting IOL in place of a conventional IOL following cataract surgery.

**CAUTION – What You Need to Know**

The beneficiary is responsible for payment of that portion of the charge for the presbyopia-correcting IOL and associated services that exceed the charge for insertion of a conventional IOL following cataract surgery.

**GO – What You Need to Do**

See the Background and Additional Information sections of this article for further details regarding this change.

**Background**

The Centers for Medicare & Medicaid Services (CMS) recently announced a ruling (CMS Ruling 05-01 dated May 2005) that clarified its payment rules to present beneficiaries with the choice to receive presbyopia-correcting intraocular lenses (IOLs). Prior to this ruling, limitations on Medicare payment prevented beneficiaries from receiving these lenses. Now beneficiaries who choose to purchase this additional feature will be able to do so, provided they assume liability for the additional expense of that feature.

**Note:** CMS ruling 05-01 is included below in the Additional Information section of this article.

**Presbyopia-Correcting IOL**

Presbyopia is a type of age-associated refractive error that results in progressive loss of the focusing power of the lens of the eye, causing difficulty-seeing objects at near distance, or close-up. Presbyopia occurs as the natural lens

of the eye becomes thicker and less flexible with age.

A single presbyopia-correcting IOL can provide what would otherwise be achieved by two separate items:

- An implantable conventional IOL that restores far vision; and
- Eyeglasses or contact lenses that correct for presbyopia.

**Note:** The statute specifically excludes correction of common refractive errors from Medicare coverage.

**Coverage Ruling**

Payment for conventional IOLs furnished in an outpatient setting is covered by Medicare. However, providers have generally not offered beneficiaries presbyopia-correcting IOLs because the costs for this advanced technology substantially exceed Medicare's payment.

This ruling by CMS clarifies that a beneficiary may request insertion of a presbyopia-correcting IOL in place of a conventional IOL following cataract surgery.

The beneficiary is responsible for payment of that portion of the charge for the presbyopia-correcting IOL and associated services that exceed the charge for insertion of a conventional IOL following cataract surgery.

Effective for services furnished on or after May 3, 2005, the following are considered "presbyopia-correcting IOLs" by CMS:

- Crystalens™, manufactured by Eyeonics, Inc.
- AcrySof RESTOR™, manufactured by Alcon Laboratories, Inc.
- ReZoom™, manufactured by Advanced Medical Optics, Inc.

As a result of CMS ruling 05-01, the following policies may be stated:

**Payment Policy for Facility Services and Supplies**

- For an IOL inserted **following removal of a cataract** in a hospital, on either an outpatient or inpatient basis, that is paid under the hospital outpatient prospective payment system (OPPS) or the inpatient prospective

## Implementation of Presbyopia-Correcting Intraocular Lenses (continued)

payment system (IPPS), respectively; or in a Medicare-approved ambulatory surgical center (ASC) that is paid under the ASC fee schedule:

- ♦ Payment for the IOL is packaged into the payment for the surgical cataract extraction/lens replacement procedure. Medicare does not make separate payment to the hospital or the ASC for an IOL inserted following removal of a cataract.
- ♦ Any person or ASC, who presents or causes to be presented a bill or request for payment for an IOL inserted following removal of a cataract for which payment is made under the ASC fee schedule, is subject to a civil money penalty.
- For a presbyopia-correcting IOL inserted **following removal of a cataract** in a hospital, on either an outpatient or inpatient basis, that is paid under the OPPOS or the IPPS, respectively; or in a Medicare approved ASC that is paid under the ASC fee schedule:
  - ♦ The facility will bill for removal of a cataract with insertion of a conventional IOL, regardless of whether a conventional or presbyopia-correcting IOL is inserted. When a beneficiary receives a presbyopia-correcting IOL **following removal of a cataract**, hospitals and ASCs shall report the same CPT code that is used to report removal of a cataract with insertion of a conventional IOL (see “Coding” below).
  - ♦ There is no Medicare benefit category that allows payment of facility charges for services and supplies required to insert and adjust a presbyopia-correcting IOL **following removal of a cataract** that exceed the facility charges for services and supplies required for the insertion and adjustment of a conventional IOL.
  - ♦ There is no Medicare benefit category that allows payment of facility charges for subsequent treatments, services and supplies required to examine and monitor the beneficiary who receives a presbyopia-correcting IOL **following removal of a cataract** that exceed the facility charges for subsequent treatments, services and supplies required to examine and monitor a beneficiary **after cataract surgery** followed by insertion of a conventional IOL.

### Payment Policy for Physician Services and Supplies

- For an IOL inserted following removal of a cataract in a physician’s office:
  - ♦ Medicare makes separate payment, based on reasonable charges, for an IOL inserted following removal of a cataract that is performed at a physician’s office.
- For a presbyopia-correcting IOL inserted following removal of a cataract in a physician’s office:
  - ♦ A physician shall bill for a conventional IOL, regardless of whether a conventional or presbyopia correcting IOL is inserted (see “Coding,” below).
  - ♦ There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust a presbyopia-correcting IOL **following removal of a cataract**

that exceed the physician charges for services and supplies for the insertion and adjustment of a conventional IOL.

- ♦ There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, services and supplies required to examine and monitor a beneficiary **following removal of a cataract** with insertion of a presbyopia-correcting IOL that exceed the physician charges for services and supplies to examine and monitor a beneficiary **following removal of a cataract** with insertion of a conventional IOL.
- For a presbyopia-correcting IOL inserted **following removal of a cataract** in a hospital or ASC:
  - ♦ A physician may not bill Medicare for a presbyopia-correcting IOL inserted during a cataract procedure performed in those settings because payment for the lens is included in the payment made to the facility for the entire procedure.
  - ♦ There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust a presbyopia-correcting IOL **following removal of a cataract** that exceed physician charges for services and supplies required for the insertion of a conventional IOL.
  - ♦ There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, services and supplies required to examine and monitor a beneficiary **following removal of a cataract** with insertion of a presbyopia-correcting IOL that exceed the physician charges for services and supplies required to examine and monitor a beneficiary **following cataract surgery** with insertion of a conventional IOL.

### Coding Requirements

- No new codes are being established at this time to identify a presbyopia-correcting IOL or procedures and services related to a presbyopia-correcting IOL.
- Hospitals, ASCs, and physicians should use one of the following CPT codes to bill Medicare for removal of a cataract with IOL insertion:

66982 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage*

66983 *Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)*

66984 *Extracapsular cataract removal with insertion*

**Implementation of Presbyopia-Correcting Intraocular Lenses (continued)**

*of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)*

- Physicians inserting an IOL or a presbyopia-correcting IOL in a **physician's office setting only**, may bill code V2632 (posterior chamber intraocular lens) for the IOL or the presbyopia-correcting IOL, which is paid on a reasonable charge basis. **Physicians must remember that they may only bill for professional services and not the lens itself when performing cataract surgery in an ASC or outpatient setting. In these settings, payment for the lens is packaged into the facility payment for the cataract extraction.**
- Hospitals, ASCs, and physicians should use the following CPT codes to bill Medicare for evaluation and management services usually associated with services following cataract extraction surgery:
  - 92002 *Ophthalmological services; medical examination and evaluation with initiation of diagnostic an treatment program; intermediate, new patient*
  - 92004 *Ophthalmological services; medical examination and evaluation with initiation of diagnostic an treatment program; comprehensive, new patient, one or more visits*
  - 92012 *Ophthalmological services; medical examination and evaluation with initiation or continuation of diagnostic and treatment program; intermediate, established patient*
  - 92014 *Ophthalmological services; medical examination and evaluation with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more services*
- Hospital outpatient claims should be submitted on type of bill (TOB) 12x, 13x, 83x, or 85x, as appropriate.

**Beneficiary Liability**

- When the beneficiary requests and receives a presbyopia-correcting IOL instead of a conventional IOL **following removal of a cataract**, the beneficiary is responsible for payment of facility and physician charges for services and supplies attributable to the presbyopia-correcting functionality of the presbyopia-correcting IOL:
  - ♦ In determining the beneficiary's liability, the facility and physician may take into account any additional work and resources required for insertion, fitting, vision acuity testing, and monitoring of the presbyopia-correcting IOL that exceeds the work and resources attributable to insertion of a conventional IOL.
  - ♦ The physician and the facility may not charge for cataract extraction with insertion of a presbyopia-correcting IOL unless the beneficiary requests this service.

- ♦ The physician and the facility may not require the beneficiary to request a presbyopia-correcting IOL as a condition of performing a cataract extraction with IOL insertion.

**Provider Notification Requirements**

- When a beneficiary requests insertion of a presbyopia-correcting IOL instead of a conventional IOL following removal of a cataract:
  - ♦ Prior to the procedure to remove a cataractous lens and insert a presbyopia-correcting IOL, the facility and the physician must inform the beneficiary that Medicare will not make payment for services that are specific to the insertion, adjustment or other subsequent treatments related to the presbyopia-correcting functionality of the IOL.
  - ♦ The presbyopia-correcting functionality of a presbyopia-correcting IOL does not fall into a Medicare benefit category, and therefore, is not covered. Therefore, the facility and physician are not required to provide an advanced beneficiary notice (ABN) to beneficiaries who request a presbyopia-correcting IOL
  - ♦ Although not required, CMS strongly encourages facilities and physicians to issue a notice of exclusion from Medicare benefits to beneficiaries in order to clearly identify the non-payable aspects of a presbyopia-correcting IOL insertion. This notice may be found in English language at [http://cms.hhs.gov/medicare/bni/2007\\_English.pdf](http://cms.hhs.gov/medicare/bni/2007_English.pdf) and in Spanish on the CMS web site at: [http://cms.hhs.gov/medicare/bni/2007\\_Spanish.pdf](http://cms.hhs.gov/medicare/bni/2007_Spanish.pdf).

**Additional Information**

The actual CMS ruling may be viewed on the CMS website at <http://www.cms.hhs.gov/rulings/CMSR0501.pdf>.

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

From that Web page, look for CR 3927 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3927  
 Related CR Release Date: August 5, 2005  
 Related CR Transmittal Number: 636  
 Effective Date: May 3, 2005  
 Implementation Date: September 6, 2005

Source: CMS Pub. 100-4, Transmittal 636, CR 3927

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## Modification to Reporting Diagnosis Codes for Screening Mammography Claims

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

**Note:** CMS has revised this Medlearn Matters article on October 11, 2005, to reflect changes made to CR 3562 on October 7, 2005. The CR release date and transmittal date were revised and the effective date was changed from July 1, 2005, to January 1, 1998. All other information remains the same. This article was published in the Second Quarter 2005 Medicare A Bulletin (page 24).

### 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”
- **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.

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### 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](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: October 7, 2005

Related CR Transmittal Number: 705

Effective Date: January 1, 1998

Implementation Date: July 5, 2005

Source: CMS Pub. 100-4, Transmittal 705, CR 3562

## Correct Coding Initiative Edits to Apply to ALL Therapy Providers

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

### Provider Types Affected

Skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), outpatient physical therapy and speech-language pathology providers (OPTs), and home health agencies (HHAs)

### Provider Action Needed

#### STOP – Impact to You

Effective January 1, 2006, the Medicare CCI edits will be applied to **ALL** outpatient services furnished by the above-mentioned providers.

#### CAUTION – What You Need to Know

Be aware that application of correct coding initiative (CCI) edits under the Medicare physician fee schedule (MPFS) will make uniform the manner in which all outpatient rehabilitation therapy services – including physical therapy, occupational therapy, and speech-language pathology services – are paid. To review the CCI edits that apply to Medicare Part B services paid by Medicare fiscal intermediaries (FIs) see the CMS website at <http://www.cms.hhs.gov/providers/hopps/cciedits/>.

#### GO – What You Need to Do

Affected providers should begin immediately to prepare their systems with any necessary software, educate their staff

and management about the 2006 CCI application to their claims, and watch for forthcoming information from CMS and their local contractor (carrier or fiscal intermediary), after October 1, 2005, **although the CCI concept should not be unfamiliar- just its application.**

### Background

This special edition article, SE0545, is published by the Centers for Medicare & Medicaid Services (CMS) as a ‘heads-up’ to institutional therapy providers to make certain that they are aware of the changes in Medicare’s payment processes that are to begin January 1, 2006. **It is important to note that the CCI edits are applied to services billed by the same provider for the same beneficiary on the same date of service.**

Medicare’s National Correct Coding Initiative (NCCI) is an edit system that was developed to promote national correct coding methodologies and eliminate improper coding. These edits are developed based on coding conventions defined in the American Medical Association’s *Current Procedural Terminology (CPT)* manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practices.

Carriers currently apply the CCI edits to all practitioners filing claims for rehabilitation therapy services,

**Correct Coding Initiative Edits to Apply to ALL Therapy Providers (continued)**

including the services of physicians (and their incident-to services) and the services provided by physical therapists and occupational therapists in private practices. Additionally, CCI edits are applied in the outpatient hospital setting by the intermediaries, including rehabilitation therapy services. However, until now, CCI edits have not been applied to other institutional therapy providers of outpatient rehabilitation therapy services, including physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services. These institutional therapy providers include:

- Skilled nursing facilities (SNFs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Outpatient physical therapy and speech-language pathology providers (OPTs)
- Home health agencies (HHAs).

In January 1999, the institutional therapy providers were changed, via the 1997 Balanced Budget Act (BBA) requirements, from cost-based reimbursement to payment under the MPFS. At that time, these entities were granted a temporary postponement from the CCI edits because there was no outpatient code editor (OCE) CCI mechanism in place.

Congressional concerns about rising utilization of therapy services and the fact that these facilities have had five-plus years to adjust to the billing requirements of the MPFS, CMS has determined that this is the appropriate time to apply the CCI edits in these settings. Application of the CCI edits ensures that all therapy providers are subject to the same billing and coding rules and requirements. It is believed that these changes will have a positive budgetary effect as it incorporates safeguards against improper coding and over-payment of therapy services.

**Billing Instructions**

SNFs, CORFs, outpatient physical therapy and speech-language pathology providers (OPTs) (sometimes referred to as rehabilitation agencies), and HHAs (home health services not under a home health plan of treatment) will see the CCI edits applied to types of bills (TOBs) as follows:

**Skilled Nursing Facilities:**

- Skilled nursing facility inpatient Part B – TOB 22x
- Skilled nursing facility outpatient – TOB 23x

Comprehensive outpatient rehabilitation facilities – TOB 75x

Rehabilitation agencies/outpatient physical therapy and speech-language pathology providers (OPTs) – TOB 74x

Home health agency (HHAs) (home health services not under a home health plan of treatment) – TOB 34x.

The CCI edits will be applied to the above bill types as of January 1, 2006. Since calendar year 2000, the edits have been applied to all services, including outpatient therapy services, provided by OPFS hospitals.

Please also note the following billing pointers:

- A therapy billing web page, developed specifically for PTs and OTs, contains billing information and includes

the requirements that are necessary pre-conditions to the service delivery framework that CMS assumes is in place when Part B therapy services are delivered. This site outlines the “assumptions” for payment of outpatient Part B PT and OT therapy services and lists some references to help underscore that all of these services are subject to the payment rules of the MPFS. This information may be found or accessed on the CMS website at

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

- Physical and occupational therapists (PTs and OTs) and their therapy assistants – physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) – and speech-language pathologists (SLPs) must all meet Medicare personnel qualifications at 42 CFR 484.4 to provide outpatient therapy services in these therapy providers. The standards that apply to therapists are detailed in our manual at Pub. 100-02, chapter 15, sections 220 and 230.
- Affected providers should pay special note to modifier 59 that permits a distinct procedural service to be billed for the same patient on the same day by the same provider. These distinct services are identified as independent of other services provided that day by using modifier 59. At the <http://www.cms.hhs.gov/providers/therapy/billing.asp> website, scenario #6 (of 11 scenarios) contains the following example of the use of modifier 59:
  - ♦ Billing for both individual (one-on-one) and group services provided to the same patient in the same day is allowed, provided the CMS and coding rules for one-on-one and group therapy are both met, and that the group therapy session be clearly distinct or independent from other services and billed using modifier 59.
  - ♦ The group therapy CPT code 97150 and the direct one-on-one 15-minute CPT code for therapeutic exercises (97110), are a mutually exclusive CCI code pair: 97150 is the column one code, 97110 is the column two code, and modifier 59 is permitted to be used.
  - ♦ This requires the group therapy and the one-on-one exercise therapy to occur in different sessions, separate encounters, or different timeframes – occurring sequentially, not concurrently – that are distinct or independent from each other.
  - ♦ The therapist would bill for both group therapy and therapeutic exercises, appending modifier 59 to the column two code, 97110. Without modifier 59, payment would be made for the column one group therapy CPT code, 97150. The CCI edits are based upon interpretation of coding rules.
- Review the FAQs explaining two kinds of edits: FAQ 3373 (Column1/Column2) and FAQ 3372 (Mutually Exclusive). Click on the following link and enter NCCI in the search box—the CMS FAQ site. 3373 is on page one and 3372 page two.

**Correct Coding Initiative Edits to Apply to ALL Therapy Providers (continued)**

[http://questions.cms.hhs.gov/cgi-bin/cms\\_hhs.cfg/php/enduser/std\\_alp.php](http://questions.cms.hhs.gov/cgi-bin/cms_hhs.cfg/php/enduser/std_alp.php)

- The preceding bullet point refers to the code pairs that are a crucial underpinning of the CCI edits.

Keep in mind that whether you bill a carrier or an intermediary, the CCI principles and logic are the same. However, a few code-pair edits and modifier 59 applicability may vary from the two versions: OPPS and physician. Remember that the NCCI edits are updated quarterly and the hospital version is one calendar quarter behind the carrier “physician” version. Review the background information regarding the NCCI edits for the hospital outpatient prospective payment (OPPS) on the CMS website at: <http://www.cms.hhs.gov/providers/hopps/cciedits/background.asp>.

**Additional Information**

There is Medlearn information on the Web written about the CCI edits. The Medlearn Matters article numbers are: MM3244, MM3995, MM3823, MM3349, and MM3688 and may be viewed by going to: <http://www.cms.hhs.gov/medlearn/matters/> then clicking on the appropriate number.

Another Medlearn product is a CCI reference guide published in 2002. The guide is comprehensive and helpful in terms of acquainting the reader with the entire CCI edit process. Keep in mind that the latest edits will always be available on the Web—this Guide is excellent background information and available on the CMS website at <http://www.cms.hhs.gov/contractors/customerserv/ccirefge.pdf>.

Another version of this guide focused on the viewpoint of interest to hospitals may be found on the CMS website at <http://www.cms.hhs.gov/providers/hopps/cciedits/>.

A version of the CCI guide for physicians may be found on the CMS website at <http://www.cms.hhs.gov/physicians/cciedits/>.

The following site describes eleven therapy-billing scenarios and scenario number six explains CCI edits with modifier 59, an excellent reference for all types of billing: <http://www.cms.hhs.gov/providers/therapy/billing.asp>.

The following AMA site is a primer on CCI edits and presents a history of the CCI initiative, column one and two codes and the rationale behind modifier 59: <http://www.ama-assn.org/ama/pub/category/3233.html>.

Further information on these CCI edit applications will be made available via future Medlearn Matters articles as well. Watch the Medlearn Matters site and information made available from your carrier/intermediary for further developments. As always, if you have questions, please contact your carrier or intermediary at their toll free number available on the CMS website at <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: N/A  
Effective Date: January 1, 2006

Source: Special Edition Medlearn Matters Article SE0545

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**Medical Nutrition Therapy—Manual Update**

The Centers for Medicare & Medicaid Services (CMS) has issued change request (CR) 3955 that manualizes sections in the CMS Internet-only-manual (IOM) for medical nutrition therapy (MNT) services (Pub 100-04, Chapter 4, Sections 300 through 300.6). The definition for diabetes mellitus has been changed based on the 2003 Medicare physician fee schedule regulation. Also, material that was excluded from the new IOM has been added. Updated sections include:

- 300.1 – General Conditions and Limitations on Coverage
- 300.2 – Referrals for MNT Services
- 300.3 – Dietitians and Nutritionists Performing MNT Services
- 300.4 – Payment for MNT Services
- 300.5 – General Claims Processing Information
- 300.6 – Common Working File (CWF) Edits

**300 – Medical Nutrition Therapy Services**  
(Rev.673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)

Section 105 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) permits Medicare coverage of MNT services when furnished by a registered dietitian or nutrition professional meeting certain requirements. The benefit is available for beneficiaries with diabetes or renal disease, when referral is made by a physician as defined in section 1861(r)(1) of the Act. It also allows registered dietitians and nutrition professionals to receive direct Medicare reimbursement for the first time. The effective date of this provision is January 1, 2002.

The benefit consists of an initial visit for an assessment; follow-up visits for interventions; and reassessments as necessary during the 12-month period beginning with the initial assessment (“episode of care”) to assure compliance with the dietary plan. Effective October 1, 2002, basic coverage of MNT for the first year a beneficiary receives MNT with either a diagnosis of renal disease or diabetes as defined at 42 CFR, 410.130 is three hours. Also effective October 1, 2002, basic coverage in subsequent years for renal disease is two hours.

**Medical Nutrition Therapy—Manual Update (continued)**

For the purposes of this benefit, renal disease means chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant within the last six months. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation (glomerular filtration rate (GFR) 13-50 ml/min/1.73m<sup>2</sup>). Effective January 1, 2004, CMS updated the definition of diabetes to be as follows: Diabetes is defined as diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria: a fasting blood sugar greater than or equal to 126 mg/dL on two different occasions; a two-hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions; or a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

The MNT benefit is a completely separate benefit from the diabetes self-management training (DSMT) benefit. CMS had originally planned to limit how much of both benefits a beneficiary might receive in the same time period. However, the national coverage decision, published May 1, 2002, allows a beneficiary to receive the full amount of both benefits in the same period. Therefore, a beneficiary can receive the full 10 hours of initial DSMT and the full three hours of MNT. However, providers are not allowed to bill for both DSMT and MNT on the same date of service for the same beneficiary.

**300.1 – General Conditions and Limitations on Coverage****A.– General Conditions on Coverage**

The following are the general conditions of coverage:

- The treating physician must make a referral and indicate a diagnosis of diabetes or renal disease. As described above, a treating physician means the primary care physician or specialist coordinating care for beneficiary with diabetes or renal disease.
- The number of hours covered in an episode of care may not be exceeded unless a second referral is received from the treating physician.
- Services may be provided either on an individual or group basis without restrictions.
- For a beneficiary with a diagnosis of diabetes, diabetes self-management training (DSMT) and MNT services can be provided within the same time period, and the maximum number of hours allowed under each benefit are covered. The only exception is that DSMT and MNT may not be provided on the same day to the same beneficiary. For a beneficiary with a diagnosis of diabetes who has received DSMT and is also diagnosed with renal disease in the same episode of care, the beneficiary may receive MNT services based on a change in medical condition, diagnosis or treatment as stated in 42 CFR 410.132(b)(5).

**B. – Limitations on Coverage**

The following limitations apply:

- MNT services are not covered for beneficiaries receiving maintenance dialysis for which payment is made under Section 1881 of the Act.

- A beneficiary may not receive MNT and DSMT on the same day.

**300.2 – Referrals for MNT Services**

Medicare covers three hours of MNT in the beneficiary's initial calendar year. No initial hours can be carried over to the next calendar year. For example, if a physician gives a referral to a beneficiary for three hours of MNT but a beneficiary only uses two hours in November, the calendar year ends in December and if the third hour is not used, it cannot be carried over into the following year. The following year a beneficiary is eligible for two follow-up hours (with a physician referral). Every calendar year a beneficiary must have a new referral for follow-up hours. Referral may only be made by the treating physician when the beneficiary has been diagnosed with diabetes or renal disease.

Documentation must be maintained by the referring physician in the beneficiary's medical record. Referrals must be made for each episode of care and reassessments prescribed during an episode of care as a result of a change in medical condition or diagnosis. The UPIN number of the referring physician must be on the Form CMS-1500 claim submitted by a registered dietitian or nutrition professional. The carrier or fiscal intermediary (FI) shall return claims that do not contain the referring UPIN of the referring physician.

**Note:** Additional covered hours of MNT services may be covered beyond the number of hours typically covered under an episode of care when the treating physician determines there is a change of diagnosis or medical condition within such episode of care that makes a change in diet necessary. Appropriate medical review for this provision should only be done on a post payment basis. Outliers may be judged against nationally accepted dietary or nutritional protocols in accordance with 42 CFR 410.132 (a).

**300.3 – Dietitians and Nutritionists Performing MNT Services****A. – Professional Standards for Dietitians and Nutritionists**

For Medicare Part B coverage of MNT, only a registered dietitian or nutrition professional may provide the services. "Registered dietitian or nutrition professional" means a dietitian or nutritionist licensed or certified in a State as of December 21, 2000 (they are not required to meet any other requirements); or an individual whom, on or after December 22, 2000:

- Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized for this purpose. The academic requirements of a nutrition or dietetics program may be completed after the completion of the degree;
- Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. Documentation of the

*Medical Nutrition Therapy—Manual Update (continued)*

supervised dietetics practice may be in the form of a signed document by the professional/facility that supervised the individual; and

- Is licensed or certified as a dietitian or nutrition professional by the state in which the services are performed. In a state that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a “registered dietitian” by the Commission on Dietetic Registration or its successor organization, or meets the requirements stated above.

**B – Enrollment of Dietitians and Nutritionists**

- In order to file claims for MNT, a registered dietitian/nutrition professional must be enrolled as a provider in the Medicare program and meet the requirements outlined above. MNT services can be billed with the effective date of the provider’s license and the establishment of the practice location.
- The carrier shall establish a permanent UPIN for any new registered dietitian or nutrition professional who is applying to become a Medicare provider for MNT.
- Registered dietitians and nutrition professionals must accept assignment. Since these new providers must accept assignment, the limiting charge does not apply.

**300.4 – Payment for MNT Services**

The contractor shall pay for MNT services under the physician fee schedule for dates of service on or after January 1, 2002, to a registered dietitian or nutrition professional that meets the above requirements. Deductible and coinsurance apply. As with the diabetes self management training (DSMT) benefit, payment is only made for MNT services actually attended by the beneficiary and documented by the provider, and for beneficiaries that are not inpatients of a hospital or skilled nursing facility.

The contractor shall pay the lesser of the actual charge, or 85 percent of the physician fee schedule amount when rendered by a registered dietitian or nutrition professional. Coinsurance is based on 20 percent of the lesser of these two amounts. As required by statute, use this same methodology for services provided in the hospital outpatient department.

**A. – Payable Codes for MNT with Applicable Instructions**

97802 *Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes. (Note: This HCPCS code must only be used for the initial visit.)*

This code is to be used only once for the initial assessment of a new patient. The provider shall bill all subsequent individual visits (including reassessments and interventions) as 97803. The provider shall bill all subsequent group visits as 97804.

97803 *Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes*

The provider shall bill this code for all reassessments and all interventions after the initial visit (see 97802). This code should also be used when there is a change in the patient’s medical

condition that affects the nutritional status of the patient (see the heading, Additional Covered Hours for Reassessments and Interventions).

97804 *Group (2 or more individual(s)), each 30 minutes*  
The provider shall bill this code for group visits, initial and subsequent. This code can also be used when there is a change in a patient’s condition that affects the nutritional status of the patient and the patient is attending in a group.

**Note:** The above codes can be paid if submitted by a registered dietitian or nutrition professional who meet the specified requirements; or a hospital that has received reassigned benefits from a registered dietitian or nutritionist. These services cannot be paid “incident to” physician services.

**B – HCPCS Codes for MNT When There is a Change in the Beneficiaries Condition (for services effective on or after January 1, 2003)**

The following HCPCS codes shall be used when there is a change in the beneficiary’s condition:

G0270 *Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes.*

G0271 *Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease) group (2 or more individuals), each 30 minutes.*

**Note:** These G codes should be used when additional hours of MNT services are performed beyond the number of hours typically covered, (three hours in the initial calendar year, and two follow-up hours in subsequent years with a physician referral) when the treating physician determines there is a change of diagnosis or medical condition that makes a change in diet necessary. Appropriate medical review for this provision should only be done on a post payment basis. Outliers may be judged against nationally accepted dietary or nutritional protocols in accordance with 42 CFR 410.132(a).

**300.5 – General Claims Processing Information**

This benefit is payable for beneficiaries who have diabetes or renal disease. Contractors are urged to perform data analysis of these services in your jurisdiction. If you determine that a potential problem exists, you should verify the cause of the potential error by conducting an error validation review as described in the Program Integrity Manual (PIM), Chapter 3, Section 2A. Where errors are verified, initiate appropriate corrective actions found in the PIM, Chapter 3, Sections 3 through 6. If no diagnosis is on the claim, return the claim as unprocessable. If the claim does not contain a diagnosis of diabetes or renal disease, then deny the claim under Section 1862(a)(1)(A) of the Act.



*Medical Nutrition Therapy—Manual Update (continued)***A. – Special Requirements for Carriers**

- Registered dietitians and nutrition professionals can be part of a group practice in which case the provider identification number of the registered dietitian or nutrition professional that performed the service must be entered in on the claim form. – The specialty code for “dietitians/nutritionists” is 71.

**B. – Medicare Summary Notices (MSNs)**

- Use the following MNT messages where appropriate. If you locate a more appropriate message, then you should use it.
- If a claim for MNT is submitted with dates of service before January 1, 2002, use MSN 21.11 (This service was not covered by Medicare at the time you received it). The Spanish version is ‘Este servicio no estaba cubierto por Medicare cuando usted lo recibio.’
- If a claim for MNT is submitted by a provider that does not meet the criteria use MSN 21.18 (This item or service is not covered when performed or ordered by this provider). The Spanish version is ‘Este servicio no esta cubierto cuando es ordenado o rendido por este proveedor.’

**C. – Fiscal Intermediary Special Billing Instructions**

MNT Services can be billed to FIs when performed in an outpatient hospital setting. The hospital outpatient departments can bill for the MNT services through the local FI if the nutritionists or registered dietitians reassign their benefits to the hospital. If the hospitals do not get the reassignments the nutritionists and the registered dietitians will have to bill the local Medicare carrier under their own

provider number or the hospital will have to bill the local Medicare carrier.

**Note:** Nutritionists and registered dietitians must obtain a Medicare provider number before they can reassign their benefits.

The only applicable bill types are 13x, 14x, 23x, 32x, and 85x.

**300.6 – Common Working File (CWF) Edits**

The CWF edit will allow three hours of therapy for MNT in the initial calendar year. The edit will allow more than three hours of therapy if there is a change in the beneficiary’s medical condition, diagnosis, or treatment regimen, and this change must be documented in the beneficiary’s medical record. Two new G codes have been created for use when a beneficiary receives a second referral in a calendar year that allows the beneficiary to receive more than three hours of therapy. Another edit will allow two hours of follow up MNT with another referral in subsequent years.

**Advance Beneficiary Notice (ABN)**

The beneficiary is liable for services denied over the limited number of hours with referrals for MNT. An ABN should be issued in these situations. In absence of evidence of a valid ABN, the provider will be held liable. An ABN should not be issued for Medicare-covered services such as those provided by hospital dietitians or nutrition professions who are qualified to render the service in their state but who have not obtained Medicare provider numbers.

Source: CMS Pub. 100-4, Transmittal 673, CR 3955

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**PET Scan Billing Requirements—Manual Update**

The Centers for Medicare & Medicaid Services (CMS) has issued change request (CR) 3945 that updates the CMS Internet-only-manual (IOM), Pub 100-04, Chapter 13, Section 60 to include the applicable HCPCS codes for radiopharmaceutical diagnostic imaging agents (tracers) when billing for PET scan services performed on or after January 28, 2005.

The allowances for myocardial perfusion imaging PET scans (CPT codes 78491 and 78492) **do not include** the radiotracer as several products may be utilized. Providers are required to separately bill the ammonia N-13 or rubidium per the guidelines listed in the local coverage determination 78460 – Myocardial Perfusion Imaging.

**Note:** Change request 3945 makes no changes to the current policy, but simply reflects current policy more accurately.

You can obtain additional information about the billing requirements for FDG PET scans by going to <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3741.pdf>.

Section 60 has been revised as follows:

**60.3.1 – Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005**

(Rev. 628, Issued: 07-29-05; Effective: 10-31-05; Implementation: 10-31-05)

**Note:** All PET scan services require the use of a radiopharmaceutical diagnostic imaging agent (tracer). The applicable tracer code should be billed when billing for a PET scan service. See section 60.3.2 below for applicable tracer codes.

CPT	Description
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation
78491	Myocardial imaging, positron emission tomography (PET), perfusion, single study at rest or stress
78492	Myocardial imaging, positron emission tomography (PET), perfusion, multiple studies at rest and/or stress
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation

**PET Scan Billing Requirements—Manual Update (continued)**

- 78811 Tumor imaging, positron emission tomography (PET); limited area (eg, chest, head/neck)
- 78812 Tumor imaging, positron emission tomography (PET); skull base to mid thigh
- 78813 Tumor imaging, positron emission tomography (PET); whole body
- 78814 Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (e.g., chest, head/neck)
- 78815 Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid thigh
- 78816 Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body

**60.3.2 – Tracer Codes Required for PET Scans**

**Tracer codes applicable to CPT 78491 and 78492:**

**Institutional providers billing the fiscal intermediary**

<b>HCPCS</b>	<b>Description</b>
Q3000	Supply of radiopharmaceutical diagnostic imaging agent, rubidium RB-82
A9526	Supply of radiopharmaceutical diagnostic imaging agent, ammonia N-13

**Physicians/practitioners billing the carrier:**

<b>HCPCS</b>	<b>Description</b>
A4641	Supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified
A9526	Supply of radiopharmaceutical diagnostic imaging agent, ammonia N-13

**Tracer codes applicable to CPT 78459, 78608, 78609, 78811-78816:**

**Institutional providers billing the fiscal intermediary:**

<b>HCPCS</b>	<b>Description</b>
C1775	Supply of radiopharmaceutical diagnostic imaging agent, fluorodeoxyglucose F18 (OPPS Only)
A4641	Supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified

**Physicians / practitioners billing the carrier:**

<b>HCPCS</b>	<b>Description</b>
A4641	Supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified

Source: CMS Pub. 100-4, Transmittal 628, CR 3945

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# LOCAL COVERAGE DETERMINATIONS

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

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

## Effective and Notice Dates

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

## Electronic Notification

To receive quick, automatic notification when new and revised LMRPs/LCDs are posted to the Web site, subscribe to the FCSO *eNews* mailing list. It is very easy to do; simply sign on to the provider education website, <http://www.floridamedicare.com>; click on the *eNews* link on the navigational menu and follow the prompts.

## More Information

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

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

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**This Bulletin Should Be Shared with All Health Care Practitioners and Managerial Members of the Provider Staff. Bulletins Are Available at no Cost from Our Provider Education Website at <http://www.floridamedicare.com>.**

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## **NEW LCD IMPLEMENTATION**

### **A0067T: Computed Tomographic Colonography—New Determination**

Computed tomographic colonography (CT colonography) also known as virtual colonoscopy utilizes helical computed tomography of the abdomen and pelvis to visualize the colon lumen, along with 2-D or 3-D reconstruction. The test requires colonic preparation similar to that required for standard colonoscopy (instrument colonoscopy), and air insufflation to achieve colonic distention. CT colonography has desirable features for a screening test. It does not require sedation. It is minimally invasive, rarely has complications and less expensive than conventional colonoscopy. Diagnosis and staging of colon cancer can be accomplished in one examination and detection of extracolonic abnormalities can be observed. However, gas insufflation of the intestine, which may be uncomfortable to the patient, is required and interpretation of the images is described as difficult and time consuming. When polyps are detected with CT colonography, patients could presumably undergo subsequent endoscopic colonography, which may require another bowel preparation.

CT colonography is not endorsed for screening by the American Cancer Society, the U.S. Preventive Services Task Force, or any professional body and is noncovered by the Centers for Medicare & Medicaid Services (CMS).

Medicare will consider CT colonography medically reasonable and necessary for failure of conventional colonoscopy due to the inability to pass the colonoscope proximally. CT colonography will not be covered when used for routine screening.

This local coverage determination (LCD) has been developed to identify indications and limitations of medical necessity for coverage and documentation requirements.

#### **Effective Date**

This policy is effective for services provided **on or after January 1, 2006**.

The full-text for this LCD is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

### **A92548: Computerized Dynamic Posturography—New Determination**

Computerized dynamic posturography (CDP) is a means of assessing a patient's ability to use vestibular system information. The equipment for dynamic posturography consists of a moveable platform surrounded by a moveable screen that is computer-controlled. Both can move separately or simultaneously. CDP includes three protocols: 1). The sensory organization test (SOT) assesses the patient's ability to balance using visual, vestibular, and proprioceptive information and to appropriately suppress disruptive visual and/or proprioceptive information under sensory conflict conditions. 2). The motor control test (MCT) measures the ability to reflexively recover from unexpected external provocations. 3). Adaptation test (ADT) measures the ability to modify automatic reactions when the support surface is irregular or unstable.

Posturographic methods that do not satisfy the American Academy of Otolaryngology-Head and Neck Surgery (AA)-HNS and the American Academy of Neurology (ANN)

criteria cannot be considered equivalent to those that do comply with the AAO-HNS and AAN guidelines.

This LCD was developed to define the indications and limitations of coverage and define ICD-9-CM codes that Support Medical Necessity and Documentation Requirements. The ICD-9-CM codes include:

334.0-334.9	386.00-386.9	438.84	438.85
719.7	780.4	781.2	781.3
850.11	850.12	850.2	850.3
850.4	850.5	850.9	951.5

#### **Effective Date**

This LCD is effective for services provided **on or after January 1, 2006**.

The full-text for this LCD is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

### **AINPTPSYCH: Psychiatric Inpatient Hospitalization—New Determination**

Inpatient psychiatric hospitalization provides twenty-four hours of daily care in a structured, intensive, and secure setting for patients who cannot be safely and/or adequately managed at a lower level of care. This setting provides physician (MD/DO) supervision, twenty-four hour nursing/treatment team evaluation and observation, diagnostic services, and psychotherapeutic and medical interventions. Medicare patients admitted to inpatient psychiatric hospitalization must be under the care of a physician. The physician must certify/re-certify the need for inpatient psychiatric hospitalization. The patient must require "active treatment" of his/her psychiatric disorder. The patient or legal guardian must provide written informed consent for inpatient psychiatric hospitalization in accord with state law.

If the patient is subject to involuntary or court-ordered commitment, the services must still meet the requirements for medical necessity in order to be covered by Medicare.

This LCD was developed to define indications and limitations for billing inpatient psychiatric services. It further defines admission and discharge criteria, as well as, documentation requirements.

#### **Effective Date**

This revision is effective for services provided **on or after January 1, 2006**.

The revised full-text for this LCD is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**AIRF: Inpatient Rehabilitation Facilities—New Determination**

This local coverage determination (LCD) addresses Medicare coverage for inpatient rehabilitation services provided in freestanding and “excluded” inpatient rehabilitation facilities (IRFs). For the purposes of this LCD, a distinction exists between the ‘percent’ rule and medical necessity. This LCD describes the relevant factors that differentiate Medicare coverage for rehabilitation in an IRF from coverage for rehabilitation in other settings, such as acute care hospitals, skilled nursing facilities (SNFs), home health care, and outpatient settings.

Notations in italics are quotations taken from the online CMS manual system, Pub. 100-2, Medicare Benefit Policy, Chapter 1, Section 110. This LCD is not intended to replace or re-quote the entire language in the Medicare Benefit Policy Manual, but to highlight portions of this section that warrant further interpretation, guidance, and education for coverage. The Medicare Benefit Policy manual may be viewed at [http://www.cms.hhs.gov/manuals/102\\_policy/bp102index.asp](http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp).

Patients needing rehabilitative services require a hospital level of care, if they need a relatively intense rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade their ability to function. Two basic requirements must be met for inpatient hospital stays for rehabilitation care to be covered:

- The services must be reasonable and necessary (in terms of efficacy, duration, frequency, and amount) for the treatment of the patient’s condition.
- It must be reasonable and necessary to furnish the care on an inpatient hospital basis rather than in a less intensive facility such as an SNF, or on an outpatient basis.

In order to meet the above requirements, the LCD defines the basic components and documentation requirements that must be met.

In addition, based on a recommendation from a wide-spread probe performed in July 2004, this local coverage determination was developed to further define and clarify the national indications and limitation of coverage and/or medical necessity that would qualify an individual to receive rehabilitation therapy in an inpatient rehabilitation facility.

**Effective Date**

This policy is effective for services provided **on or after January 1, 2006**.

The full-text for this LCD is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**AJ0128: Abarelix for the Treatment of Prostate Cancer—New Determination**

Abarelix also called Plenaxis™ is a drug used to reduce the amount of testosterone made in patients with advanced symptomatic prostate cancer for which no other treatment options are available. It belongs to the family of drugs called gonadotropin-releasing hormone (GnRH) antagonists. Abarelix has received FDA approval for palliative treatment of men with advanced symptomatic prostate cancer, in whom GnRH agonist therapy is not appropriate and who refuse surgical castration, and have one or more of the following: (1) risk of neurological compromise due to metastases, (2) ureteral or bladder outlet obstruction due to local encroachment or metastatic disease, or (3) severe bone pain from skeletal metastases persisting on narcotic analgesia.

Effective March 15, 2005, the Centers for Medicare & Medicaid Services (CMS) has extended national coverage for the use of abarelix (Plenaxis™) as a palliative treatment in patients with advanced symptomatic prostate cancer.

This local coverage determination (LCD) is being developed to identify the ICD-9-CM code to be used by providers when billing abarelix. Providers need to use ICD-9-CM code 185 – Malignant neoplasm of the prostate when billing abarelix. The entire text of coverage guidelines is located in the Medicare National Coverage Determinations Manual, Chapter 1, Part 2, Section 110.19. The NCD manual may be viewed at [http://www.cms.hhs.gov/manuals/103\\_cov\\_determ/ncd103index.asp](http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp).

**Effective Date**

This policy is effective for services provided **on or after January 1, 2006**.

The full-text for this LCD is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**AJ9041: Bortezomib (Velcade®)—New Determination**

Bortezomib (Velcade®) is an antineoplastic agent which inhibits the activity of the 26S proteasome. It exhibits cytotoxicity to various malignant cells, including myeloma and lymphoma cells. Bortezomib is given by intravenous injection.

Based on documentation submitted to the Antineoplastic Drugs Workgroup meeting, a decision was made to develop a local coverage determination (LCD) to include indications and limitations of coverage, and ICD-9-CM codes that support medical necessity.

- The following FDA approved indication is covered:
- Treatment of multiple myeloma patients who have received at least one prior therapy.
- The following off-labeled indications are covered:
- Treatment of relapsed or refractory B-Cell Non-Hodgkin’s lymphoma specifically; mantle-cell lymphoma (MCL) and follicular lymphoma (FL).
- The following ICD-9-CM codes are covered:

### AJ9041: Bortezomib (Velcade®)—New Determination (continued)

202.00 – 202.08 Nodular lymphoma  
202.80 – 202.88 Other lymphomas  
203.00 Multiple myeloma without mention of remission

#### Effective Date

This policy is effective for services provided **on or after January 1, 2006**.

The full-text for this LCD is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

## ADDITIONS/REVISIONS TO LMRPs/LCDs

### A17304: Mohs Micrographic Surgery (MMS)—Revision to Policy

The local medical review policy (LMRP) for Mohs micrographic surgery (MMS) was previously revised on January 1, 2003. Since that time, the policy was revised to remove indications and ICD-9-CM diagnosis codes 161.0-161.9, for laryngeal carcinoma, as this would not be an appropriate indication for the MMS procedure, and add ICD-9-CM diagnosis codes 140.0-140.9 and 173.4.

In addition, the LMRP has been converted to a local coverage determination (LCD) format.

#### Effective Date

This revision is effective for services provided **on or after January 1, 2006**.

The revised full-text for this LCD is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

### A70450: Computed Tomography Scans—Revision to Policy

The local medical review policy (LMRP) for computed tomography scans was last updated on October 01, 2004. Since that time, the policy was updated with references under “CMS National Coverage Policy” and “Sources of Information and Basis for Decision” sections. Under the “Type of Bill Code” section, 71x (rural health clinic) was removed and TOB 21x, 22x, and 23x (skilled nursing facility) were added.

Under the “ICD-9 Codes that Support Medical Necessity” section, an asterisk was added to ICD-9-CM diagnosis code V45.2 and a statement that according to the ICD-9-CM book, diagnosis code V45.2 is a secondary diagnosis code and should not be billed as the primary diagnosis.

In addition, the LMRP has been converted to a local coverage determination (LCD) format.

#### Effective Date

This revision is effective for services provided **on or after September 22, 2005**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

### A70551: Magnetic Resonance Imaging of the Brain—Revision to Policy

The local medical review policy (LMRP) for magnetic resonance imaging of the brain was last updated on October 1, 2004. Since then, the following sections have been revised:

- Indications and Limitations of Coverage and/or Medical Necessity – A statement and indications of investigational reasons were added from the old format with correction of “and” instead of “or” for procedures involving spatial resolution of bone **and** calcifications.
- CMS National Coverage Policy – References were updated
- Documentation Requirements – Phraseology was changed to include “nonphysician practitioner.”

- Sources of Information and Basis for Decision – References were updated

Furthermore, under the “ICD-9 Codes that Support Medical Necessity” section, all diagnosis codes with descriptors were removed.

In addition, the LMRP has been converted to a local coverage determination (LCD) format.

#### Effective Date

This revision is effective for claims processed **on or after October 13, 2005**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**A72192: Computed Tomography of the Pelvis—Revision to Policy**

The local coverage determination (LCD) for computed tomography (CT) of the pelvis (72192) was last revised on November 18, 2004. Since that time, ICD-9-CM codes 593.9 (Unspecified disorder of kidney and ureter), and 752.41 (Embryonic cyst of cervix, vagina, and external female genitalia) were added to the local coverage determination.

**Effective Date**

This revision is effective for services provided **on or after October 1, 2005**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**A72192: Computed Tomography of the Abdomen and Pelvis—Revision to Policy**

The local coverage determinations (LCDs) for computed tomography (CT) of the abdomen (74150) and computed tomography (CT) of the pelvis (72192) were last revised on October 1, 2005. Since that time, it was determined the CT of the pelvis and CT of the abdomen policy should be combined. As a result, a major revision was done to combine these policies and change the policy name to computed tomography of the abdomen and pelvis (72192). The following changes were made to the combined policy:

- The national coverage information has been italicized.

- The ICD-9-CM codes have been removed from the policy.
- The Indications and Limitations of Coverage/Medical Necessity and Documentation Requirements sections have been revised accordingly.

**Effective Date**

This revision is effective for services provided **on or after January 1, 2006**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**A77301: Intensity Modulated Radiation Therapy (IMRT)—Revision to Policy**

The local medical review policy (LMRP) for intensity modulated radiation therapy (IMRT) was previously revised on January 1, 2005. Since that time, the policy was revised to include CPT category III code *0073T – Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session*. In addition, the indications for coverage have been updated and all ICD-9-CM codes were removed from the policy.

In addition, the LMRP has been converted to a local coverage determination (LCD) format.

**Effective Date**

This revision is effective for services provided **on or after January 1, 2006**.

The revised full-text for this LCD is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

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**A82310: Total Calcium—Revision to Policy**

The local medical review policy (LMRP) for total calcium was last updated on October 1, 2004. Since then, the policy has been updated to include updating references under “CMS National Coverage Policy” and “Sources of Information and Basis for Decision” sections. The last paragraph under “Indications and Limitations of Coverage and/or Medical Necessity” section and the “Coding Guidelines” were removed since this information is in the Utilization Guidelines. Under “Type of Bill Code” section, 71x – rural health clinic was removed.

Furthermore, the following additional ICD-9-CM codes were added under the “ICD-9 Codes that Support Medical Necessity” section of the policy:

293.83	Mood disorder in conditions classified elsewhere (depressive type)	592.0	Calculus of kidney
300.00-300.09	Anxiety states	729.82	Other musculoskeletal symptoms referable to limbs, cramp
		780.09	Other alteration of consciousness (stupor)
		788.43	Nocturia
		789.00	Abdominal pain, unspecified site

Additionally, the LMRP has been converted to a local coverage determination (LCD) format.

**Effective Date**

This revision is effective for services provided on or after **September 22, 2005**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**A82330: Ionized Calcium—Revision to Policy**

The local medical review policy (LMRP) for ionized calcium was last updated on October 1, 2004. Since then, the sections of “CMS National Coverage Policy” and “Sources of Information and Basis for Decision” were updated. Under the “Type of Bill Code” section, rural health clinic – 71x was removed and critical access hospital – 85x was added.

Under the “ICD-9 Codes that Support Medical Necessity” section, the following additional ICD-9-CM codes with descriptors were added:

- 293.83 Mood disorder in conditions classified elsewhere (depressive type)
- 298.9 Unspecified psychosis
- 458.9 Hypotension, unspecified

- 780.6 Fever
- 782.4 Jaundice, unspecified, not of newborn
- 785.0 Tachycardia, unspecified
- 786.06 Tachypnea
- 789.06 Abdominal pain, epigastric

In addition, the LMRP has been converted to a local coverage determination (LCD) format.

**Effective Date**

This revision is effective for services provided **on or after September 22, 2005**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**A83970: Parathormone (Parathyroid Hormone)—Revision to Policy**

The local medical review policy (LMRP) for parathormone (parathyroid hormone) was last updated on October 1, 2004. Since then, the sections of “CMS National Coverage Policy” and “Sources of Information and Basis for Decision” were updated. Under the “Type of Bill Code” section, rural health clinic – 71x was removed and critical access hospital – 85x was added.

Under the “ICD-9 Codes that Support Medical Necessity” section, the following additional ICD-9-CM codes with descriptors were added:

- 293.0 Delirium due to conditions classified elsewhere
- 293.83 Mood disorder in conditions classified elsewhere (depressive type)

- 728.85 Spasm of muscle
- 788.42 Polyuria

In addition, the LMRP has been converted to a local coverage determination (LCD) format.

**Effective Date**

This revision is effective for services provided **on or after October 1, 2005**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**A84100: Serum Phosphorus—Revision to Policy**

The local medical review policy (LMRP) for serum phosphorus was last updated on October 1, 2004. Since then, the policy has been updated to include updating references under “CMS National Coverage Policy” and “Sources of Information and Basis for Decision” sections. In addition, the following two ICD-9-CM codes were added under the “ICD-9 Codes that Support Medical Necessity” section of the policy:

- 283.9 Acquired hemolytic anemia, unspecified
- 646.90 Unspecified complication of pregnancy

Additionally, the LMRP has been converted to a local coverage determination (LCD) format.

**Effective Date**

This revision is effective for services provided **on or after October 1, 2005**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**A92506: Speech-Language Pathology Services**

**A97001: Physical Medicine and Rehabilitation**

**A97003: Occupational Therapy Policy for Rehabilitation Services**

**A97110: Complex Decongestive Physiotherapy—Revision to Policies**

The above local medical review policies have been combined into one therapy policy titled Therapy and Rehabilitation Services – ATHERSVCS:

**Effective Date**

This revision is effective for services provided **on or after June 6, 2005**.

The full-text of the new LCD is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖



**A95934: H-Reflex Study—Revision to Policy**

The local medical review policy (LMRP) for H-reflex study was last updated on March 27, 2003. Since then, the following sections have been revised:

- CMS National Coverage Policy
- Coding Guidelines
- Documentation Requirements
- Sources of Information and Basis for Decision

Furthermore, under the “ICD-9 Codes that Support Medical Necessity” section, all diagnosis codes with

descriptors and statement regarding coding guidelines for use with certain ICD-9-CM codes were removed.

In addition, the LMRP has been converted to a local coverage determination (LCD) format.

**Effective Date**

This revision is effective for services provided **on or after September 29, 2005**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**AJ0640: Leucovorin (Wellcovorin®)—Revision to Policy**

The local coverage determination (LCD) for leucovorin (Wellcovorin) was last updated on September 29, 2003. Since then, additional ICD-9-CM diagnosis code range 156.0 – 156.9 (Malignant neoplasm of gallbladder and extrahepatic bile ducts) was added to match the off-labeled indication of “Gallbladder and extrahepatic bile duct carcinoma when used in combination with fluorouracil” under the “Indications and Limitations of Coverage and/or Medical Necessity” section. References under “CMS

National Coverage Policy” and “Sources of Information and Basis for Decision” sections were updated.

**Effective Date**

This revision is effective for claims processed **on or after July 28, 2005**, for services provided **on or after June 30, 2003**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**AJ2430: Pamidronate (Aredia®)—Revision to Policy**

The local coverage determination (LCD) for pamidronate (Aredia®) was last updated on January 1, 2005. Since then, the following sections have been revised:

- CMS National Coverage Policy – References updated
- Sources of Information and Basis for Decision – References updated
- Documentation Requirements – Phraseology added to include “nonphysician practitioner”

- Coverage Topic – Chemotherapy Inpatient and Outpatient was changed to Prescription Drugs

**Effective Date**

This revision is effective for claims processed **on or after November 3, 2005**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**AJ2916: Ferrlecit® and Venofer®—Revision to Policy**

The local coverage determination (LCD) for Ferrlecit was last updated October 1, 2005. Since that time, a revision to this LCD was made after a request was received to include coverage of Venofer for the FDA approved indications. For consistency, Venofer is being added to the Ferrlecit LCD. The section for ICD-9-CM codes that support medical necessity was updated to include the

appropriate ICD-9-CM codes for Venofer. References were added to the policy to support the indications for Venofer.

**Effective Date**

This revision is effective for services provided **on or after January 1, 2006**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**AJ3487: Zoledronic Acid (Zometa®)—Revision to Policy**

The local coverage determination (LCD) for zoledronic acid (Zometa®) was last updated on July 7, 2005. Since that time, the following off-label indication was added to the “Indication and Limitations of Coverage and/or Medical Necessity” section of the LCD:

- Drug-induced osteopenia, secondary to androgen-deprivation therapy in prostate cancer patients (prophylaxis).

In addition, all diagnosis codes were removed under the “ICD-9 Codes that Support Medical Necessity” section.

Revisions were also made to the “Documentation Requirements” to include physician/nonphysician practitioner and the “Sources of Information and Basis for Decision” section was updated.

**Effective Date**

This revision is effective for services provided **on or after September 29, 2005**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**AJ9000: Antineoplastic Drugs—Revision to Policy**

The local coverage determination (LCD) for antineoplastic drugs was last updated on June 16, 2005. A revision to this LCD was made that included updating references under “CMS National Coverage Policy” and “Sources of Information and Basis for Decision” sections. The following revisions were made to the drugs listed below:

**Gemcitabine (J9201)** – Under the “Indications and Limitations of Coverage and/or Medical Necessity” section, added “Intrahepatic bile duct(s) carcinoma” to the off-label indications. Under the “ICD-9 Codes that Support Medical Necessity” section, added ICD-9-CM code 155.1 (Intrahepatic bile ducts).

**Irinotecan (J9206)** – Under the “Indications and Limitations of Coverage and/or Medical Necessity” section, added “Carcinoma of small intestine” to the off-label indications. Under the “ICD-9 Codes that Support Medical Necessity” section, added ICD-9-CM code range 152.0-152.9 (Malignant neoplasm of small intestine, including duodenum).

**Oxaliplatin (J9263/C9205)** – Under the “Indications and Limitations of Coverage and/or Medical Necessity” section, removed off-labeled indication statement “oxaliplatin may be used alone or in combination with other chemotherapeutic drugs.” Added “or small intestine” to off-labeled indication of first line treatment for colon cancer for this drug. In addition, under the “ICD-9 Codes that Support Medical Necessity” section, added ICD-9-CM code range 152.0-152.9 (Malignant neoplasm of small intestine, including duodenum).

**Trastuzumab (J9355)** – Under the “Indications and Limitations of Coverage and/or Medical Necessity” section, added the following off-label indications for non-metastatic breast cancer:

For non-metastatic breast cancer, trastuzumab may be considered medically reasonable and necessary when incorporated into the adjuvant therapy in any of the following situations:

- In patients with breast cancer who over-express HER-2 (IHC 3+ or FISH amplified at the level of 2.1 or

greater) and positive axillary lymph node(s).

- In patients with lymph node negative tumors greater than or equal to 1 cm and smaller than or equal to 2 cm who over-express HER-2 and are estrogen receptor negative.
- In patients with lymph node negative tumors greater than or equal to 2 cm who over-express HER-2 and are estrogen receptor positive.

The timing of therapy, combination with other agents or regimen, dosage, and duration of therapy should be based on NCCN guidelines and the package insert.

Under the “ICD-9 Codes that Support Medical Necessity” section, removed “Note” at the bottom of this section concerning dual diagnoses because dual diagnoses are no longer required for trastuzumab.

In addition to the above revisions, under the “Other Comments” of the Coding Guidelines, the following statement concerning discarded drugs and biologicals from the CMS Manuals, Pub. 100-4, Chapter 17, Section 40 was added:

*CMS encourages physicians to schedule patients in such a way that they can use drugs most efficiently. However, if a physician must discard the remainder of a vial or other package after administering it to a Medicare patient, the program covers the amount of drug discarded alone with the amount administered*

**Note:** *The coverage of discarded drugs applies only to single use vials. Multi-use vials are not subject to payment for discarded amounts of drug.*

**Effective Date**

This revision is effective for services provided on or after **October 20, 2005**.

The revised full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**AOOS: Outpatient Observation Services—Revision to Policy**

The local medical review policy (LMRP) for outpatient observation services – AOOS was last revised January 1, 2005. Since that time, change request 3756, transmittal 508, dated March 18, 2005, deleted diagnostic testing requirements when billing HCPCS code G0244 – Observation care provided by a facility to a patient with CHF, chest pain or asthma, minimum eight hours.

Therefore, this policy has been revised to delete diagnostic testing requirements when billing HCPCS code G0244. Furthermore, CMS manual references were updated, and the addition of coding guidelines is included in this revision.

In addition, the LMRP has been converted to a local coverage determination (LCD) format.

**Effective Date**

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

The full-text for this LCD is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**AQ9941: Intravenous Immune Globulin—Revision to Policy**

The local coverage determination (LCD) for intravenous immune globulin was last updated April 1, 2005. A revision to this LCD was made to the indications and limitation section for **Immunodeficiency Disorders—Primary Humoral Immunodeficiency Syndromes**. A request was received to add an exception to the functional antibody testing requirements, found in this section, for patients whose diagnosis was established prior to this

technology being in place. After review, this exception was added to the LCD.

**Effective Date**

This revision is effective for claims processed **on or after September 1, 2005**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**ATHERSVCS: Therapy and Rehabilitation Services—Revision to Policy**

The local coverage determination (LCD) for therapy and rehabilitation services – ATERSVCs was formerly known as:

- A92506 – Speech-language Pathology Services
- A97001 – Physical Medicine and Rehabilitation
- A97003 – Occupational Therapy Policy for Rehabilitation Services
- A97110 – Complex Decongestive Physiotherapy.

All of the therapy policies have been incorporated into one LCD and renamed, as above.

The guidelines for evaluation, treatment plans, and certification requirements have been updated, per change request 3648. National language has been identified with italics. *CPT* code 97010 (*hot or cold packs*) has been moved to the coding guideline attachment with coverage

guidelines. *CPT* codes 97545-97546 (*work hardening/conditioning*) have been removed from the LCD, as these codes are noncovered. *CPT* codes 97750 (*physical performance test or measurement*) and 97755 (*assistive technology assessment*) have been added to the coding guideline attachment as “codes that always represent therapy codes,” (per change request 3647).

In addition, coding guidelines have been added to the coding guideline attachment for manual muscle testing and range of motion services (*CPT* codes 95831-95834).

**Effective Date**

This revision is effective for services provided **on or after June 6, 2005**.

The revised full-text for this LCD is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

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**RETIREMENT OF EXISTING LMRPs**

**A20974: Osteogenic Stimulation—Retirement of Policy**

The local medical review policy (LMRP) for osteogenic stimulation was last updated on December 20, 2003. Based on data analysis this policy is no longer necessary. Therefore, the LMRP for osteogenic stimulation has been retired. Coverage guidelines for osteogenic stimulation may be obtained from the online CMS manual system, Pub. 100-3, Medicare National Coverage Determination, Section 150.2. The NCD manual may be viewed at

[http://www.cms.hhs.gov/manuals/103\\_cov\\_determ/ncd103index.asp](http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp).

**Effective Date**

The retirement of this policy is effective for services provided **on or after September 9, 2005**.

The full-text for this retired policy is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**A76092: Screening Mammograms—Retirement of Policy**

The local medical review policy (LMRP) for screening mammograms – 76092 was previously revised on April 1, 2005. Since that time, diagnosis code V76.11 (screening mammogram for high-risk patient) has been added to the LMRP, per Change Request 3562, effective July 1, 2005. In addition, based on the online CMS manual system, Pub. 100-3, Medicare National Coverage Determination, Section 220.4, this policy has been retired. The NCD manual may be viewed at [http://www.cms.hhs.gov/manuals/103\\_cov\\_determ/ncd103index.asp](http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp).

**Effective Date**

The retirement of this policy is effective for services provided **on or after July 7, 2005**.

The full-text for this retired policy is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**A82784: Gammaglobulin (Immunoglobulins); IgA, IgD, IgG, IgM, Each—Retirement of Policy**

The local medical review policy (LMRP) for gammaglobulin (immunoglobulins); IgA, IgD, IgG, IgM, each – A82784 was last revised on October 1, 2003. Since that time, based on data analysis and local standards of medical practice, it was determined to retire the current policy.

**Effective Date**

The retirement of this policy is effective for services provided **on or after September 9, 2005**.

The full-text for this retired policy is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**A84152: Complexed and Free Prostate Specific Antigen—Retirement of Policy**

The local medical review policy (LMRP) for complexed and free prostate specific antigen – A84152 was last revised on January 1, 2001. Since that time, based on data analysis and local standards of medical practice, it was determined to retire the current policy. The coverage guidelines for this policy are outlined in the CMS national regulations.

Coverage guidelines for these services may be found at the following online CMS manual system:

- Pub. 100-03, Medicare National Coverage Determinations, Chapter 1, Section 210.1 at

[http://www.cms.hhs.gov/manuals/103\\_cov\\_determ/ncd103c1\\_Part4.pdf](http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103c1_Part4.pdf)

- Pub. 100-04, Medicare Claims Processing Manual, Chapter 18, Section 50 at [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c18.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c18.pdf).

**Effective Date**

The retirement of this policy is effective for services provided **on or after September 9, 2005**.

The full-text for this retired policy is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**A93015: Cardiovascular Stress Test—Retirement of Policy**

The local medical review policy (LMRP) for cardiovascular stress test – A93015 was last revised on January 1, 2002. Since that time, based on data analysis and local standards of medical practice, it was determined to retire the current policy. The coverage guidelines for this policy are outlined in the CMS national regulations.

Coverage guidelines for these services may be found in the online CMS manual system, Pub. 100-03, Medicare National Coverage Determination, Chapter 1, Section 20.10

at [http://www.cms.hhs.gov/manuals/103\\_cov\\_determ/ncd103c1\\_Part1.pdf](http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103c1_Part1.pdf).

**Effective Date**

The retirement of this policy is effective for services provided **on or after September 9, 2005**.

The full-text for this retired policy is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**AJ0150: Adenosine (Adenocard®, Adenoscan®)—Retirement of Policy**

The local medical review policy (LMRP) for adenosine was last updated on January 1, 2005. Since that time, it has been determined that based on data analysis and standards of local practice the LMRP is no longer necessary. Therefore, the LMRP for adenosine has been retired. Coverage guidelines for adenosine may be obtained from the CMS online manual system, Pub. 100-4, Medicare Claims Processing Manual, Chapter 13, Section 50.2.2.

**Effective Date**

The retirement of this policy is effective for services provided **on or after September 9, 2005**.

The full-text for this retired policy is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**Multiple Policies Being Retired**

The following local medical review policies (LMRPs) have been retired. The decision to retire these policies was based on data analysis and standards of local medical practice.

**Policy Number Policy Name**

A86781	Fluorescent Treponemal Antibody Absorption (FTA-abs)
A92240	Indocyanine-Green Angiography
A92499	Computerized Corneal Topography
A92567	Tympanometry
A95004	Allergy Skin Tests

A95115	Allergen Immunotherapy
A95250	Continuous Glucose Monitoring System (CGMS)
A95857	Tensilon Test
A95860	Electromyography
A95930	Visual Evoked Potential (VEP) Testing
AJ0850	Cytomegalovirus Immune globulin (Human), Intravenous (CMV-IVG)
AJ3240	Thyrotropin Alfa (Thyrogen®)

**Effective Date**

The retirement of the above policies is effective for services provided **on or after August 4, 2005**.

*Multiple Policies Being Retired (continued)*

<b>Policy Number</b>	<b>Policy Name</b>
A11600	Excision of Malignant Skin Lesion
A33282	Insertable Loop Recorder (ILR)
A36470	Sclerotherapy of Varicose Veins
A36515	Therapeutic Apheresis using Absorption Columns
A52282	Urethral Stents
A53850	Prostate Treatment
A55700	Biopsy of Prostate Using Image Guidance
A66821	Yag Laser Capsulotomy
A69220	Mastoidectomy Cavity Debridement
A93025	Microvolt T-Wave Alternans
A93268	Patient Demand Single or Multiple Event Recorder
A93724	Electronic Analysis of Pacemaker System and Pacer Cardioverter-Defibrillator

**Effective Date**

The retirement of the above policies is effective for services provided **on or after August 26, 2005**.

<b>Policy Number</b>	<b>Policy Name</b>
A82108	Aluminum

**Effective Date**

The retirement of the above policy is effective for services provided **on or after September 1, 2005**.

<b>Policy Number</b>	<b>Policy Name</b>
A71010	Chest X-Ray

**Effective Date**

The retirement of the above policy is effective for services provided **on or after September 9, 2005**.

<b>Policy Number</b>	<b>Policy Name</b>
AJ9212	Interferon

**Effective Date**

The retirement of the above policy is effective for services provided **on or after September 15, 2005**.

<b>Policy Number</b>	<b>Policy Name</b>
AJ2355	Oprelvekin (Neumega®)

**Effective Date**

The retirement of the above policy is effective for services provided **on or after September 22, 2005**.

<b>Policy Number</b>	<b>Policy Name</b>
A10060	Incision and Drainage of Abscess of Skin, subcutaneous and Accessory Structures
A22520	Percutaneous Vertebroplasty
A64550	Application of Surface (Transcutaneous) Neurostimulator
A76090	Diagnostic Mammography
A78472	Cardiac Blood Pool Imaging
A84066	Phosphatase, Acid; Prostatic
A93886	Transcranial Doppler Studies
A95925	Somatosensory Testing
A96000	Comprehensive Motion Analysis Studies

**Effective Date**

The retirement of the above policies is effective for services provided **on or after October 1, 2005**.

The full-text for these retired policies are available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**ADDITIONAL MEDICAL INFORMATION**

**Local Medical Review Policy to Local Coverage Determination Conversion**

Section 522 of the Benefits Improvement and Protection Act (BIPA), created the term “local coverage determination (LCD).” The Centers for Medicare & Medicaid Services (CMS) published the final rule establishing LCDs on November 11, 2003. Beginning December 7, 2003, local policies were referred to as LCDs, and contractors issued draft and new policies as LCDs. All existing local medical review policies (LMRPs) shall be converted to LCDs no later than December 2005. ❖

**Policies Revised to Identify Diagnosis Codes Considered Secondary (Diagnoses Beginning with “E” and “V”)**

The use of “E” diagnosis codes is supplemental to the application of ICD-9-CM diagnosis codes. “E” diagnosis codes are never to be recorded as principal diagnoses. “E” diagnosis codes provide classification of environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. Where an “E” code from the “Supplementary Classification of External Causes of Injury and Poisoning” section of the International Classification of Diseases is applicable, it is intended that it shall be used in addition to a code from one of the main chapters of ICD-9-CM, indicating the nature of the condition. Certain other conditions, which may be stated as being due to external causes should be used as an additional code for more detailed analysis.

ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The “Supplementary Classification of Factors Influencing Health Status and contact with Health Services” section of the International Classification of Diseases is provided to deal with occasions when circumstances other than a disease or injury are recorded as a diagnosis or problem. Certain “V” diagnosis codes may only be used as secondary codes and are identified as such in the International Classification of Diseases.

Applicable policies have been revised to identify those diagnosis codes that can only be used as secondary diagnosis codes. ❖

**2006 ICD-9-CM Local Coverage Determination Changes**

The 2006 update to the ICD-9-CM diagnosis coding structure is effective October 1, 2005. Providers are required to use the 2006-updated ICD-9-CM coding effective for all hospital discharges and outpatient services occurring **on or after October 1, 2005**.

Due to the direct relationship between coding and reimbursement, it is particularly important that providers reimbursed under the outpatient prospective payment system (OPPS) used the appropriate ICD-9-CM coding. Other providers that code diagnoses and procedures (non-OPPS providers) are also affected. In addition, the new diagnosis coding is used in hospital outpatient billing.

Florida Medicare has revised the local coverage determinations (LCDs), for procedure codes with specific diagnosis criteria that are affected by the 2006 ICD-9-CM update. The following table lists the LCDs affected and the specific conditions revised as a result of the 2006 ICD-9-CM update:

<b>LCD Title</b>	<b>2006 Changes</b>
A70544 – Magnetic Resonance Angiography (MRA)	Change descriptor for 403.00-403.91 (Hypertensive kidney disease) and 404.00-404.93 (Hypertensive heart and kidney disease) for <i>CPT</i> codes 74185, C8900, C8901, and C8902. Add 443.82 (Erythromelalgia) for <i>CPT</i> codes 73725, C8912, C8913, and C8914.
A72192 – Computed Tomography of the Pelvis	Add 567.21 (Peritonitis (acute) generalized), 567.22 (Peritoneal abscess), 567.23 (Spontaneous bacterial peritonitis), 567.29 (Other suppurative peritonitis), 567.31 (Psoas muscle abscess), 567.38 (Other retroperitoneal abscess), 567.39 (Other retroperitoneal infections), 599.60 (Urinary obstruction, unspecified), and 599.69 (Urinary obstruction, not elsewhere classified) for <i>CPT</i> codes 72192, 72193, and 72194.
A73218 – Magnetic Resonance Imaging of Upper Extremity	Add 996.40 (Unspecified mechanical complication of internal orthopedic device, implant, and graft), 996.41 (Mechanical loosening of prosthetic joint), 996.42 (Dislocation of prosthetic joint) 996.43 (Prosthetic joint implant failure), 996.44 (Peri-prosthetic fracture around prosthetic joint), 996.45 (Peri-prosthetic osteolysis), 996.46 (Articular bearing surface wear of prosthetic joint), 996.47 (Other mechanical complication of prosthetic joint implant), and 996.49 (Other mechanical complication of other internal orthopedic device, implant, and graft) for <i>CPT</i> codes 73218, 73219, 73220, 73221, 73222, and 73223.
A74150 – Computed Tomography of the Abdomen	Change descriptor for 567.0-567.9 (Peritonitis and retroperitoneal infections) for <i>CPT</i> codes 74150, 74160, and 74170. Add 599.60 (Urinary obstruction, unspecified) and 599.69 (Urinary obstruction, not elsewhere classified) for <i>CPT</i> codes 74150, 74160, and 74170.
A82310 – Total Calcium	Change descriptor for 728.87 (Muscle weakness [generalized]) for <i>CPT</i> code 82310. Add 585.1-585.9 (Chronic kidney disease) for <i>CPT</i> code 82310. Add “Note” indicating that renal dialysis facilities (72x) should report a diagnosis code of 585.6 for submission of claims.
A82330 – Ionized Calcium	Add 585.1-585.9 (Chronic kidney disease) for <i>CPT</i> code 82330. Add “Note” indicating that renal dialysis facilities (72x) should report a diagnosis code of 585.6 for submission of claims.
A83735 – Magnesium	Change descriptor for 728.87 (Muscle weakness [generalized]) for <i>CPT</i> code 83735. Add 276.50-276.52 (Volume depletion), 585.1-585.9 (Chronic kidney disease), and V58.11 (Encounter for antineoplastic chemotherapy) for <i>CPT</i> code 83735. Add “Note” indicating that renal dialysis facilities (72x) should report a diagnosis code of 585.6 for submission of claims.
A83880 – B-Type Natriuretic Peptide (BNP)	Change descriptor for 404.01 (Hypertensive heart and kidney disease, malignant, with heart failure), 404.03 (Hypertensive heart and kidney disease, malignant, with heart failure and chronic kidney disease), 404.11 (Hypertensive heart and kidney disease, benign, with heart failure), 404.13 (Hypertensive heart and kidney disease, benign, with heart failure and chronic kidney disease), 404.91 (Hypertensive heart and kidney disease, unspecified, with heart failure), and 404.93 (Hypertensive heart and kidney disease, unspecified, with heart failure and chronic kidney disease) for <i>CPT</i> code 83880.
A83970 – Parathormone (Parathyroid Hormone)	Add 585.1-585.9 (Chronic kidney disease) for <i>CPT</i> code 83970. Add “Note” indicating that renal dialysis facilities (72x) should report a diagnosis code of 585.6 for submission of claims.

*2006 ICD-9-CM Local Coverage Determination Changes (continued)*

LCD Title	2006 Changes
A84100 – Serum Phosphorus	<p>Change descriptor for 403.01 (Malignant hypertensive kidney disease with chronic kidney disease), 403.11 (Benign hypertensive kidney disease with chronic kidney disease), 404.02 (Malignant hypertensive heart and kidney disease, with chronic kidney disease), 404.03 (Malignant hypertensive heart and kidney disease, with heart failure and chronic kidney disease), 404.12 (Benign hypertensive heart and kidney disease, with chronic kidney disease), 404.13 (Benign hypertensive heart and kidney disease, with heart failure and chronic kidney disease), and 728.87 (Muscle weakness [generalized]) for <i>CPT</i> code 84100.</p> <p>Add 585.1-585.9 (Chronic kidney disease) for <i>CPT</i> code 84100.</p> <p>Add “Note” indicating that renal dialysis facilities (72x) should report a diagnosis code of 585.6 for submission of claims.</p>
A86706 – Hepatitis B Surface Antibody and Surface Antigen	<p>Change descriptor for 403.01 (Malignant hypertensive kidney disease with chronic kidney disease), 403.11 (Benign hypertensive kidney disease with chronic kidney disease), 404.02 (Malignant hypertensive heart and kidney disease, with chronic kidney disease), 404.03 (Malignant hypertensive heart and kidney disease, with heart failure and chronic kidney disease), 404.12 (Benign hypertensive heart and kidney disease, with chronic kidney disease), 404.13 (Benign hypertensive heart and kidney disease, with heart failure and chronic kidney disease) for <i>CPT</i> codes 86706 and 87340.</p> <p>Add 585.4 (Chronic kidney disease, Stage IV [severe]), 585.5 (Chronic kidney disease, Stage V), and 585.6 (End stage renal disease) for <i>CPT</i> codes 86706 and 87340.</p> <p>Add “Note” indicating that renal dialysis facilities (72x) should report a diagnosis code of 585.6 for submission of claims.</p>
A90901 – Biofeedback	<p>Change descriptor for 728.87 (Muscle weakness [generalized]) for <i>CPT</i> code 90901.</p>
A92081 – Visual Field Examination	<p>Diagnosis 362.07 (Diabetic macular edema) requires a dual diagnosis. It must be billed with a diagnosis code for diabetic retinopathy (362.01, 362.02, 362.03, 362.04, 362.05, or 362.06) for <i>CPT</i> codes 92081, 92082, and 92083.</p>
A92135 – Scanning Computerized Ophthalmic Diagnostic Imaging	<p>Add 362.03 (Nonproliferative diabetic retinopathy NOS), 362.04 (Mild nonproliferative diabetic retinopathy), 362.05 (Moderate nonproliferative diabetic retinopathy), 362.06 (Severe nonproliferative diabetic retinopathy), and 362.07 (Diabetic macular edema) for <i>CPT</i> code 92135.</p> <p>Diagnosis 362.07 (Diabetic macular edema) requires a dual diagnosis. It must be billed with a diagnosis code for diabetic retinopathy (362.01, 362.02, 362.03, 362.04, 362.05, or 362.06) for <i>CPT</i> code 92135.</p>
A92225 – Ophthalmoscopy	<p>Add 362.07 (Diabetic macular edema) for <i>CPT</i> codes 92225 and 92226.</p> <p>Diagnosis 362.07 (Diabetic macular edema) requires a dual diagnosis. It must be billed with a diagnosis code for diabetic retinopathy (362.01 or 362.02) for <i>CPT</i> codes 92225 and 92226.</p>
A92235 – Fluorescein Angiography	<p>Add 362.03 (Nonproliferative diabetic retinopathy NOS), 362.04 (Mild nonproliferative diabetic retinopathy), 362.05 (Moderate nonproliferative diabetic retinopathy), 362.06 (Severe nonproliferative diabetic retinopathy), and 362.07 (Diabetic macular edema) for <i>CPT</i> code 92235.</p> <p>Diagnosis 362.07 (Diabetic macular edema) requires a dual diagnosis. It must be billed with a diagnosis code for diabetic retinopathy (362.01, 362.02, 362.03, 362.04, 362.05, or 362.06) for <i>CPT</i> code 92235.</p>
A93000 – Electrocardiography	<p>Add 799.01-799.02 (Asphyxia and hypoxemia) for <i>CPT</i> codes 93000, 93005, and 93010.</p>
A93224 – Electrocardiographic Monitoring for 24 hours (Holter Monitoring)	<p>Add 426.82 (Long QT syndrome) for <i>CPT</i> codes 93224, 93225, 93226, 93227, 93230, 93231, 93232, 93233, 93235, 93236, and 93237.</p>

## LOCAL COVERAGE DETERMINATIONS

### 2006 ICD-9-CM Local Coverage Determination Changes (continued)

LCD Title	2006 Changes
A93303 – Transthoracic Echocardiography (TTE)	Change descriptor for 404.00-404.93 (Hypertensive heart and kidney disease), 780.51 (Insomnia with sleep apnea, unspecified), and 780.53 (Hypersomnia with sleep apnea, unspecified) for CPT codes 93307 and 93308. Add 276.50 (Volume depletion, unspecified), 276.51 (Dehydration), 276.52 (Hypovolemia), and 426.82 (Long QT syndrome) for CPT codes 93307 and 93308.
A93312 – Transesophageal Echocardiogram	Change descriptor for 278.00-278.01 (Overweight and obesity) for CPT codes 93312, 93313, 93314, 93315, 93316, 93317, and 93318. Add 278.02 (Overweight) for CPT codes 93312, 93313, 93314, 93315, 93316, 93317, and 93318.
A93701 – Cardiac Output Monitoring by Thoracic Electrical Bioimpedance	Change descriptor for 403.00-403.01 (Malignant hypertensive kidney disease), 403.11 (Benign hypertensive kidney disease with chronic kidney disease), 403.91 (Unspecified hypertensive kidney disease with chronic kidney disease), 404.00-404.03 (Malignant hypertensive heart and kidney disease), 404.11 (Benign hypertensive heart and kidney disease with heart failure), 404.12 (Benign hypertensive heart and kidney disease, with chronic kidney disease), 404.13 (Benign hypertensive heart and kidney disease, with heart failure and chronic kidney disease), 404.91 (Unspecified hypertensive heart and kidney disease with heart failure), 404.92 (Unspecified hypertensive heart and kidney disease, with chronic kidney disease), and 404.93 (Unspecified hypertensive heart and kidney disease, with heart failure and chronic kidney disease) for CPT code 93701.
AEPO – Epoetin alfa	Change descriptor for 403.01 (Malignant hypertensive kidney disease with chronic kidney disease), 403.11 (Benign hypertensive kidney disease with chronic kidney disease), 403.91 (Unspecified hypertensive kidney disease with chronic kidney disease), 404.02 (Malignant hypertensive heart and kidney disease with chronic kidney disease), 404.03 (Malignant hypertensive heart and kidney disease with heart failure and chronic kidney disease), 404.12 (Benign hypertensive heart and kidney disease, with chronic kidney disease), 404.13 (Benign hypertensive heart and kidney disease, with heart failure and chronic kidney disease), 404.92 (Unspecified hypertensive heart and kidney disease, with chronic kidney disease), and 404.93 (Unspecified hypertensive heart and kidney disease, with heart failure and chronic kidney disease) for HCPCS codes Q0136. Add 585.1 (Chronic kidney disease, Stage I), 585.2 (Chronic kidney disease, Stage II [mild]), 585.3 (Chronic kidney disease, Stage III [moderate]) and 585.9 (Chronic kidney disease, unspecified), and V58.11 (Encounter for antineoplastic chemotherapy) for HCPCS code Q0136. Add 585.4 (Chronic kidney disease, Stage IV [severe]), 585.5 (Chronic kidney disease, Stage V), and 585.6 (End stage renal disease) for HCPCS code Q4055. Add “Note” indicating that renal dialysis facilities (72x) and hospitals (13x and 85x) should report a diagnosis code of 585.6 for submission of claims for HCPCS code Q4055.
AJ1440 – G-CSF (Filgrastim, Neupogen®)	Add V58.11 (Encounter for antineoplastic chemotherapy) for HCPCS codes J1440 and J1441.
AJ1955 – Levocarnitine (Carnitor®, L-carnitine®)	Add 585.4 (Chronic kidney disease, Stage IV [severe]), 585.5 (Chronic kidney disease, Stage V), and 585.6 (End stage renal disease) for HCPCS code J1955. Add “Note” indicating that renal dialysis facilities (72x) should report a diagnosis code of 585.6 for submission of claims.
AJ2505 – Pegfilgrastim (Neulasta™)	Add V58.11 (Encounter for antineoplastic chemotherapy) for HCPCS code J2505.
AJ2792 – Rho (D) Immune Globulin Intravenous	Add 287.30-287.39 (Primary thrombocytopenia) for HCPCS codes J2788, J2790, and J2792.
AJ2916 – Ferrlecit®	Add 585.4 (Chronic kidney disease, Stage IV [severe]), 585.5 (Chronic kidney disease, Stage V), and 585.6 (End stage renal disease) for HCPCS code J2916. Add “Note” indicating that renal dialysis facilities (72x) should report a diagnosis code of 585.6 for submission of claims.



*2006 ICD-9-CM Local Coverage Determination Changes (continued)*

<b>LCD Title</b>	<b>2006 Changes</b>
AJ9000 – Antineoplastic Drugs	Add 287.31 (Immune thrombocytopenic purpura) and 287.32 (Evans’ syndrome) for HCPCS code J9310.
ANESP – Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])	Add 585.1 (Chronic kidney disease, Stage I), 585.2 (Chronic kidney disease, Stage II [mild]), 585.3 (Chronic kidney disease, Stage III [moderate]), 585.4 (Chronic kidney disease, Stage IV [severe]), 585.9 (Chronic kidney disease, unspecified), and V58.11 (Encounter for anti-neoplastic chemotherapy) for HCPCS code Q0137. Add 585.4 (Chronic kidney disease, Stage IV [severe]), 585.5 (Chronic kidney disease, Stage V), and 585.6 (End stage renal disease) for HCPCS code Q4054. Add “Note” indicating that renal dialysis facilities (72x) and hospitals (13x and 85x) should report a diagnosis code of 585.6 for submission of claims for HCPCS code Q4054.
AOOS – Outpatient Observation Services	Change descriptor for 404.01 (Malignant hypertensive heart and kidney disease, with heart failure), 404.03 (Malignant hypertensive heart and kidney disease, with heart failure and chronic kidney disease), 404.11 (Benign hypertensive heart and kidney disease with heart failure), 404.13 (Benign hypertensive heart and kidney disease, with heart failure and chronic kidney disease), 404.91 (Unspecified hypertensive heart and kidney disease with heart failure), and 404.93 (Unspecified hypertensive heart and kidney disease, with heart failure and chronic kidney disease) for HCPCS code G0244.
APULMDIAGSVCS – Pulmonary Diagnostic Services	Change descriptor for 780.51 (Insomnia with sleep apnea, unspecified), 780.53 (Hypersomnia with sleep apnea, unspecified), and 780.57 (Unspecified sleep apnea) for CPT codes 93720, 93721, 93722, 94010, 94060, 94070, 94150, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94620, 94621, 94720, 94725, and 94750.
AQ9941 – Intravenous Immune Globulin	Add 287.31 (Immune thrombocytopenic purpura) and 287.32 (Evans’ syndrome) for HCPCS codes Q9941, Q9942, Q9943, and Q9944.

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**ASKINSUB: Skin Substitutes—Coding Guidelines**

The coding guideline for skin substitutes – ASKINSUB was previously revised on January 1, 2005. Since that time, the coding guidelines have been updated to include clarification regarding the use of modifier 58 when used for the application of a skin substitute per FDA approved indications. In addition, clarified information on the use of CPT codes 15000 and 15001 with CPT codes 15342 and 15343. Initial preparation of the wound for skin grafting (CPT codes 15100-15400), may be billed on the initial day of service. Documentation must support both procedures were performed.

**Effective Date**

This revision is effective for services provided **on or after August 25, 2005**.

The full-text for this coding guideline may be viewed on the provider education website

<http://www.floridamedicare.com> on or after this effective date. ❖

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**Stereotactic Radiosurgery and Stereotactic Radiotherapy—Coding Guide**

Stereotactic radiosurgery is a form of external beam radiation that delivers a high-dose during a single session to shrink or destroy lesions while leaving tissue surrounding the lesion unaffected. Initially restricted to intracranial lesions, advances in technology have extended interventions to other parts of the body for lesions inaccessible or unsuitable for open surgery. The stereotactic techniques have incorporated single session high-dose, hyper fractionation (currently defined as 2-5 high-dose sessions), and conventional fractionation collectively referred to as stereotactic radiotherapy (SRT). Stereotactic radiotherapy relies on reproducible spatial correlation of the target of interest and the radiation source using computer generated three dimensional simulations. This can be accomplished with several methodologies including specially designed

external frames, implanted fiducial markers or imaging techniques.

Currently FCSO does not have a local medical policy addressing stereotactic radiotherapy. Specifically, body radiation therapy (therapy outside the CNS) is considered an emerging technology as indicated by the assignment of a category III code in 2005. Review of current literature and discussion with radiation oncologists suggest that there is no consensus on the optimal technology (planning and Rx delivery) for given indications.

Currently there are satisfactory coding and billing guidelines for hospitals to submit claims to the fiscal intermediary (FI) for stereotactic radiotherapy treatment planning and delivery. Free standing facilities that bill the carrier should use this article as a guide to coding and billing

*Stereotactic Radiosurgery and Stereotactic Radiotherapy—Coding Guide (continued)*

the carrier when applicable given there are no active HCPCS codes with pricing in the Medicare fee schedule for claims administration of stereotactic radiotherapy treatment planning and delivery. Claims to the carrier will continue to be developed for documentation and evaluated for coverage and payment on individual consideration. The documentation must show what was done. Also it must support that the intervention was medical necessary and reasonable for the condition as well as superior to conventional radiation therapy or IMRT given the risk and benefit to the beneficiary.

This coding article addresses:

- Physician *treatment management* services: Stereotactic radiation therapy and radiosurgery is an emerging technology and involves a process of care directed by radiation oncologist, in some cases neurosurgeons, and other allied health care professionals.
- Stereotactic radiation therapy and radiosurgery *treatment planning* and *delivery* given with either Co 60 gamma rays or with mega voltage photons from a linear accelerator for claims submitted to the carrier from a free standing facility. The goal of these treatments is great accuracy and precision in the delivery of dose to the planned target.

The conduct of a course of radiation therapy includes an episode of care with steps of consultation, clinical treatment planning, establishment of treatment parameters, and treatment delivery & management. All of the coding encompassed in an episode of care is not addressed in this article. However, it is expected that professional and technical components billed to Medicare on behalf of a beneficiary are medically necessary and reasonable with no duplication of services within the episode of care unless the medical necessity of the repeated or duplicated services is clearly documented. If multiple providers are involved in the patient's episode of care, clinical treatment planning, establishment of treatment parameters, and treatment delivery & management should be appropriately coordinated.

**Coding of CPT/HCPCS Codes**

***SRT Treatment Management:***

*61793 Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions.*

- Reported for work attributed to neurosurgeon or surgeon
- Same physician cannot report 77427-77432

*77432 Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session):*

- Generally reflects the work by the radiation oncologist

*0083T Stereotactic body radiation therapy, treatment management, per day*

- SRT per day management of non-cerebral lesions
- Do not report 0083T in conjunction with 77427-77432, 61793

**Free Standing Facilities billing technical work to the Carrier**

***SRT Treatment Planning:***

*77295-TC Therapeutic radiology simulation-aided field setting; three-dimensional, per course of treatment*

Or one of the following, as appropriate:

***LINAC based***

**G0338** Linear accelerator based stereotactic radiosurgery plan, including dose volume histograms for target critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment

***Cobalt 60-based***

**G0242** Multi-source photon stereotactic radiosurgery (cobalt-60 multi-source converging beams) plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment

***SRT Treatment Delivery:***

*0082T Stereotactic body radiation therapy, treatment delivery, one or more treatment areas, per day*

Use G codes as outlined below, if appropriate, unless more than five sessions, then use 0082T (per day) as noted.

The work should reflect the following descriptors currently used in the hospital setting:

***LINAC based***

• ***Image-guided robotic LINAC treatment***

**G0339** Image guided robotic linear accelerator base stereotactic radiosurgery, complete course of therapy in one session, or first session of fractionated treatment

**G0340** Image guided robotic linear accelerator base stereotactic radiosurgery, delivery including collimator changes in custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment

• ***Non-robotic LINAC treatment***

**G0173** Stereotactic radiosurgery, complete course of therapy in one session

**G0251** Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum five sessions per course of treatment

• ***Cobalt 60-based***

**G0243** Multi-source photon stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, all lesions ❖

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## Review of ICD-9-CM Coding for HIV Testing: Diagnostic Codes and Prognosis/Monitoring Codes

A recent claim review of CPT 87536 – HIV quantification denials demonstrated that many of the denials were diagnosis/medical necessity related. It was observed that many of the ICD-9-CM codes listed for CPT 87536 – HIV prognosis and monitoring actually supported medical necessity for HIV testing.

### HIV Prognosis and Monitoring Codes (Quantification)

Quantification assays of HIV plasma RNA are used prognostically to assess relative risk for disease progression and predict time to death, as well as to assess efficacy of antiretroviral therapies over time. Studies indicate that HIV RNA levels can predict disease progression, assist in making decisions when to stop using an ineffective treatment and when to add or switch to a new treatment and allow patients/physicians to make treatment decision much earlier, prior to a significant loss of CD4 cells and before clinical decline occurs. CD4 cell loss is thought to be a relatively late result of increased HIV replication.

HIV quantification is achieved through the use of assays that measure the amount of circulating RNA. The tests employ nucleic acid amplification techniques to enhance sensitivity and the results are expressed as the HIV copy number.

### Codes for HIV Quantification Tests

Code	Descriptor
87536	<i>Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification</i>
87539	<i>Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, quantification</i>

### HIV Diagnostic Codes

Diagnosis of human immunodeficiency virus (HIV) infection is primarily made through the use of serologic assays. These assays take one of two forms: antibody detection assays and specific HIV antigen procedures. Currently, there are a total of ten HIV diagnostic codes covered by the Medicare program for these tests. Please refer to the online CMS manual system, Pub. 100-3,

Medicare National Coverage Determination, Section 190.14, Human Immunodeficiency Virus (HIV) Testing (Diagnosis). The NCD manual may be viewed at [http://www.cms.hhs.gov/manuals/103\\_cov\\_determ/ncd103index.asp](http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp).

### Codes for HIV Diagnostic Tests

Code	Descriptor
86689	<i>Qualitative or semiquantitative immunoassays performed by multiple step methods; HTLV or HIV antibody, confirmatory test (eg. Western Blot)</i>
86701	<i>Qualitative or semiquantitative immunoassays performed by multiple step methods; HIV-1</i>
86702	<i>Qualitative or semiquantitative immunoassays performed by multiple step methods; HIV-2</i>
86703	<i>Qualitative or semiquantitative immunoassays performed by multiple step methods; HIV-1 and HIV-2, single assay</i>
87390	<i>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; HIV-1</i>
87391	<i>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; HIV-2</i>
87534	<i>Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique</i>
87535	<i>Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, amplified probe technique</i>
87537	<i>Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, direct probe technique</i>
87538	<i>Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, amplified probe technique</i>

The CMS Medicare National Coverage Database website has both laboratory national coverage decisions in their entirety with test specific information and a complete list of covered ICD-9-CM codes (updated quarterly). For human immunodeficiency virus testing (diagnosis) see section 190.14 and for human immunodeficiency virus testing (prognosis including monitoring) see section 190.13. Please refer to these documents for more detailed information. ❖

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## AJ2324: Draft LCD for Nesiritide (Natrecor®) Infusion for Chronic Congestive Heart Failure—New Draft Policy

A local coverage determination (LCD) draft for nesiritide (Natrecor) infusion for chronic congestive heart failure was developed for Florida Part A Medicare. This LCD outlined entrance criteria for intravenous infusion of nesiritide for the treatment of patients diagnosed with acutely decompensated congestive heart failure in the outpatient setting.

Due to controversy about the safety of giving nesiritide in this setting, and the fact that a request for a national coverage determination has been submitted to the Centers for Medicare & Medicaid Services (CMS) and is under consideration, FCSO has elected not to finalize this policy.

In addition, information was published from a panel of cardiology experts with recommendations to the manufacturer of this drug that its use should be strictly limited to patients presenting to the hospital with acutely decompensated congestive heart failure. ❖

# HOSPITAL SERVICES

## Inpatient Prospective Payment System Outlier Reconciliation

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

### Provider Types Affected

Hospitals billing services paid under the IPPS to Medicare fiscal intermediaries (FIs)

### Provider Action Needed

This article is informational in nature and condenses information contained in change request (CR) 3966 that instructs your FI:

- How to calculate cost-to-charge ratios (CCRs), and when to use alternative data for CCRs.
- Which CCR to apply in instances of hospital mergers, and what to do when errors occur with CCRs and outlier payments.
- How to implement IPPS reconciliation policies, and how to apply the time value of money to reconciliation.

### Background

The Social Security Act provides basic Medicare prospective payments to Medicare-participating hospitals and additional payments for cases incurring extraordinarily high costs (Section 1886(d)(5)(A)). These additional payments are known as “outlier payments,” and they are designed to protect the hospital from large financial losses due to unusually expensive cases. The regulations governing payments for operating costs under the IPPS are located in 42 CFR Part 412, and the specific regulations governing outlier payment cases are located at 42 CFR 412.80 through 412.86.

**Note:** You can review all 42 CFR 412 (Title 42 (Public Health), Chapter IV (CMS & HHS), Part 412 (IPPS)) regulations at the following Government Printing Office (GPO) website: [http://www.access.gpo.gov/nara/cfr/waisidx\\_04/42cfr412\\_04.html](http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr412_04.html).

To qualify for an outlier payment, a case must have costs above a fixed-loss cost threshold amount, which is:

- The dollar amount by which the costs of a case must exceed payments in order to qualify for outliers; and
- Published in the annual inpatient prospective payment system (IPPS) final rule which can be found on the CMS website at <http://www.cms.hhs.gov/providers/hipps/frnotices.asp>.

The actual determination of whether a case qualifies for outlier payments is made by the FI using a software program called PRICER, which takes into account both operating and capital costs and diagnosis related group (DRG) payments. That is, the combined operating and capital costs of a case must exceed the fixed loss outlier threshold to qualify for an outlier payment.

Outliers are not applicable to non-PPS hospitals. The PRICER program makes all outlier determinations except for the medical review determination.

Included in this manual update is the complete formula for calculating an inpatient hospital’s CCR.

Effective November 7, 2005, for hospitals that merge, the Medicare FI will continue to use the operating and capital CCR from the hospital with the “surviving” provider number. But, effective November 7, 2005, if hospitals merge and a new provider number is issued, FIs will use the statewide average CCR because a new provider number indicates the creation of a new hospital.

A hospital may request that its FI use a different (higher or lower) CCR based on substantial evidence presented by the hospital.

For discharges occurring on or after August 8, 2003, high cost outlier payments may be reconciled upon cost report settlement to account for differences between the cost-to-charge ratios (CCR) used to pay the claim at its original submission by the provider, and the CCR determined at final settlement of the cost reporting period during which the discharge occurred (42 CFR Section 412.84(i)(4)).

Under 42 CFR 412.84 (i)(4) and 412.84 (h)(3), effective for discharges occurring on or after August 8, 2003, outlier payments may be adjusted at the time of reconciliation to account for the time value of any underpayments or overpayments. Any adjustment will be:

- Based on a widely available index which is the monthly rate of return that the Medicare trust fund earns; and
- Applied from the midpoint of the cost reporting period to the date of reconciliation.

A complete explanation of outlier reconciliation and the time value of money can be found by viewing CR 3966 in its entirety. Particular attention should be given to the new sections of the *Medicare Claims Processing Manual*, which are included with CR 3966.

### Implementation

The implementation date for the related instruction is November 7, 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 the CMS website at [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3966 in the CR NUM column on the right, and click on the file for that CR. That CR provides details on how intermediaries calculate a hospital’s operating and capital CCRs. For a more detailed explanation on the calculations (including examples) of outlier payments, go to the CMS website at <http://www.cms.hhs.gov/providers/hipps/ippsoftr.asp>.

Also, the annual IPPS Proposed and final rule, which

**Inpatient Prospective Payment System Outlier Reconciliation (continued)**

includes statewide average CCRs in Tables 8A and 8B) may be reviewed at and downloaded from the CMS website <http://www.cms.hhs.gov/providers/hipps/frnotices.asp>.

For a detailed list of cost-to-charge ratios by provider and by federal fiscal year please download the impact files from the CMS public use file website at <http://www.cms.hhs.gov/providers/hipps/ippspufs.asp>.

If you have any questions, please contact your intermediary at their toll-free number, which may be found on the CMS website at

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

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

Medlearn Matters Number: MM3966  
Related Change Request (CR) Number: 3966  
Related CR Release Date: October 12, 2005  
Related CR Transmittal Number: 707  
Effective Date: November 7, 2005  
Implementation Date: November 7, 2005

Source: CMS Pub. 100-4, Transmittal 707, CR 3966

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## Hospital Audit Workload Updates Related to Medicare Secondary Payer

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

### Provider Types Affected

Hospitals billing fiscal intermediaries (FIs)

### Provider Action Needed

#### STOP – Impact to You

This article is based on Change Request (CR) 4056, which updates the hospital audit sections in Chapter 5 of the *Medicare Secondary Payer Manual* (Pub. 100-05).

#### CAUTION – What You Need to Know

CR 4056 clarifies the workload expectations for FIs having multiple states for which they have claims processing responsibility. *CMS wants to ensure that a facility is not audited multiple times by multiple contractors because of the contractor presence in the state.*

#### GO – What You Need to Do

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

### Background

The Centers for Medicare & Medicaid Services (CMS) issued CR 4056 to provide the following updates to the hospital audit sections of the *Medicare Secondary Payer Manual*, Chapter 5 (Contractor Prepayment Processing Requirements), Section 70 (Hospital Review Protocol for Medicare Secondary Payer):

- It clarifies the workload expectations for a Medicare contractor having multiple states for which they have claims processing responsibility.
- It replaces references to "fiscal intermediary" with "contractor" in preparation for the implementation of Medicare Contracting Reform provision of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

CR 4056 instructs Medicare contractors to:

- Conduct reviews on 10 percent of the hospitals (or a maximum of 20, whichever is the lesser of the two) in each state for which they have Medicare claims processing responsibility.

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- Select samples of claims from two months of the hospital's processed claims history.
- Provide a listing of claims selected for review within 15 days of the date of initial notice of the review.

**Note:** Multiple contractors having a presence in one state are instructed to communicate with each other to ensure that duplicate reviews do not occur and multiple contractors do not review more hospital providers (as a combined total) than would have been reviewed if only one contractor processed claims for all hospital providers in that state.

### Implementation

The implementation date for the instruction is January 14, 2006.

### Additional Information

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

From that Web page, look for CR 4056 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 4056  
Related CR Release Date: October 14, 2005  
Related CR Transmittal Number: 38  
Effective Date: January 14, 2006  
Implementation Date: January 14, 2006

Source: CMS Pub. 100-5, Transmittal 38, CR 4056

## Calculation of the Interim Payment of Indirect Medical Education Full-Time Equivalent Resident Caps

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

### Provider Types Affected

Inpatient PPS teaching hospitals that receive an increase to their indirect medical education (IME) full-time equivalent (FTE) resident caps under Section 422 of the Medicare Modernization Act (MMA), P.L. 108-173

### Provider Action Needed

MM4025 is based on related CR 4025, which provides the methodology for calculating a hospital’s interim payment of indirect medical education through the inpatient prospective payment system (PPS) PRICER for hospitals that received an increase to their full-time equivalent resident caps under Section 422 of the MMA.

Inpatient PPS hospitals operating graduate medical education (GME) programs may want to review CR 4025 in order to understand the methodology for calculating a hospital’s interim IME payments to ensure that the appropriate payments for residents are being made.

### Background

Social Security Act Sections 1886(d)(5)(B)(v) – Indirect Medical Education (IME), and Section 1886(h)(4)(F) – Direct Graduate Medical Education (GME), established caps on the number of allopathic and osteopathic residents that a hospital (operating an approved GME program) may count when requesting payment for indirect and direct medical education costs.

While Medicare only makes direct GME and IME payments for the number of FTE residents up to a hospital’s FTE cap, some hospitals have trained allopathic and osteopathic residents in excess of their FTE caps. However, there are a number of hospitals that have reduced their resident positions to a level below their caps.

### Redistribution of Unused Residency Positions

Section 422 (Redistribution of Unused Residency Positions) of the MMA, Public Law 108-173, addressed the above issue by adding Section 1886 (h)(7) to the Social Security Act. This provision allows the FTE caps to be reduced for certain hospitals, and the positions that are generated from this reduction to be redistributed to other hospitals that demonstrate they can use the additional positions, effective on or after July 1, 2005.

The formula multiplier for calculating the IME adjustment factor, for additional residents reported by the hospital as a result of increase in the FTE resident cap under Section 422, is 0.66 for patient discharges occurring **on or after July 1, 2005**.

### Indirect Medical Education Payments

The August 11, 2004, *Final Rule* (69 FR 49088) provided that a hospital that counts additional residents as a result of an increase in its FTE resident cap under Section 422 would receive IME payments based on the **sum of two** different IME adjustment factors:

1. An IME adjustment factor that is calculated using the “annual” schedule of formula multipliers (established by section 502(a) of Pub. L. 108-173), and the hospital’s number of FTE residents, not including residents attributable to an FTE cap increase under Section 422, in the numerator of the intern and resident-to-bed (IRB) ratio.
2. An IME adjustment factor that is calculated using the formula multiplier 0.66, and the additional number of FTE residents that are attributable to the increase in the hospital’s FTE resident cap under Section 422 in the numerator of the IRB ratio.

The number of available beds used in the denominator would be the same for both IME adjustments.

### Additional Information

CR 4025 provides detailed instructions for calculating the interim payment of IME through the inpatient PPS PRICER for hospitals that received an increase to their FTE resident caps under Section 422 of the MMA.

Hospitals eligible for these payments may want to review those detailed instructions and the examples presented with the instructions. CR 4025 may be viewed by going to CMS website at [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 4025 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 contractor at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 4025  
 Related CR Release Date: September 16, 2005  
 Related CR Transmittal Number: 179  
 Effective Date: July 1, 2005

Implementation Date: No later than the next IPPS interim rate review after the CR is issued or no later than December 1, 2005

Source: CMS Pub. 100-20, Transmittal 179, CR 4025

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## Override of Medicare System Edit for Observation Services Exceeding 48 Hours—CR 3311 Rescinded

As of October 7, 2005, the Centers for Medicare & Medicaid Services (CMS) has rescinded instructions related to the override edit implemented in the common working file system for observation services exceeding 48 hours. These instructions were previously issued under the online CMS manual system Pub-100-20 (One Time Notification), transmittal 120, change request 3311, and published in the Second Quarter 2005 *Medicare A Bulletin* (page 35).

CMS will not be replacing these instructions at this time.

### Action Affecting Providers

Claims submitted for observation services provided on or after April 1, 2005, exceeding 48 hours, will be returned to the provider for correction. ❖

Source: CMS Pub. 100-20, Transmittal 120, CR 3311, October 7, 2005

## Enforcement of Hospital Inpatient Bundling: Carrier Denial of Ambulance Claims During an Inpatient Stay

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

### Provider Types Affected

Independent ambulance services suppliers billing Medicare carriers

### Provider Action Needed

#### STOP – Impact to You

Independent ambulance services suppliers cannot bill Medicare carriers for ambulance services that they provide to an inpatient of an acute care hospital, long-term care hospital, inpatient rehabilitation facility, or inpatient psychiatric facility (on or after December 31, 2004), unless the services are provided either:

- On the dates of hospital admission and/or discharge, or
- Within an occurrence span code 74 from and through dates plus one day.

If services other than these two scenarios are billed separately as Part B, the bills will be rejected.

#### CAUTION – What You Need to Know

If an ambulance supplier bills Medicare and is paid prior to Medicare’s receipt of the hospital inpatient claim, Medicare will recover the improper payment from the ambulance supplier.

#### GO – What You Need to Do

Make sure that your billing staffs are aware of these ambulance service billing requirements.

### Background

The Centers for Medicare & Medicaid Services (CMS) is strengthening its claims processing edits to detect incorrect payments to prevent (or correct) improper payments to ambulance suppliers for transporting hospital inpatients. In CR 3933 (on which this article is based), CMS explains the rules that govern payment for the ambulance services that such suppliers provide to hospital inpatients.

**Sections 1882(a)(14), 1886(d) and (g) of the Social Security Act, and Code of Federal Regulations (CFR) 411.15(m) disallow payment for ambulance services furnished to hospital inpatients by independent ambulance service suppliers on dates that fall between the patients’ admission and discharge dates.**

As a result, the independent supplier of ambulance services must look to the hospital for payment for these services, rather than to the Medicare beneficiary or carrier. More specifically, with the exception of services on the admission and discharge dates, or ambulance services that fall that fall within the occurrence span code 74 from and through dates plus one day, all ambulance transportation provided to hospital inpatients must be bundled into the hospital bill.

Medicare carriers will reject any bill for ambulance services that are provided to a hospital inpatient on a date that falls between their admission and discharge dates unless they are within occurrence span code 74 from and through dates plus one day.

### How the Process Works

In summary, here is how this process works:

- Effective for dates of service on or after December 31, 2004, Medicare’s systems search the claim histories and compare the line item service dates (line items with specialty codes of “59”) on the ambulance claims to the admission and discharge dates on hospital inpatient stays.
- Medicare then rejects the line items when an ambulance line item service date falls between the admission and discharge dates on a hospital inpatient bill or outside the occurrence span code 74 from and through dates.
- And, if Medicare receives the ambulance claim prior to receiving the hospital inpatient bill, it performs the same search, and if the ambulance claim falls within the admission and discharge dates or outside the occurrence span code 74 from and through dates plus one day, the ambulance claim is adjusted and the incorrect payment for the ambulance service will be recovered from the ambulance supplier.
- Finally, when Medicare rejects/adjusts an ambulance claim, the carrier will indicate, by using remittance advice remark code M2, “Not paid separately when the patient is an inpatient,” that:

**Enforcement of Hospital Inpatient Bundling: Carrier Denial of Ambulance Claims During an Inpatient Stay (continued)**

- ♦ The ambulance transportation occurred during a hospital inpatient stay (on a date that falls within the admission and discharge dates of a covered hospital inpatient stay), and is not separately payable; or
- ♦ The service date falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on an acute care hospital, LTCH, IPF or IRF, and is not separately payable.

In addition, the carrier will also indicate the adjustment using remittance advice (RA) adjustment reason code 97, "Payment is included in the allowance for another service/procedure."

**Additional Information**

You may find more information about the payment of ambulance claims during an inpatient stay by going to: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3933 in the CR NUM column on the right, and click on the file for that CR.

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You might also want to look at the Medicare Claims Processing Manual, Chapter 3 (Inpatient Part A Hospital) Section 10.5 (Hospital Inpatient Bundling). You may find this manual chapter as an attachment to CR 3933.

Finally, if you have any questions, please contact your carrier at their toll-free number, which may be found on the CMS website at:

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

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

Related Change Request (CR) Number: 3933

Related CR Release Date: September 2, 2005

Related CR Transmittal Number: 668

Effective Date: Ambulance claims received on or after January 3, 2006 and four years after initial determination for adjustments

Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 668, CR 3933

**Update to the Repetitive Billing Instructions**

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

**Provider Types Affected**

Providers billing Medicare fiscal intermediaries (FIs) for repetitive Part B services, including inpatient hospital Part B and outpatient prospective payment system (OPPS) services, and repetitive hospice Part A services

**Provider Action Needed**

This article is based on Change Request (CR) 4047, which updates repetitive billing instructions in the *Medicare Claims Processing Manual* (Pub. 100-04). It is intended to be informational only to convey the clarifications made in CR 4047.

**Background**

CMS issued Change Request (CR) 3633 (Transmittal 407, "Hospital Billing for Repetitive Services," dated December 17, 2004) with an effective date of January 1, 2005. CR 3633 may be found on the CMS website at [http://www.cms.hhs.gov/manuals/pm\\_trans/R407CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R407CP.pdf).

A Medlearn Matters article (MM3633) is also available on the CMS web site at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3633.pdf>.

Soon after the release of CR 3633, CMS became aware of difficulties that may arise from instructions contained in CR 3633. Therefore, CMS re-evaluated the policy of repetitive billing and provided clarifications in CR 4047.

**General Billing Requirements**

**Frequency of Billing to FIs for Outpatient Services**

Repetitive Part B services furnished to a single individual by providers who bill FIs should be billed monthly (or at the conclusion of treatment).

**Note:** These instructions (which were taken from CR4047) also apply to hospice services billed under Part A, and they do not apply to home health services.

By consolidating repetitive services into a single monthly claim, CMS processing costs will be reduced for:

- Relatively small claims; and
- Instances where bills are held for monthly review.

Services are defined as repetitive services if they are repeated over a span of time and billed with the following revenue codes:

Type of Service	Revenue Code(s)
DME Rental	0290 – 0299
Respiratory Therapy	0410, 0412, 0419
Physical Therapy	0420 – 0429
Occupational Therapy	0430 – 0439
Speech Pathology	0440 – 0449
Skilled Nursing	0550 – 0559
Kidney Dialysis Treatments	0820 – 0859
Cardiac Rehabilitation Services	0482, 0943

One bill for repetitive services will be submitted for the entire month (during a period of repetitive outpatient services) for cases in which there is:

- An inpatient stay; or
- Outpatient surgery; or
- Outpatient hospital services subject to OPPS.

The provider will use an occurrence span code 74 (leave of absence) on the repetitive bill to encompass the:



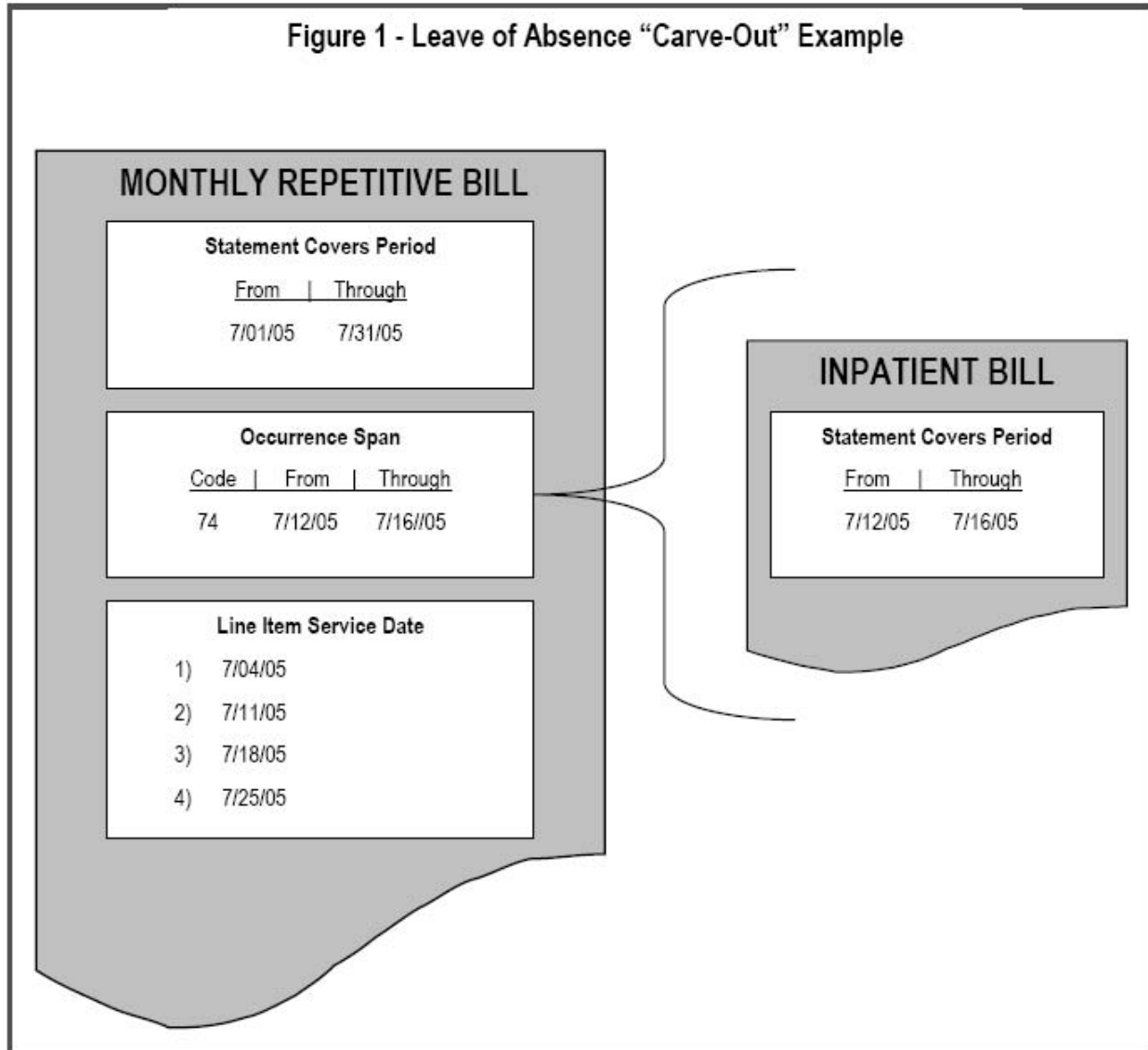
*Update to the Repetitive Billing Instructions (continued)*

- Inpatient stay
- Day of outpatient surgery; or
- Outpatient hospital services subject to OPPS.

This permits submission of a single bill for the repetitive services for the month and simplifies FI review of these bills.

**Note:** This is in addition to the bill for the inpatient stay or outpatient surgery.

This is shown in Figure 1 below.



Any items and/or services in support of the repetitive service will be reported on the same claim even if the revenue code(s) reported with those supported services are not on the repetitive revenue code list.

**Note:** Supporting items and/or services are those needed specifically in the performance of the repetitive service. Examples may include disposable supplies, drugs, or equipment used to furnish the repetitive service.

To facilitate ambulatory payment classification (APC) recalibration, do not report unrelated, one-time nonrepetitive services that have the same date of service as a repetitive

service (even if both the nonrepetitive service and the repetitive service are paid under OPPS). If a nonrepetitive OPPS service is provided on the same date as a repetitive service, report on a separate OPPS claim:

- The nonrepetitive OPPS services; and
- Any packaged and/or services related to the nonrepetitive OPPS service.

For example, if a chemotherapy drug is administered on a day a repetitive service is also rendered, then report the chemotherapy drug, its administration, its related supplies, and so on, on a separate claim from the monthly repetitive services claim.

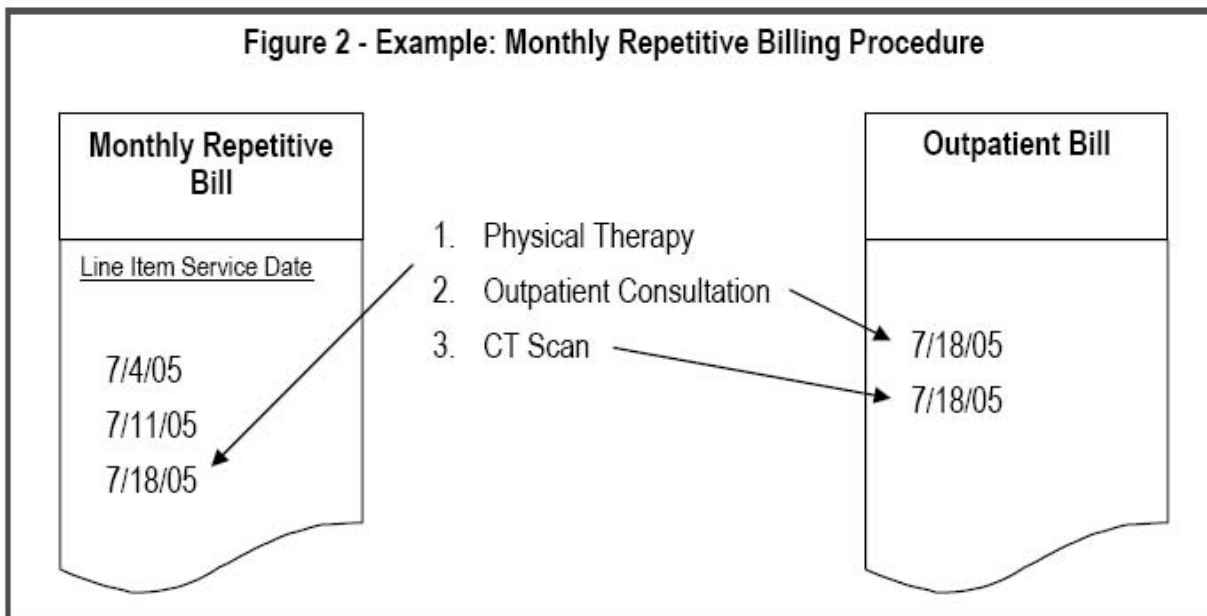
*Update to the Repetitive Billing Instructions (continued)*

Similarly, as shown in Figure 2, “Example: Monthly Repetitive Billing Procedure,” the following occurs on the same day:

- A physical therapy treatment (which is a repetitive service because it is reported under a revenue code on the repetitive service list) is administered;

- An outpatient consultation is furnished; and
- A CT scan is furnished.

In this case, report the physical therapy service on the claim with the other physical therapy services provided during the applicable month, and report the visit for the consultation and the CT scan on a separate claim.



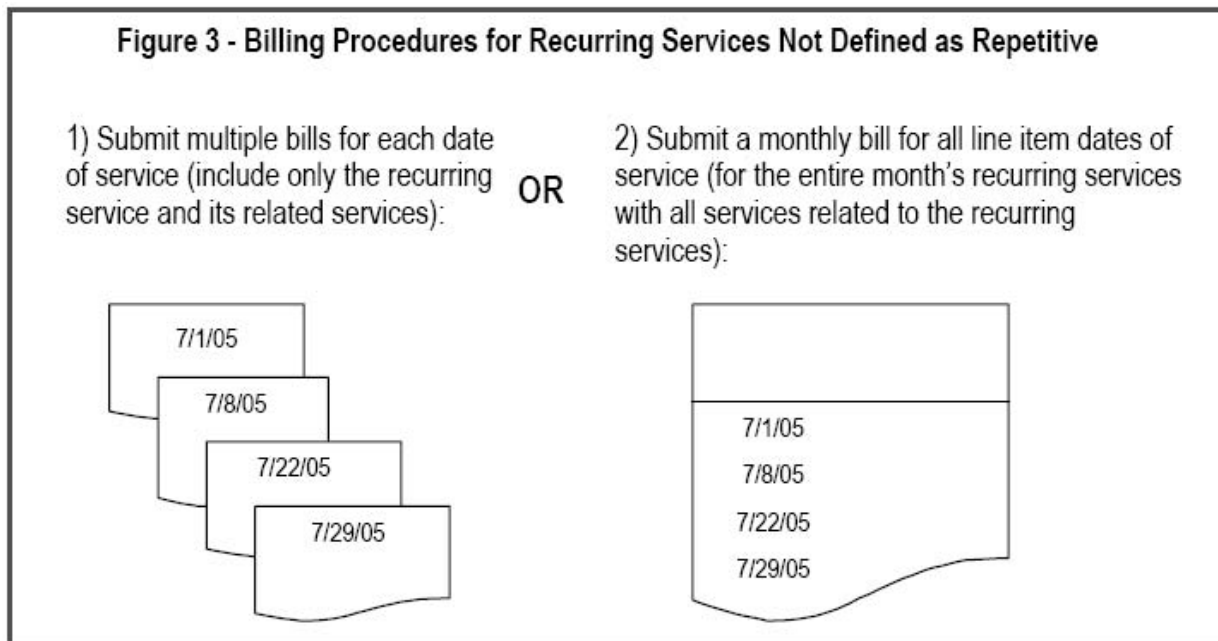
Revenue codes usually reported for chemotherapy and radiation therapy are not on the list of revenue codes that may only be billed monthly. Therefore, hospitals may bill chemotherapy or radiation therapy sessions on separate claims for each date of service.

However, because it is common for these services to be furnished in multiple encounters that occur over several weeks or over the course of a month, hospitals have the option of reporting charges for those recurring services on a single bill, as though they were repetitive services.

If hospitals elect to report charges for recurring, non-repetitive services (such as chemotherapy or radiation therapy) on a single bill, they must also report all charges for services and supplies associated with the recurring service on the same bill. The services may be billed:

- On the same claim; or
- Separately (by date of service).

This is shown in Figure 3 below:



*Update to the Repetitive Billing Instructions (continued)***Part B Hospital (Including Inpatient Hospital Part B and OPSS)  
Hospital and Community Mental Health Center Reporting Requirements for Services Performed on the Same Day**

When reporting a HCPCS code for a separately payable, nonrepetitive hospital OPSS service, report charges for all services and supplies associated with that service that were furnished on the same date. (Services subject to the three-day payment window are an exception to this OPSS policy.)

When a hospital provides electroconvulsive therapy (ECT) on the same day as partial hospitalization services, both the ECT and partial hospitalization services should be reported on the same hospital claim. In this instance, the claim should contain condition code 41. Report charges for all services and supplies associated with the ECT service that was furnished on the same date(s) on the same claim.

**Additional Information**

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

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

From that Web page, look for CR 4047 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 4047  
Related CR Release Date: October 14, 2005  
Related CR Transmittal Number: 711  
Effective Date: N/A  
Implementation Date: N/A

Source: CMS Pub. 100-4, Transmittal 711, CR 4047

**Payment Methodology for Rehabilitation Services in IHS/Tribally Owned and/or Operated Hospitals and Hospital-Based Facilities**

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

**Provider Types Affected**

Indian health service/tribally owned and/or operated hospitals and hospital-based facilities

**Provider Action Needed**

The Centers for Medicare & Medicaid Services (CMS) is revising the methodology used for paying for Medicare Part B therapy services billed by IHS/tribally owned and/or operated hospitals and hospital based facilities. The background section of this article clarifies the payment methodologies that will be used based on the type of bill (TOB) submitted to the Medicare intermediary.

**Background**

Effective for services on or after January 1, 2006, Medicare intermediaries will make payment on claims from IHS/tribally owned and/or operated hospitals and IHS/tribally owned and/or operated hospital-based facilities (referred to as IHS/tribal facilities in the remainder of this article) as follows:

- Claims submitted on TOBs 12x, 13x or 83x by IHS/tribal facilities for physical therapy, occupational therapy, speech-language pathology, and audiology services (revenue codes 042x, 043x, 044x, and 047x) will be paid by the Medicare intermediary, based on the Medicare physician fee schedule (MPFS).
- Claims submitted on TOB 85x by IHS/tribal facilities that are also critical access hospitals for physical therapy, occupational therapy, speech-language pathology and audiology services (revenue codes 042x,

043x, 044x, and 047x) will be paid by the Medicare intermediary on a reasonable cost basis.

- Beneficiary coinsurance and deductibles apply whether the claim is paid on a reasonable cost basis or based on the MPFS.
- Until the effective date of January 1, 2006, Medicare will pay IHS/tribal facilities for these services using the all inclusive rate.

**Additional Information**

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

From that Web page, look for CR 3934 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 3934  
Related CR Release Date: October 7, 2005  
Related CR Transmittal Number: 706  
Effective Date: January 1, 2006  
Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 706, CR 3934

## Changes in Inpatient Rehabilitation Facility Prospective Payment System for Fiscal Year 2006

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

### Provider Types Affected

Inpatient rehabilitation facilities (IRFs) billing Medicare fiscal intermediaries (FIs) under the IRF prospective payment system (IRF PPS)

### Provider Action Needed

#### STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) will use the core-based statistical area (CBSA) methodology for computing the IRF payment rate for fiscal year (FY) 2006.

#### CAUTION – What You Need to Know

A one-year transition policy provides for a blended wage index (50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index) to be applied to all IRFs. This transition policy is effective for patient discharges occurring on or after October 1, 2005, and on or before September 30, 2006.

#### GO – What You Need to Do

Ensure your billing staff is aware of the above change and the policy regarding the payment of IRF services paid under the IRF PPS.

### Background

Section 1886(j) (5) of the Social Security Act requires the Secretary of Health & Human Services to publish in the *Federal Register*, on or before August 1, prior to each fiscal year, the classification and weighting factors for the IRF case-mix groups and a description of the methodology and data that will be used in computing the IRF prospective payment rates for that fiscal year.

CMS has published the FY 2006 IRF PPS final rule in the *Federal Register*, which announces that the CBSA methodology will be used for computing the IRF PPS payment rate for FY 2006.

#### One-Year Transition Policy

A one-year transition policy provides for a blended wage index (50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index, based on the FY 2001 hospital wage data) to be applied to all IRFs.

The one-year transition policy is effective for patient discharges occurring on or after October 1, 2005, and on or before September 30, 2006. The objective of the transition policy is to decrease the negative impact for IRFs that experience a decrease in the wage index and allow one year for all IRFs to transition from the MSA-based wage index to the CBSA-based index.

The FY 2006 IRF PPS Final Rule may be viewed by going to the CMS website at <http://www.cms.hhs.gov/providers/irfpps/pubs.asp>.

Once at the site, click on the link for the *Inpatient Rehabilitation Facility PPS for FY 2006 Final Rule*.

#### Computing IRF Prospective Payment Rates

In computing the IRF prospective payment rates for FY 2006, CMS used categories of data including:

- Inpatient rehabilitation facility rate setting
- Inpatient rehabilitation facility wage index
- Geographic designation crosswalk
- Comorbidity tier reassignment changes.

Information regarding these data sources may be found on the CMS website at

<http://www.cms.hhs.gov/providers/irfpps/fy06nprm.asp>.

### Additional Information

The following are areas in which CMS made key changes and refinements in the IRF PPS for FY 2006:

- **Case-Mix Groups** – CMS clarified the language regarding Rehabilitation Impairment Categories in Chapter 3, Section 140.2.2 of the *Medicare Claims Processing Manual*.
- **Facility Level Adjustments** – In Section 140.2.4 of the same chapter, CMS added language to show an adjustment for teaching facilities.
- **Area Wage Adjustments** – In Section 140.2.4.1, CMS provides more detail on these adjustments and a detailed discussion of the use of the CBSAs.
- **Rural Adjustment** – Chapter 3, Section 140.2.4.2 discusses an additional hold harmless for rural providers that is in addition to the one-year blended wage index.
- **Outliers** – Section 140.2.4.4 of the same chapter explains additional outlier payments.
- **Teaching Status Adjustment** – Section 140.2.4.5 explains the teaching status adjustment that is a facility level adjustment to the federal discharge base rate that accounts for the higher indirect operating costs of facilities that participate in graduate medical education.
- **FTE Resident Cap** – Section 140.2.4.5.1 of Chapter 3 discusses the IRF FTE Resident Cap and how it is calculated.

The details of these changes are included as an attachment to the official instructions (CR4099) issued to your FI. That instruction and the revised portions of Chapter 3 of the *Medicare Claims Processing Manual* may be viewed by going to the CMS website at [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 4099 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 4099

Related CR Release Date: September 30, 2005

Related CR Transmittal Number: 693

Effective Date: Discharges on or after October 1, 2005

Implementation Date: October 31, 2005

Source: CMS Pub. 100-4, Transmittal 693, CR 4099

## Inpatient Rehabilitation Facility 2006 Annual Update—Prospective Payment System PRICER Changes

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

### Provider Types Affected

Inpatient rehabilitation facilities (IRFs) billing Medicare fiscal intermediaries (FIs) for services paid under the IRF prospective payment system (PPS)

### Provider Action Needed

#### STOP – Impact to You

This article is based on change request (CR) 4037, which provides details about the changes that will be required as part of the annual IRF PPS update for fiscal year (FY) 2006.

This article highlights several of the major refinements from the FY 2006 IRF PPS final rule.

#### CAUTION – What You Need to Know

Updated rates are effective for claims with discharges that fall on or after October 1, 2005, and on or before September 30, 2006.

#### GO – What You Need to Do

See the *Background* section of this article for further details regarding this IRF annual update.

### Background

On August 7, 2001, the Centers for Medicare & Medicaid Services (CMS) published a final rule in the *Federal Register* (see [http://www.access.gpo.gov/su\\_docs/fedreg/a010807c.html](http://www.access.gpo.gov/su_docs/fedreg/a010807c.html)) that established the PPS for IRFs, as authorized under the Social Security Act (Section 1886(j)). In that final rule, CMS set forth per discharge federal rates for federal fiscal year 2002. These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002. The Social Security Act (Section 1886(j)(3)(C)) requires annual updates to the IRF PPS rates.

CR 4037 highlights several of the major refinements from the FY 2006 IRF PPS final rule that impact the IRF PRICER, including:

- Changes to the case mix groups (CMGs)
- Changes made within the comorbidity tier codes
- The transition from the metropolitan statistical areas (MSAs) to core based statistical areas (CBSAs)
- The three-year hold harmless policy
- The update to the rural adjustment
- The update to the low income patient (LIP) adjustment
- The update to the outlier threshold
- The new teaching status adjustment.

On August 15, 2005, CMS published a final rule in the *Federal Register* (70 FR 47880 at [http://www.access.gpo.gov/su\\_docs/fedreg/a050815c.html](http://www.access.gpo.gov/su_docs/fedreg/a050815c.html)) that sets forth the prospective payment rates applicable for IRFs for FY 2006.

A new IRF PRICER software package will contain updated rates effective for claims with discharges on or after October 1, 2005, through September 30, 2006.

Under existing IRF PPS outlier methodology, the cost-

to-charge ratio (CCR) from an IRF's latest settled cost report is used in determining:

- Whether a case qualifies for payment as an outlier; and
- The amount of any such payment.

The following provides a brief description of the changes and updates to IRF PPS policies:

#### Case Mix Groups (CMGs) and Comorbidity Tiers

Prior to October 1, 2005, there were 95 CMGs and five special CMGs. For discharges occurring on or after October 1, 2005, there are 87 CMGs and five special CMGs. There will also be updates to the comorbidity tiers as discussed in the final rule.

#### Transition Wage Index

For FY 2006, all IRFs will receive a one-year transition policy that consists of a blended wage index (50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index that are both based on the FY 2001 hospital wage data).

This transition policy is effective for discharges occurring on or after October 1, 2005, and on or before September 30, 2006. The transition will mitigate the negative impact for IRFs that experience a decrease in the wage index and will allow one year for all IRFs to transition from the MSA-based wage index to the CBSA-based wage index.

**Note:** To determine an IRF's actual geographic location, please refer to Table 1 in the final rule. (See 70 FR 47954 at <http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-15419.pdf> or <http://www.cms.hhs.gov/providers/irfpps/cms1290-f-display.pdf>.)

For FY 2006, IRFs may have a special CBSA code to capture the transition wage index appropriate for their state and county combination. Please refer to the IRF PPS website at <http://www.cms.hhs.gov/providers/irfpps/fy06nprm.asp> for state and county combinations with a special CBSA Code in the 50000 series for some areas.

#### Hold Harmless Policy

A three-year budget neutral hold harmless policy applies to IRFs that meet the definition for “rural” in the final rule in FY 2005 (70 FR 47883, Section 412.602) that will become urban under the FY 2006 CBSA based designations to mitigate the loss of the FY 2005 rural adjustment of 19.14 percent.

For the IRFs that meet the criteria, CMS will increase payments for these IRFs by 12.76 percent (or two thirds of the 19.14 FY 2005 rural adjustment) for FY 2006.

The intent of the hold harmless policy is not for an IRF to realize greater payments (as a result of the policy) than the IRF would have had if the IRF had been paid under its rural designation in FY 2006 (including the FY 2005 rural adjustment of 19.14 percent). This adjustment is in addition to the one-year blended wage index described above.

**Inpatient Rehabilitation Facility 2006 Annual Update—PPS PRICER Changes (continued)**

CMS has identified four remaining IRFs (listed at <http://www.cms.hhs.gov/providers/irfpps/irfdata.asp>) that qualify for the hold harmless policy, but would get higher payments with the application of the full 12.76 percent hold harmless adjustment than they would have received if they had been paid under their rural designation in FY 2006 (including the FY 2005 rural adjustment of 19.14 percent). In other words, CMS is essentially capping a facility's payments under the hold harmless policy at this level. Because CMS can change the wage index for a particular IRF on a quarterly basis (whereas CMS can only change an IRF's rural adjustment annually), CMS will implement the hold harmless policy for these four facilities by creating a special wage index value for these IRFs, rather than lowering the amount of their hold harmless adjustment. This will also apply to any other IRFs that are discovered later that would receive higher payments as a result of the hold harmless policy.

CMS will provide FIs with the applicable special wage index values for these four IRFs (and for any other IRFs that are later discovered that would receive higher payments as a result of the hold harmless policy). These special wage index values will be used by the FIs instead of the blended wage index values for determining FY 2006 IRF PPS payments for these IRFs.

**Teaching Status Adjustment**

CMS is implementing an adjustment for teaching facilities to compensate them for the higher costs they incur in providing care to beneficiaries. This adjustment is based on an analysis of IRF PPS data from FY 2003. The new teaching status adjustment for IRFs is similar to the one used in the inpatient psychiatric facility PPS. For FY 2006, CMS will implement a teaching adjustment based on the ratio of residents and interns to the average daily census, raised to some power as discussed in the final rule.

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## **Late Submission Penalty Protocol Within the Inpatient Rehabilitation Facility Prospective Payment System**

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

**Provider Types Affected**

Inpatient rehabilitation facilities (IRFs) billing Medicare fiscal intermediaries (FIs) for services paid under the IRF prospective payment system (PPS)

**Provider Action Needed**

IRFs billing FIs for Medicare Part A fee-for-service inpatient services should be aware of the policy regarding the transmission of patient's assessment data to the Centers for Medicare & Medicaid Services' (CMS) National Assessment Collection Database and how late transmission impacts the payment amount.

**Rural Adjustment, LIP Adjustment, and Outlier Threshold**

The rural adjustment LIP adjustment, and outlier threshold will all be updated as set forth in the final rule.

**Rates**

FY 2006 rates were published in the final rule, including any subsequent correction notices. The PRICER software has the updated rates that will be published in the correction notice. Table 4, found at <http://www.cms.hhs.gov/providers/irfpps/irfdata.asp> on the CMS website, contains the rate table.

**Implementation**

The implementation date for the related instruction is October 3, 2005.

**Additional Information**

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

From that Web page, look for CR 4037 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your intermediary at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Medlearn Matters Number: MM4037  
 Related Change Request (CR) Number: 4037  
 Related CR Release Date: September 16, 2005  
 Related CR Transmittal Number: 680  
 Effective Date: October 1, 2005  
 Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 680, CR 4037

**Background**

In the IRF PPS final rule, published in the *Federal Register* on August 7, 2001 (66 FR 41316), CMS adopted a policy that allows for a penalty to be applied for the late transmission of Medicare Part A fee-for-service patient assessment data collected through the inpatient rehabilitation facility patient assessment instrument (IRF-PAI).

A penalty is applied when the IRF transmits the patient assessment data 28 calendar days or more from the date of discharge. The start date of this time period is the actual discharge date.

The August 7, 2001, final rule, CRF 412.614(e), also implemented a policy that allows CMS to waive the penalty for late transmission, when CMS or the FI acting on behalf of CMS determines that an extraordinary situation prevented the IRF from transmitting the IRF-PAI data by the mandated transmission date. Only CMS or the FI acting on behalf of CMS can determine if a particular circumstance encountered by an IRF is extraordinary and qualifies for a waiver of the penalty.

CR 3885 implements changes to the IRF PRICER to provide the FIs the capability to make payment adjustments in instances where a penalty has been assessed for the late transmission of Medicare Part A fee-for-service patient assessment data through the IRF-PAI. The modifications to the IRF PRICER described in an attachment to CR 3885.

CR 3885 also implements changes to the Medicare IRF PPS to allow FIs to bypass a late penalty assessment when CMS or the FI acting on behalf of CMS determines the circumstances that prevented the transmission of the IRF-PAI data to be extraordinary and the penalty should be waived.

The following provides a summary of how the late penalty is determined, the penalty rate, coding requirements for a Medicare Part A fee-for-service claim, and when the penalty may be waived.

#### Determination of Penalty

The August 7, 2001, final rule required that the IRF-PAI data collected on a Medicare Part A fee-for-service inpatient be transmitted to the CMS National Assessment Collection Database by the 17th calendar day from the date of the inpatient's discharge. Under the IRF PPS regulations, if the actual transmission date is later than ten calendar days from this mandated transmission date, the IRF-PAI data is considered late. The IRF receives a payment rate that is 25 percent less than the payment rate associated with the case mix group (CMG). Consequently, if the IRF transmits the patient assessment data 28 calendar days or more from the date of discharge, the penalty is applied.

Information regarding the CMGs may be found on the CMS website at [http://www.cms.hhs.gov/manuals/pm\\_trans/A0091.pdf](http://www.cms.hhs.gov/manuals/pm_trans/A0091.pdf).

#### Waiver of Penalty

The August 7, 2001, final rule allows CMS the authority to waive the penalty described above for the late transmission of patient assessment data under the following circumstances:

- When CMS or the FI determines that a claim the IRF submitted should not be subject to the payment penalty

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described above because CMS or the FI has determined that due to an extraordinary situation the IRF could not comply with the requirement, or

- When Medicare Part A fee-for-service is not the primary payer.

#### Medicare Fee-for-Service Claim Coding Requirements

When Medicare Part A fee-for-service is the primary payer, the revenue code line **0024, Field Locator 45** (or electronic equivalent) service date—when entered by the provider or the CMS adjustment process—will equal the date on which the final assessment was transmitted to the CMS National Assessment Collection Database.

This field is mandatory on all discharge IRF PPS claims, whether the IRF PAI was transmitted late or not. Transmission of the IRF-PAI data record 28 or more calendar days after the discharge date specified on the claim will result in the claim incurring the 25 percent late IRF-PAI data transmission penalty. If the provider does not complete this field accurately and the IRF PAI data record is transmitted 28 calendar days or more from the date of discharge, CMS will utilize a post-payment review process to identify claims subject to the late penalty and institute an adjustment process to correct payment. Complete details of the CMS post-payment review process will be determined at a later date.

#### Additional Information

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

From that Web page, look for CR 3885 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your Medicare FI 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: 3885

Related CR Release Date: July 29, 2005

Related CR Transmittal Number: 619

Effective Date: January 1, 2006

Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 619, CR 3885

## Supplemental Security Income Data for Fiscal Year 2006 for Inpatient Rehabilitation Facility Prospective Payment System

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

### Provider Types Affected

Inpatient rehabilitation facilities (IRFs) eligible for low-income patient adjustments

### Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued updated information, contained within this article, to determine additional payment amounts for IRFs with low-income patients (LIP). Under the IRF PPS, those facilities that furnish care to low-income patients receive supplemental payment amounts to make up for the cost of providing that care.

This is accomplished by making adjustments to the IRF PPS. The Supplemental Security Income (SSI) data are updated on an annual basis and these data are one of the components used to determine an appropriate low-income patient adjustment for each IRF. To review these data, go to the CMS website at [http://www.cms.hhs.gov/providers/irfpps/ssidata\\_ratios.asp](http://www.cms.hhs.gov/providers/irfpps/ssidata_ratios.asp).

These SSI data files show the latest available IRF-specific data to compute an IRF's SSI ratio for the associated specified fiscal year (FY).

### Background

The SSI data are updated on an annual basis, and these data are one of the components used to determine the disproportionate share hospital (DSH) variable that is part of the appropriate low-income patient adjustment for each IRF. Medicare fiscal intermediaries (FIs) use these data to determine an initial PPS payment amount and, if applicable, to determine a final outlier payment amount for IRFs whose discharges occur during a specific cost reporting period. FIs make a determination of the amount of this percentage to compute the final low-income patient adjustment, which allows the year-end settlement of a facility's cost report.

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The facility uses the most recently settled SSI ratio to settle this cost report. Once the SSI ratio is settled for the actual year the cost report corresponds to, a retrospective adjustment will be made to account for the difference between the actual amount and the initial PPS payment amount.

### Implementation

The implementation date for this instruction is November 7, 2005.

### Additional Information

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

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR 4065.

Click on the link to open and view the files for this CR.

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

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

Related Change Request (CR) Number: 4065

Related CR Release Date: October 7, 2005

Related CR Transmittal Number: 698

Effective Date: October 1, 2005

Implementation Date: November 7, 2005

Source: CMS Pub. 100-4, Transmittal 698, CR 4065



## Fiscal Year 2006 Inpatient Prospective Payment System and Long Term Care Hospital PPS Changes

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

### Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for services paid under the inpatient prospective payment system (IPPS) or the long-term care hospital (LTCH) PPS.

### Provider Action Needed

#### STOP – Impact to You

This article includes information from Change Request (CR) 4046 that announces changes to the fiscal year (FY) 2006 IPPS and the LTCH PPS based on the FY 2006 IPPS final rule.

#### CAUTION – What You Need to Know

This article outlines FY 2006 IPPS changes for hospitals, which were published in the *Federal Register* on August 12, 2005, and it also addresses new GROUPER and DRG changes that are effective October 1, 2005, for hospitals paid under the LTCH PPS. LTCH PPS rate changes occurred on July 1, 2005.

#### GO – What You Need to Do

Please see the *Background* and *Additional Information* sections of this instruction for details regarding this update.

### Background

This article is based on Change Request (CR) 4046, which outlines FY 2006 IPPS changes for hospitals that were published in the *Federal Register* on August 12, 2005. The August 12, 2005, *Federal Register* may be found at the following Government Printing Office (GPO) website: [http://www.access.gpo.gov/su\\_docs/fedreg/a050812c.html](http://www.access.gpo.gov/su_docs/fedreg/a050812c.html).

**Note:** All items covered in this article are effective for hospital discharges occurring on or after October 1, 2005, unless otherwise noted.

LTCH PPS rate changes occurred on July 1, 2005. Please refer to Transmittal 578, CR3884, published on June 10, 2005 for LTCH policy changes. CR3884 may be found on the CMS website at [http://www.cms.hhs.gov/manuals/pm\\_trans/R578CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R578CP.pdf).

Or, you may wish to review the related Medlearn Matters article, MM3884, which may be found on the CMS website at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3884.pdf>.

### International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Changes

ICD-9-CM coding changes are effective October 1, 2005. The new ICD-9-CM codes are listed, along with their DRG classifications in Tables 6a (p. 47632) and 6b (p. 47636) of the August 12, 2005, *Federal Register* (see [http://www.access.gpo.gov/su\\_docs/fedreg/a050812c.html](http://www.access.gpo.gov/su_docs/fedreg/a050812c.html)).

The ICD-9-CM codes that have been replaced by expanded codes or other codes, or have been deleted, are included in Tables 6c (p. 47637) and 6d (p. 47638). The revised code titles are in Tables 6e (p. 47638) and 6f (p. 47639).

GROUPER 23.0 assigns each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (i.e., age, sex, and discharge status) and is

effective with discharges occurring on or after October 1, 2005. Medicare code editor (MCE) 22.0 uses the new ICD-9-CM codes to validate coding for discharges and outpatient services effective October 1, 2005.

### Furnished Software Changes

The following software programs were issued for FY2006:

#### I. IPPS PRICER 06.0

IPPS PRICER 06.0 is for discharges occurring on or after October 1, 2005. This program processes bills with discharge dates on or after October 1, 2001. Rates were published in the August 12, 2005, *Federal Register* (see [http://www.access.gpo.gov/su\\_docs/fedreg/a050812c.html](http://www.access.gpo.gov/su_docs/fedreg/a050812c.html)).

### Rates

Standardized amount update factor	1.037
	1.033
	(for hospitals that do not submit quality data)
Hospital specific update factor	1.037
	1.033
	(for hospitals that do not submit quality data)
Common fixed loss cost outlier threshold	\$23,600.00
Federal capital rate	\$420.65
Puerto Rico capital rate	\$201.93
Outlier offset-operating national	0.948990
Outlier offset-operating Puerto Rico	0.974897
Outlier offset-operating national PR blend	0.955467
IME formula	1.37*
	[1 + resident-to-bed ratio]**.405-1]
MDH/SCH Budget Neutrality Factor*	0.998993

### Operating Rates

#### Rates With Wage Index Greater than 1 and Full Market Basket

	Labor Share (LS)	Non Labor Share (NLS)
National (NTL)	3297.84	1433.63
Puerto Rico (PR)	1402.46	859.57
National/Puerto Rico (NPR)	3297.84	1433.63

#### Rates With Wage Index Less than 1 and Full Market Basket

	LS	NLS
NTL	2933.52	1797.95
PR	1327.81	934.22
NPR	2933.52	1797.95

#### Rates With Wage Index Greater than 1 and Reduced Market Basket

	LS	NLS
NTL	3285.12	1428.10
PR	1397.05	856.26
NPR	3285.12	1428.10

#### Rates With Wage Index Less than 1 and Reduced Market Basket

	LS	NLS
NTL	2922.20	1791.02
PR	1322.69	930.62
NPR	2922.20	1791.02

## Fiscal Year 2006 Inpatient Prospective Payment System and Long Term Care Hospital PPS Changes (continued)

The revised hospital wage indices and geographic adjustment factors are contained in Tables 4a (urban areas), 4b (rural areas), and 4c (redesignated hospitals) of the August 12, 2005 *Federal Register* (see [http://www.access.gpo.gov/su\\_docs/fedreg/a050812c.html](http://www.access.gpo.gov/su_docs/fedreg/a050812c.html)).

### Post Acute Care Transfer Policy

On October 1, 1998, the Centers for Medicare & Medicaid Services (CMS) established a post acute care transfer policy that paid as transfers all cases assigned to one of ten diagnosis-related groups (DRGs) if the patient is discharged to:

- A psychiatric hospital or unit (patient status code 65)
- An inpatient rehabilitation hospital or unit (patient status code 62)
- A long term care hospital (patient status code 63)
- A children's hospital (patient status code 05)
- A cancer hospital (patient status code 05)
- A skilled nursing facility (patient status code 03)
- A home health agency (patient status code 06).

As of October 1, 2004, that list of ten DRGs was expanded to 29 DRGs; and, effective for discharges on or after October 1, 2005, the list has been expanded again.

**Note:** Please see Attachment A of CR 4046 for the complete and current list of all post acute care transfer DRGs. CR4046 may be found by going to the CMS website at [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

Once at that page, look for CR 4046 in the CR NUM column on the right and click on the file for that CR.

Thirteen DRGs are eligible for the special payment methodology wherein the payment is equal to 50 percent of the full DRG payment *plus the single per diem day (rather double the per diem)* for the first day of the stay plus 50 percent of the regular per diem for the remainder of the stay, up to the full amount of the DRG payment. The 13 special payment DRGs are listed in below:

### DRG Description

- |     |  |
|-----|--|
| 7   | Peripheral and cranial nerve and other nervous system procedure with complications or co-morbidities           |
| 8   | Peripheral and cranial nerve and other nervous system procedure <i>without</i> complications or co-morbidities |
| 210 | Hip and femur procedures except major joint (Age >17) with complications or co-morbidities                     |
| 211 | Hip and femur procedures except major joint (Age >17) <i>without</i> complications or co-morbidities           |
| 233 | Other musculoskeletal system and connective tissue or procedure with complications or co-morbidities           |
| 234 | Other musculoskeletal system and connective tissue or procedure <i>without</i> complications or co-morbidities |
| 471 | Bilateral or multiple major joint procedures of the lower extremity  |
| 497 | Spinal fusion except cervical with complications or co-morbidities   |
| 498 | Spinal fusion except cervical <i>without</i> complications or co-morbidities                                   |
| 544 | Major joint replacement or reattachment  |

- |     |  |
|-----|--|
| 545 | Revision of hip or knee replacement  |
| 549 | Percutaneous cardiovascular procedure with drug-eluting stent with AMI with complications or co-morbidities          |
| 550 | Percutaneous cardiovascular procedure with drug-eluting stent with AMI <i>without</i> complications or comorbidities |

Assigning the correct DRG code is important, and assigning the correct patient status code is just as important as any other coding used when filing a claim. Choosing the patient status code correctly avoids claim errors and helps speed up payment for your claim sooner.

A patient status code is a two-digit code that identifies where the patient is at the conclusion of a health care facility encounter (this could be a visit or an actual inpatient stay) or at the time end of a billing cycle (the "through" date of a claim). CMS requires patient status codes for:

- Part A inpatient claims (type of bills (TOBs) – 11x and 12x)
- Skilled nursing claims (TOBs – 18x, 21x, 22x and 23x)
- Outpatient hospital services (TOBs – 13x, 14x, 71x, 73x, 74x, 75x, 76x and 85x)
- All hospice and home health claims (TOBs – 32x, 33x, 34x, 81x and 82x).

The patient status code belongs in Field 22 on the UB-92 claim form (or its electronic equivalent) in the Health Insurance Portability and Accountability Act (HIPAA)-compliant 837 format for all Part A inpatient, SNF, hospice, home health agency (HHA) and outpatient hospital services. This code indicates the patient's status as of the "Through" date of the billing period (FL 6).

For providers who file claims in the Fiscal Intermediary Shared System (FISS), the patient status code is entered on Claim Page 1. It is important to select the correct patient status code, and if two or more patient status codes could apply, then code to the highest level of care known. Omitting the code or submitting a claim with the incorrect code is a claim billing error and could result in your claim being rejected or your claim being cancelled and payment taken back. Applying the correct code will help ensure that you receive prompt and correct payment.

### Patient Status Codes Affected by the Transfer and Post Acute Care Transfer Policy

The following describes these patient status codes and provides details regarding their appropriate use:

#### Patient Status Code 02 – Discharged/Transferred to a Short-Term General Hospital for Inpatient Care

This patient status code should be used when the patient is discharged or transferred to a short-term acute care hospital. Discharges or transfers to long-term care hospitals should be coded with patient status code 63.

#### Patient Status Code 03 – Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Covered Skilled Care

This patient status code should only be used when a patient is discharged or transferred to a Medicare certified skilled nursing bed **and** qualifies for skilled nursing care.

*Fiscal Year 2006 Inpatient Prospective Payment System and Long Term Care Hospital PPS Changes (continued)*

This code should be used whether or not the patient has skilled benefit days. (Also, see code 61 below.)

This code includes transfers to a rehabilitation unit that is located within a skilled nursing facility (SNF). This code should **not** be used:

- If the patient is at a non-skilled level of care; or
- The patient is admitted to a non-Medicare certified bed.
- For a patient who is discharged to a facility that has both skilled and non-skilled (intermediate) bed and the patient is transferred to a non-skilled bed.
- For a patient who resides at a Medicare certified skilled nursing facility but does not receive skilled care services.

**Patient Status Code 05 – Discharged/Transferred to Another Type of Institution Not Defined Elsewhere in this Code List**

Cancer hospitals excluded from the Medicare PPS and children’s hospitals are examples of such other types of institutions.

The National Uniform Billing Committee (NUBC), as well as CMS, has provided additional situations in which patient status code 05 should be used, other than transfers to non-Medicare certified children’s hospitals or cancer hospitals. These situations are as follows:

**Patient Status Code 05 – NUBC: Discharged/Transferred to a Non-Medicare PPS Children’s Hospital or Non-Medicare PPS Cancer Hospital for Inpatient Care**

The NUBC has clarified that patient status code 05 should be used when:

- A patient is discharged to a chemical dependency treatment facility that is not part of a hospital.
- A patient is transferred or discharged from a hospital-based skilled nursing unit (SNU) to the acute care hospital under observation status.
- A patient is discharged from one acute care facility to another acute care facility for an outpatient procedure with the intention that the patient will not be returning to the first acute care facility following the procedure.

**Patient Status Code 06 – Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skills Care**

This patient status code should be used when a patient is discharged to home, with home health services that will be provided within three days of the patient’s discharge. The NUBC has clarified that this would include:

- Follow-up care by visiting nurses
- Home health care where the patient is also receiving home oxygen
- Home health care where the patient is receiving durable medical equipment (DME) services.

**Patient Status Code 07 – Left Against Medical Advice or Discontinued Care (This code affects the regular transfer policy if the patient is admitted into another acute care hospital on the same day.)**

The important thing to remember about this patient

status code is that it is to be used when a patient leaves against medical advice or the care is discontinued. According to the NUBC, discontinued services may include:

- Patients who are triaged and leave without being seen by a physician or non-physician practitioner
- Patients who move without notice and the home health agency is unable to complete the plan of care.

**Patient Status Code 62 – Discharged/Transferred to an Inpatient Rehabilitation Facility Including Distinct Part Units of a Hospital**

Inpatient rehabilitation facilities (or designated units) are those facilities that meet a specific requirement that 75 percent of their patients require intensive rehabilitative services for the treatment of certain medical conditions. This code should be used when a patient is transferred to a facility or designated unit that meets this qualification.

**Patient Status Code 63 – Discharged/Transferred to Long Term Care Hospitals**

Long-term care hospitals are facilities that provide acute inpatient care with an average length of stay of 25 days or greater. This code should be used when transferring a patient to a long-term care hospital. If you are not sure whether a facility is a long term care hospital or a short term care hospital, you should contact the facility to verify their facility type before assigning a patient status code.

**Patient Status Code 65 – Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital**

Although this patient status code has been valid since April 1, 2004, the Medicare system has only accepted this code since January 1, 2005. This code should be used when a patient is transferred to an inpatient psychiatric unit or inpatient psychiatric designated unit.

**Note:** This code should not be used when a patient is transferred to an inpatient psychiatric unit of a federal hospital (e.g., Veterans Administration hospitals).

See CR 3364, transmittal 237, dated July 23, 2004, “Implementation of Patient Status Code 65, Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital,” on the CMS website at [http://www.cms.hhs.gov/manuals/pm\\_trans/R237CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R237CP.pdf).

A Medlearn Matters article is available on the CMS website at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3364.pdf>.

**New Technology Add-On Payment**

This is effective for discharges on or after October 1, 2005. In addition to Kinetra® (which was effective October 1, 2004), there are two “new” new technology add-on payments:

- Restore Rechargeable Implantable Neurostimulator, and
- GORE TAG.

**Note:** OP-1, InFUSE™, and CRT-D are no longer eligible for the new technology add-on payment. Under 42 CFR 412.88 (p. 440) of the regulations, an add-on payment is made for discharges involving approved

*Fiscal Year 2006 Inpatient Prospective Payment System and Long Term Care Hospital PPS Changes (continued)*

new technologies, if the total covered costs of the discharge exceed the DRG payment for the case (including adjustments for indirect medical education (IME), disproportionate share (DSH), transfers, and so on, but excluding outlier payments.) (See Publication 100-4, Chapter 3, Section 160, for specific payment methodology regarding the new technology add-on payment.)

In order to pay the add-on technology payment for the **Restore Rechargeable Implantable Neurostimulator**, PRICER will look for the presence of ICD-9-CM procedure code 86.98: the maximum add-on payment for the neurostimulator is \$9,320.00.

In order to pay the add-on technology payment for **GORE TAG**, PRICER will look for the presence of ICD-9-CM procedure code 39.73: the maximum add-on payment for GORE TAG is \$10,599.00.

In order to pay the add-on technology payment for **Kinetra®**, PRICER will look for the presence of ICD-9-CM procedure codes 02.93 AND 86.95: the maximum add-on payment for Kinetra® is \$8,285.00.

It is possible to have multiple new technologies on the same claim. Should multiple new technologies be present, PRICER will calculate each separately and then total the new technology payments.

**II. GROUPER 23.0**

For discharges occurring on or after October 1, 2005, PRICER calls the appropriate GROUPER based on discharge date.

**III. MCE 22.0**

This applies for discharges occurring on or after October 1, 2005. MCE 22.0 replaces earlier versions and contains complete tables driven by date. The MCE selects the proper internal tables based on discharge date.

**Other Changes**

**Disproportionate Share (DSH) Adjustment for Urban to Rural Providers**

The *Code of Federal Regulations* (42 CFR 412.102 (p. 448)) provides for a transition to a rural payment amount from an urban payment amount under the operating PPS over two years. There are a few hospitals with a DSH adjustment near or greater than 0.12 (the cap on the operating DSH adjustment for certain groups of providers) that were considered urban under the former metropolitan statistical areas (MSA) definitions (effective during FY 2004), but are now considered rural under the core based statistical areas (CBSA) definition (effective beginning in FY 2005).

**Note:** You may find all sections of 42 CFR 412 referred to in this article at the following GPO website: [http://www.access.gpo.gov/nara/cfr/waisidx\\_04/42cfr412\\_04.html](http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr412_04.html).

These providers must receive an adjustment to their operating DSH payment over the two years (FY 2005 and FY 2006). This adjustment has been coded into the PRICER in an attempt to most closely approximate the DSH payment they will receive upon cost report settlement. The adjustment gives these hospitals one-third of the difference between the urban and rural operating DSH for FY 2006

(and two-thirds of the difference between the urban and rural operating DSH for FY 2005).

**Capital PPS Payment for Providers Redesignated Under Section 1886(d)(8)(B) of the Act**

The *Code of Federal Regulations* (42 CFR 412.64(b)(II)(D)(3) (p.425) implements the Social Security Act (Section 1886(d)(8)(B)), which redesignates certain rural counties—commonly referred to as “Lugar counties”—adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. Accordingly, hospitals located in these “Lugar counties” (commonly referred to as “Lugar hospitals”) are deemed to be located in an urban area and receive the federal payment amount for the urban area to which they are redesignated.

Currently, there are 98 qualifying “Lugar counties” effective for discharges occurring on or after October 1, 2004. (August 11, 2004; 69 FR 49056 – 49059. See [http://www.access.gpo.gov/su\\_docs/fedreg/a040811c.html](http://www.access.gpo.gov/su_docs/fedreg/a040811c.html).)

Under the capital PPS, the standard federal rate is adjusted to reflect the higher costs incurred by hospitals located in large urban areas (large urban add-on at 42 CFR 412.316 [p. 493]), as well as for hospitals in urban areas with at least 100 beds serving low-income patients (capital DSH adjustment at 42 CFR 412.320 [p. 493]).

In the August 11, 2004, hospital inpatient PPS final rule (69 FR 49250; See [http://www.access.gpo.gov/su\\_docs/fedreg/a040811c.html](http://www.access.gpo.gov/su_docs/fedreg/a040811c.html)), effective for discharges occurring on or after October 1, 2004, 42 CFR 412.316 (p. 493) and 42 CFR 412.320 (p. 493) specify that capital PPS large urban add-on payments and capital PPS DSH payments, respectively, are based on a hospital’s geographic classification specified in 42 CFR 412.64 (p. 425).

Therefore, hospitals located in one of the 98 qualifying “Lugar counties” are considered urban for payment purposes under the capital PPS and are eligible for the capital PPS large-urban add-on and capital PPS DSH payments, if applicable. However, a “Lugar hospital” may decline its redesignation as urban in order to retain its rural status.

You can find 69 FR 48915-49782 (the FY 2005 Final Rule), CMS Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates, at the following GPO website: [http://www.access.gpo.gov/su\\_docs/fedreg/a040811c.html](http://www.access.gpo.gov/su_docs/fedreg/a040811c.html).

**Multi-Campus Hospitals Payment Issues**

Under current Medicare policy, a multi-campus hospital with campuses located in the same labor market area receives a single wage index. However, if the campuses are located in more than one labor market area, payment for each discharge is determined using the wage index value for the CBSA (or metropolitan division, where applicable) in which the campus of the hospital is located.

**Reclassification**

For FY 2006, FY 2007, or FY 2008, for a campus of a multi-campus hospital that wishes to seek reclassification to a geographic wage area where another campus(es) is located, CMS will allow the campus of a multi-campus hospital to use the average hourly wage data submitted on the cost report for the entire multi-campus hospital as its wage data under 42 CFR 412.230(d)(2) (p. 475).

*Fiscal Year 2006 Inpatient Prospective Payment System and Long Term Care Hospital PPS Changes (continued)*

The deadline for multi-campus hospitals to reclassify is the same as all other hospitals; that is, they must submit their application to the Medicare Geographic Classification Review Board (MGCRB) by September 1st of each year.

**Wage Index Corrections**

For FY 2006 and subsequent years, classification/reclassification errors made during the proposed rule:

- CMS made a technical error in assigning the hospital to a geographic labor market area.
- The hospital notifies CMS of the technical error using the formal comment process and during the comment period on the proposed rule.
- The error was not corrected in the final rule.
- The hospital again notifies CMS of the geographic assignment error, via written correspondence or email following the publication of the final rule, and CMS agrees prior to October 1 that an error was made.
- The hospital or its representatives provide documentation to the FI that the criteria above have been met.

For FY 2006 and subsequent years, classification/reclassification errors made for the first time during the final rule:

- CMS made a technical error in the final rule in assigning the hospital to a geographic labor market area.
- The hospital notifies CMS of the error via written correspondence or email, following the publication of the final rule, and CMS agrees prior to October 1 that an error was made.
- The hospital or its representatives provide documentation to the FI that the criteria above have been met.

**LTCH Changes****LTCH PPS Cost-to-Charge Ratios (CCR)**

To ensure that the distribution of outlier payments remains equitable for FY 2006, an LTCH's overall Medicare cost-to-charge ratio **is considered not to be reasonable if the value exceeds** the combined (operating plus capital) upper (ceiling) cost-to-charge ratio thresholds. These are calculated annually by CMS under the hospital inpatient PPS and published in the *Federal Register*. The combined operating and capital upper limit for FY 06 is 1.423.

The appropriate (combined) statewide average cost-to-charge ratios for FY 2006 may be found in Tables 8A and 8B of the IPPS Final Rule (p.47672). You may review the IPPS and FY 2006 rates final rule at the following GPO website: [http://www.access.gpo.gov/su\\_docs/fedreg/a050812c.html](http://www.access.gpo.gov/su_docs/fedreg/a050812c.html).

**LTCH PRICER , DRGs, and Relative Weights**

The annual update of the LTC-DRGs, relative weights, and GROUPER software for FY 2006 are published in the annual IPPS final rule. The same GROUPER software developed by 3M for the hospital inpatient PPS will be used for the LTCH PPS.

Version 23.0 of the hospital inpatient PPS GROUPER will be used for FY 2006, but with LTCH-specific relative weights reflecting the resources used to treat the medically complex LTCH patients.

The annual update of the LTC-DRGs, relative weights, (geometric) average length of stay, and 5/6th of the average length of stay (for short-stay outlier cases) for FY 2006 was determined using the most recent available LTCH claims data (FY 2004).

For those LTCHs paid under the transition blend methodology under 42 CFR 412.533 (p.514), for FY 2006 CMS is using the rebased FY 2002-based excluded hospital market basket to update the reasonable cost based portion of their payments.

As stated in the August 12, 2005, FY 2006 IPPS final rule, the forecast for FY 2006 for the FY 2002-based excluded hospital market basket is 3.8 percent. The LTC-DRGs, relative weights, (geometric) average length of stay, and 5/6th of the average length of stay effective for discharges on or after October 1, 2005, may be found in Table 11 of the final rule (p. 47682). The IPPS and FY 2006 rates final rule may be found at the following GPO website: [http://www.access.gpo.gov/su\\_docs/fedreg/a050812c.html](http://www.access.gpo.gov/su_docs/fedreg/a050812c.html).

**Implementation**

The implementation date for the related instruction is October 3, 2005.

**Additional Information**

For complete details regarding CR 4046, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to the CMS website at [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 4046 in the CR NUM column on the right, and click on the file for that CR.

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

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

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 Related CR Release Date: September 30, 2005  
 Related CR Transmittal Number: 692  
 Effective Date: October 1, 2005  
 Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 692, CR 4046

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# CRITICAL ACCESS HOSPITAL SERVICES

## October Update to the Medicare Outpatient Code Editor for Hospitals Not Paid Under the Outpatient Prospective Payment System

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

### Provider Types Affected

Hospitals and providers billing outpatient services to Medicare intermediaries that are not paid under the outpatient prospective payment system (OPPS)

### Provider Action Needed

#### STOP – Impact to You

This article includes information from Change Request (CR) 4009, which informs your fiscal intermediaries (FIs) that the October 2005 non-outpatient prospective payment system outpatient code editor (non-OPPS OCE) specifications have been updated with new additions, deletions, and changes to ensure correct billing.

#### CAUTION – What You Need to Know

CR 4009 includes diagnosis codes and descriptions that have been reviewed and approved by the Centers for Medicare & Medicaid Services (CMS), which are the same code and description changes specified for the Medicare code editor (MCE), version 22.0.

#### GO – What You Need to Do

Please see the Background section of this article for more information on these non-OPPS OCE updates.

### Background

The non-OPPS OCE has been updated with new additions, changes, and deletions to Healthcare Common Procedure Coding System/*Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4)* codes. This OCE is used to process bills from hospitals not paid under the OPSS. The number and types of changes are numerous and may be found in the published version of CR 4009. This may be found on the CMS website at [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

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Once at that site, scroll down the CR NUM column field on the right and click on the file for CR 4009.

**Note:** Because the list is extensive, we are referring providers to the actual CR 4009 rather than list all the codes within this article.

The October release of the non-OPPS OCE is version 21.0. Please be aware that many of the changes are effective on October 1, 2005. However, some changes are effective on other dates as shown in CR 4009.

### Implementation

The implementation date for this version of the non-OPPS OCE is October 3, 2005.

### Additional Information

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

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

Related Change Request (CR) Number: CR 4009

Related CR Release Date: August 12, 2005

Related CR Transmittal Number: 644

Effective Date: October 1, 2005

Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 644, CR 4009

## Certified Registered Nurse Anesthetists Pass-Through Payments for Critical Access Hospitals

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

### Provider Types Affected

Critical access hospitals (CAHs) billing Medicare fiscal intermediaries (FIs)

### Provider Action Needed

#### STOP – Impact to You

This article is based on information from Change Request (CR) 3833 that: 1) clarifies payment for method I and method II CAHs that keep their pass-through exemptions; and 2) includes billing instructions for method II CAHs that gave up their pass-through exemption.

#### CAUTION – What You Need to Know

Method I CAHs were not given instructions on certified registered nurse anesthetists (CRNAs) pass-through billing. As a result, some CAHs have not been paid for their CRNA pass-through services since October 2002. Consequently CR 3833 directs FIs to pay CRNA pass-throughs whenever the CRNA indicator is present on the provider files. Method II CAHs that gave up their pass-through exemptions were not receiving proper reimbursement and the formula has been corrected.

#### GO – What You Need to Do

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

### Background

Critical access hospitals with certified registered nurse anesthetists pass-through exemptions have not been receiving the correct payment. Regardless of which option a CAH chooses (method I or method II), CAHs that qualify for the CRNA exemption can receive payment for the CRNA professional fees from their FI.

CR 3833 instructs FIs to annotate the provider file to allow the CRNA indicator for method I and method II CAHs that are qualified with a CRNA pass-through exemption.

In addition, CR 3833 instructs FIs to:

- Accept revenue code 037x on type of bills (TOBs) 11x and 85x for CRNA technical services for all CAHs.
- Make payment as follows for TOBs 11x and 85x **CAHs paid under methods I and method II that have a CRNA pass-through exemption:**
  - ♦ Revenue code – 037x = technical service – cost reimbursement
  - ♦ Revenue code – 0964 = professional services – cost reimbursement for both inpatient and outpatient

- ♦ CPT code reflects anesthesia (00100 through 01999 range)
- ♦ Deductible and coinsurance apply.
- Make payment as follows for the TOBs 85x CAHs paid under method II that gave up their CRNA pass-through exemption:
  - ♦ Revenue code – 037x = technical service – cost reimbursement
  - ♦ Revenue code 0964 = professional service – 115 percent times 80 percent (not medically directed) or 115 percent times 50 percent (medically directed) of allowed amount for outpatient CRNA professional services.
- Submit modifier **QZ** to identify the non-medically directed CRNA service.
- Fiscal intermediaries will pay CRNA pass-throughs back to October 1, 2002, if the CAH attests in writing that they did not receive payment for CRNA pass-through exemption (professional) services and they are eligible for the CRNA pass-through exemption.

### Implementation

The implementation date for CR 3833 is January 3, 2006.

### Additional Information

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

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

From that Web page, look for CR 3833 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: 3833

Related CR Release Date: July 22, 2005

Related CR Transmittal Number: 616

Effective Date: October 1, 2002

Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 616, CR 3833

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Applicable FARS/DEARS apply.

# ESRD SERVICES

## Payment Guidelines for Vaccines (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) and their Administration at Renal Dialysis Facilities

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

**Note:** This Medlearn Matters article was revised on August 4, 2005, because the Centers for Medicare & Medicaid Services revised change request (CR) 3936. The article was revised to reflect the new CR release date and transmittal number. No other changes were made to the article. This article was published in the Fourth Quarter 2005 *Medicare A Bulletin* (pages 67-68).

### Provider Types Affected

Freestanding and provider-based renal dialysis facilities (RDFs) that bill Medicare fiscal intermediaries (FI) for vaccines and vaccine administration

### Provider Action Needed STOP – Impact to You

Change request (CR) 3936 clarifies Medicare processing and payment of claims by Medicare FIs to RDFs for virus and pneumococcal pneumonia vaccines and their administration. **FIs pay** for PPV, influenza, and hepatitis B virus vaccines provided by freestanding RDFs based on the lower of the actual charge or 95 percent of the average wholesale price (AWP). Provider-based RDF payment is based on reasonable cost. Deductible and coinsurance do not apply. Vaccine administration payments to freestanding RDFs are based on the Medicare physician fee schedule according to its rate associated with CPT code 90782 for services provided prior to March 1, 2003 and on CPT code 90471 for services provided on or after March 1, 2003. Payments to provider-based RDFs are made on a reasonable cost basis.

### CAUTION – What You Need to Know

Be cognizant of the applicable HCPCS codes and their definitions. Also, these clarifications apply to affected services provided on or after January 1, 2006.

### GO – What You Need to Do

Use the appropriate codes when billing for the vaccines, see information listed within this article.

### Background

The goal for CR 3936 is to clarify payment rules for vaccines furnished to end-stage renal disease (ESRD) patients (PPV, influenza virus, and hepatitis B virus) and their administration provided by RDFs (type of bill 72x). The Medicare program covers **influenza virus and pneumococcal pneumonia vaccines and their administration** when furnished to eligible beneficiaries in accordance with coverage rules. Payment may be made for both the **vaccine and the administration**. The costs associated with the syringe and supplies are included in the administration fee and thus **HCPCS code A4657 should not be billed for these vaccines**.

Vaccines and their administration are reported using separate codes. The following CPT codes are for reporting the vaccines only:

- 90655 *Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use*
- 90656 *Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use*
- 90657 *Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use*
- 90658 *Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use*
- 90659 *Influenza virus vaccine, whole virus, for intramuscular or jet injection use (Discontinued December 31, 2003)*
- 90732 *Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use*
- 90740 *Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use*
- 90743 *Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use*
- 90744 *Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use*
- 90746 *Hepatitis B vaccine, adult dosage, for intramuscular use*
- 90747 *Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use*

The following HCPCS codes are for reporting administration of the vaccines only:

- G0008 Administration of influenza virus vaccine
- G0009 Administration of pneumococcal vaccine
- G0010 Administration of hepatitis B vaccine

One of the following diagnosis codes must be reported as appropriate. If the sole purpose for the visit is to receive a vaccine or if a vaccine is the only service billed on a claim, the applicable following diagnosis code may be used.

Diagnosis Code	Description
V03.82	PPV
V04.8	Influenza
V04.81	Influenza
V05.3	Hepatitis B



*Payment Guidelines for Vaccines... and their Administration at Renal Dialysis Facilities (continued)***Implementation**

The implementation date for this instruction is January 3, 2006

**Additional Information**

The revised portions of the Medicare Claims Processing Manual are attached to CR 3936, which is the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to:  
[http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 3936 in the CR NUM column on the right and click on the file for that CR. If you

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

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

Related Change Request (CR) Number: 3936  
Related CR Release Date: August 3, 2005  
Related CR Transmittal Number: 634  
Effective Date: January 1, 2006  
Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 634, CR 3936

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**New ICD-9-CM Code for Beneficiaries with Chronic Kidney Disease**

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

**Provider Types Affected**

Providers billing Medicare fiscal intermediaries (FIs) for services provided to beneficiaries with chronic kidney disease

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

This article is based on change request (CR) 4108, which announces that ICD-9-CM code 585 for chronic renal failure will no longer be acceptable without the fourth digit extension for claims with dates of service on or after October 1, 2005.

**CAUTION – What You Need to Know**

The ICD-9-CM diagnosis code 585 for chronic kidney disease has been extended to include a fourth digit to provide a higher degree of specificity in reporting the stage of kidney disease. The new ICD-CM codes are described in the table below:

**GO – What You Need to Do**

See the *Background* section of this article for further details regarding the new ICD-9-CM codes for Medicare beneficiaries with chronic kidney disease.

**Background**

Transmittal 591, change request 3888, issued on June 24, 2005, provided instructions for the annual update of the *International Classification of Diseases*, 9th Rev, Clinical Modification (ICD-9-CM) coding (effective on October 1, 2005).

This annual update extends the diagnosis code of 585 for chronic kidney disease to include a fourth digit for a higher degree of specificity in reporting the stage of kidney disease.

Renal dialysis facilities, hospitals, and providers should be aware that the ICD-9-CM code 585 for chronic renal failure will **no longer be acceptable without the fourth**

**digit extension** for claims with dates of service on or after October 1, 2005.

The new codes for chronic kidney disease are defined in below:

585.1	Chronic kidney disease, Stage I
585.2	Chronic kidney disease, Stage II (mild)
585.3	Chronic kidney disease, Stage III (moderate)
585.4	Chronic kidney disease, Stage IV (severe)
585.5	Chronic kidney disease, Stage V
585.6	End stage renal disease
585.9	Chronic kidney disease, unspecified

**Type of Bill (TOB) 72x**

Renal dialysis facilities (RDFs) submitting claims with TOB 72x should report **diagnosis code 585.6** (end stage renal disease).

**Note:** The first two digits of the TOB 72x indicate a claim for an ESRD facility, and the third digit identifies the frequency of the claim being submitted.

**Epoetin Alfa and Darbepoetin Alfa**

RDFs and hospitals billing for epoetin alfa (EPO) with Healthcare Common Procedure Coding System (HCPCS) code Q4055 and darbepoetin alfa (Aranesp<sup>®</sup>) with HCPCS code Q4054 must have **diagnosis code 585.6** (end stage renal disease).

Epoetin alfa (EPO), billed with HCPCS code Q0136, and darbepoetin alfa (Aranesp), billed with HCPCS code Q0137, are not appropriate for beneficiaries who have been diagnosed with end stage renal disease and, therefore, should not be billed in conjunction with the diagnosis code of 585.6 (end stage renal disease).

Also, please note the change to the codes being used for EPO and Aranesp, since some codes are being terminated and replaced with new codes as of January 1, 2006. Those changes, **effective January 1, 2006**, are as follows:

*New ICD-9-CM Code for Beneficiaries with Chronic Kidney Disease (continued)*

- Q0136 – Epoetin alfa for non-ESRD use is replaced with J0885.
- Q0137 – Darbepoetin alfa for non-ESRD use is replaced with J0881.
- Q4054 – Darbepoetin alfa for ESRD use is replaced with J0882.
- Q4055 – Epoetin alfa for ESRD use is replaced with J0886.

**Implementation**

The implementation date for the instruction is April 3, 2006.

**Additional Information**

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

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From that Web page, look for CR 4108 in the CR NUM column on the right, and click on the file for that CR. For the annual ICD-9-CM update, look for CR 3888.

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

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

Related Change Request (CR) Number: 4108  
 Related CR Release Date: October 31, 2005  
 Related CR Transmittal Number: 737  
 Effective Date: October 1, 2005  
 Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 737, CR 4108

**Temporary Hold of Claims with HCPCS Codes G0369 or G0370 Received on or after October 1, 2005**

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

**Provider Types Affected**

Maryland hospitals, other hospitals **not paid** under the outpatient prospective payment system (OPPS), and dialysis facilities billing Medicare fiscal intermediaries (FIs) for supplying fees with HCPCS codes of G0369 or G0370

**Provider Action Needed**

Affected providers are advised that the Centers for Medicare & Medicaid Services (CMS) has instructed FIs to suspend and hold the following claims:

- Claims from Maryland waiver hospitals with dates of service on and after January 1, 2005, containing HCPCS codes G0369 or G0370
- Claims from other non-OPPS hospitals and dialysis facilities with dates of service on and after January 1, 2005, containing HCPCS codes G0369 or G0370 in revenue codes **other than** 0636.

These claims are to be held until CMS can supply FIs with an October quarterly follow-up software release and the FIs have placed that software release in production. CMS has instructed the FIs to pay any applicable interest on

these held claims that will be due as a result of this delay in processing the claims. FIs are to permit claims that contain G0369 and/or G0370 in revenue code 0636, that are not subject to the Maryland hospital waiver, to process to payment.

**Release Date for Held Claims**

CMS expects the held claims to be released for processing on or about October 20, 2005.

**Additional Information**

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

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

Related Change Request (CR) Number: NA  
 Related CR Release Date: NA

Source: CMS Special Edition Medlearn Article SE0564

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# SKILLED NURSING FACILITY SERVICES

## Redesigned Skilled Nursing Facility Consolidated Billing Annual Update File and Discontinuation of the SNF HCPCS Help File

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

### Provider Types Affected

Providers billing intermediaries

### Provider Action Needed

#### STOP – Impact to You

This article is based on change request (CR) 4044, which notifies providers that the skilled nursing facility SNF HCPCS help file is discontinued. A new SNF CB website for providers billing intermediaries, including a new redesigned annual update file, is available on the CMS website at <http://www.cms.hhs.gov/providers/snfpps/snffi/>.

#### CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) has redesigned the SNF CB annual update file and created a new fiscal intermediary (FI) SNF CB Web page to enable an easier search for specific HCPCS codes, and determination of whether an HCPCS code is excluded from SNF CB.

#### GO – What You Need to Do

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

### Background

Change Request (CR) 4044 announced that CMS is discontinuing the SNF help file and is redirecting contractors and providers to a new FI SNF CB Web page, which provide more current and accurate information on SNF consolidated billing (CB).

**Note:** The SNF help file is not current and should not be used as a guide to determine whether services provided to Medicare beneficiaries are included or excluded from SNF CB.

With the removal of the SNF help file, CMS has redesigned the SNF CB annual update file in Excel® and PDF formats to enable providers to more easily:

- Search for a specific HCPCS code; and
- Determine if the HCPCS code is excluded from SNF CB.

### SNF Consolidated Billing Annual Update

Instead of accessing the SNF help file, providers should access the latest/redesigned SNF CB annual update to determine whether a service is excluded from SNF CB. The annual update may be found under the “2005 Annual and Quarterly Updates” section on the CMS website at <http://www.cms.hhs.gov/providers/snfpps/snffi/>.

This website contains information that may be used by providers and FIs to determine, by HCPCS code, whether

services rendered to beneficiaries in Part A covered SNF stays are included or excluded from CB. The file contains three columns:

- HCPCS Code
- Short Descriptor
- Major Category.

A separate file containing an explanation of the major categories will also be included. **It is important and necessary for providers to view this file** to understand the major categories (including additional exclusions) that are not driven by HCPCS codes.

In addition, providers may want to access the above CMS website to view the current file as well as previous updates to SNF CB. HCPCS codes (added or removed by subsequent quarterly update transmittals) will be listed under the respective year’s annual update tab at the above website, and the respective year’s annual update file will be updated to either add or remove the HCPCS listed in the quarterly updates.

### Implementation

The implementation date for the instruction is December 27, 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 the CMS website at [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

From that Web page, look for CR 4044 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 4044  
 Related CR Release Date: September 23, 2005  
 Related CR Transmittal Number: 685  
 Effective Date: December 27, 2005  
 Implementation Date: December 27, 2005

Source: CMS Pub. 100-4, Transmittal 685, CR 4044

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## 2006 Annual Update of Healthcare Common Procedure Coding System Codes for Skilled Nursing Facility Consolidated Billing

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

### Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and fiscal intermediaries for services supplied to Medicare patients in skilled nursing facilities SNFs

### Provider Action Needed

#### STOP – Impact to You

This article is based on change request (CR) 4086 regarding the annual update of HCPCS codes for SNF consolidated billing and how the updates affect edits in Medicare claims processing systems, especially the common working file (CWF).

#### CAUTION – What You Need to Know

CR 4086 provides updates to HCPCS codes that will be used to revise CWF edits to allow carriers and FIs to make appropriate payments in accordance with the policy for SNF consolidated billing that is detailed in Chapter 6 (Section 110.4.1) for carriers, and Chapter 6 (Section 20.6) for FIs.

#### GO – What You Need to Do

Physicians, suppliers, and providers should review the new coding files that will be posted on the CMS website.

### Background

#### The Common Working File (CWF)

Medicare claim processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a noncovered stay. These edits allow only those services excluded from consolidated billing to be separately paid by the carrier and/or FI.

**For physicians and providers billing carriers:** By the first week of December 2005, new code files will be posted on the CMS website at

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

**For those providers billing FIs:** By the first week of December 2005, new Excel and PDF files will be posted on

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the CMS website under the “2006 Annual and Quarterly Updates” section at

<http://www.cms.hhs.gov/providers/snfpps/snffi/>.

**Note:** It is important and necessary for the provider community billing the FIs to view the “General Explanation of the Major Categories” bullet located under each annual update bullet, at the <http://www.cms.hhs.gov/providers/snfpps/snffi/> link, to understand the major categories, including additional exclusions not driven by HCPCS codes.

### Implementation

The implementation date for the instruction is January 3, 2006.

### Additional Information

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

From that Web page, look for CR 4086 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 on the CMS website at

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

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

Related Change Request (CR) Number: 4086

Related CR Release Date: October 7, 2005

Related CR Transmittal Number: 696

Effective Date: January 1, 2006

Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 696, CR 4086

## January 1, 2006 Update to the Skilled Nursing Facility Prospective Payment System PRICER and Health Insurance Coding

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

### Provider Types Affected

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

### Provider Action Needed

#### STOP – Impact to You

This article is based on change request (CR) 3962, which provides 1) skilled nursing facility/swing bed (SNF/SB) payment rate updates and 2) health insurance prospective payment system (HIPPS) coding changes as a result of the refined case-mix system effective January 1, 2006.

#### CAUTION – What You Need to Know

The new HIPPS codes that will be added to the Medicare’s claims processing system result from the addition of nine new resource utilization group – III (RUG-III) categories implemented by the 2006 final rule for SNF and SB prospective payment system (PPS). CR 3962 is effective for claims with dates of service on or after January 1, 2006.

#### GO – What You Need to Do

See the Background section of this article for further details regarding these changes.

*January 1, 2006 Update to the SNF PPS PRICER and Health Insurance Coding (continued)*

**Background**

The Social Security Act (Section 1888(e)) requires annual updates to the PPS rates relating to Medicare payments and consolidated billing for SNFs, as amended by:

- The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), and
- The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).

In addition, CMS is refining the case-mix system effective January 1, 2006.

The SNF PPS *Final Rule* for fiscal year 2006 implemented **nine** new RUG-III categories that will be added effective for dates of service on or after January 1, 2006. Because of the addition of these nine new RUG-III groups, CR 3962 includes nine new health insurance prospective payment system (HIPPS) codes that are listed below:

HIPPS Code	Description
RUXxx	Rehabilitation, <b>Ultra High</b> , plus Extensive Services, High, ADL Index 16-18
RULxx	Rehabilitation, <b>Ultra High</b> , plus Extensive Services, Low, ADL Index 7-15
RVXxx	Rehabilitation, <b>Very High</b> , plus Extensive Services, High, ADL Index 16-18
RVLxx	Rehabilitation, <b>Very High</b> , plus Extensive Services, Low, ADL Index 7-15
RHXxx	Rehabilitation, <b>High</b> , plus Extensive Services, High, ADL Index 13-18
RHLxx	Rehabilitation, <b>High</b> , plus Extensive Services, Low, ADL Index 7-12
RMXxx	Rehabilitation, <b>Medium</b> , plus Extensive Services, High, ADL Index 15-18
RMLxx	Rehabilitation, <b>Medium</b> , plus Extensive Services, Low, ADL Index 7-14
RLXxx	Rehabilitation, <b>Low</b> , plus Extensive Services, ADL Index 7-18

These changes will be reflected in an updated SNF PPS PRICER, and the complete list of new HIPPS codes is included as an attachment to CR 3962.

**Note:** The HIPPS code has five digits that include the following two components:

- A three-digit classification code assigned to each RUG-III code, and
- A two-digit assessment indicator that specifies the type of Medicare-required assessment used to support billing.

CR 3962 also includes the following instructions:

- The case-mix system will be refined effective January 1, 2006; wage indices effective October 1, 2005, will continue to apply
- Medicare systems shall:
  - ♦ Apply the FY 2006 SNF PPS payment rates that are effective for dates of service on or after January 1, 2006 through September 30, 2006.
  - ♦ Discontinue temporary add-on payments, except for the add-on payment for residents with AIDS, with the implementation of the 53-Group RUG-III coding system.
  - ♦ Edit the following therapy HIPPS codes, billed under the 0022 revenue code with units greater than ten on types of bill 18x or 21x, to ensure that at least one therapy ancillary revenue code, either 042x, 043x, or 044x, is reported on the claim:
    - RHLxx, RHXxx, RLXxx, RMLxx, RMXxx, RVLxx and RVXxx
  - ♦ Edit the following therapy HIPPS codes, billed under the 0022 revenue code with units greater than ten on types of bill 18x or 21x, to ensure at least two different therapy ancillary revenue codes, either 042x and/or, 043x and/or, 044x, are reported on the claim:
    - RULxx, RUXxx.

**Implementation**

The implementation date for this instruction is January 3, 2006.

**Additional Information**

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

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

From that Web page, look for CR 3962 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: 3962  
 Related CR Release Date: July 29, 2005  
 Related CR Transmittal Number: 630  
 Effective Date: January 1, 2006  
 Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 630, CR 3962

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## Correction to Change Request 3949 to Add Type of Bill 23x

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

### Provider Types Affected

Skilled nursing facilities (SNFs) who use type of bill (TOB) 23x to bill Medicare Part B outpatient claims

### Provider Action Needed

#### STOP – Impact to You

This article is based on change request (CR) 4116 and corrects the billing instructions needed for full implementation of the expedited determinations process for discharges listed in CR3949. That article may be viewed on the CMS website at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3949.pdf>.

#### CAUTION – What You Need to Know

The expedited determinations process applies to TOB 23x, which was left off the list of TOBs in CR 3949. The system changes listed in CR 3949 **do apply** to TOB 23x.

#### GO – What You Need to Do

Please make your office staff aware of this billing information to ensure accurate claims processing.

### Background

As a result of Section 521 of the Benefits Improvement and Protection Act (BIPA), two change requests were published with preliminary instructions regarding the new expedited determinations process for discharges from the following: home health (HH) facilities, hospices, skilled nursing facilities (SNFs), and comprehensive outpatient rehabilitation facilities (CORFs), effective July 1, 2005. CRs 3903 and 3949 did not address whether the review process applied to TOB 23x, skilled nursing facility Part B outpatient claims.

Since the publication of CR 3949, the Centers for Medicare & Medicaid Services (CMS) has determined that 23x claims are subject to expedited reviews in certain

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circumstances. This decision is published on the CMS website as part of the questions and answers document about expedited determinations (see <http://www.cms.hhs.gov/medicare/bni>).

Also, this CR adds TOB 23x to the *Medicare Claims Processing Manual*, Section 150.3.3, created by CR 3949.

### Implementation

The implementation date for the instruction is January 3, 2006.

### Additional Information

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

On the above page, scroll down while referring to the CR NUM column on the right to find the links for CR4116. Click on the links to open and view the files for that CR.

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

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

Related Change Request (CR) Number: 4116

Related CR Transmittal Number: 712

Related CR Release Date: October 14, 2005

Effective Date: Applies to claims submitted on or after

January 3, 2006, with dates of service on or after July 1, 2005

Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 712, CR 4116

## Fiscal Year 2006 Update to the Skilled Nursing Facility Prospective Payment System PRICER

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

### Provider Types Affected

Skilled nursing facilities (SNFs) billing Medicare intermediaries

### Provider Action Needed

#### STOP – Impact to You

This article announces that fiscal year (FY) 2006 SNF payment rates will be effective on October 1, 2005.

#### CAUTION – What You Need to Know

Medicare systems will apply the FY 2006 SNF prospective payment system (PPS) payment rates that are effective for service dates beginning October 1, 2005 through December 31, 2005.

#### GO – What You Need to Do

See the Background section of this article to find out

further details regarding these changes.

### Background

Annual updates to the PPS rates are required by the Social Security Act, as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (the BBRA), and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), relating to Medicare payments and consolidated billing for SNFs.

The Centers for Medicare & Medicaid Services (CMS) published the SNF payment rates for FY 2005 (October 1, 2004 through September 30, 2005), in the *Federal Register* on July 30, 2004 (69 FR 45775), which may be reviewed at the following CMS website: [http://www.cms.hhs.gov/providerupdate/regs/cms1249cn\\_correction.pdf](http://www.cms.hhs.gov/providerupdate/regs/cms1249cn_correction.pdf).

*Fiscal Year 2006 Update to the Skilled Nursing Facility Prospective Payment System PRICER (continued)*

The statute mandates an update to the federal rates using the latest SNF full market basket. The update methodology is identical to that used in the previous year and it includes reimbursement for beneficiaries with AIDS (acquired immunization deficiency syndrome).

The SNF wage index notice will be effective on October 1, 2005, and the index will be published in the *Federal Register* before that date. Also, a transitional wage index will apply for FY 2006 based on the methodology described in the *Federal Register*.

**Note:** A market basket is a group of products or services in a specific market. Classic market-basket analysis treats the purchase of a number of items (for example, the contents of a shopping basket) as a single transaction. Input prices are the pure prices of inputs used by an SNF in providing services, and these include labor, capital, and materials (such as drugs). By definition, an input price reflects prices faced by the SNF in purchasing these inputs, whereas an output price reflects the prices faced by buyers of SNF services. CMS currently can measure input prices using the SNF input price index, or “market basket.” Medicare systems will apply the FY 2006 SNF PPS payment rates that are effective for service dates beginning October 1, 2005 through December 31, 2005.

You can learn more about the SNF PPS on the CMS website at <http://www.cms.hhs.gov/providers/snfpps/>.

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**Implementation**

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

**Additional Information**

Market basket definitions and general information may be found at the following CMS website: [http://www.cms.hhs.gov/statistics/market-basket/info.asp#\\_mbdef](http://www.cms.hhs.gov/statistics/market-basket/info.asp#_mbdef).

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

From that Web page, look for CR 3972 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your intermediary at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

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

Related Change Request (CR) Number: 3972

Related CR Release Date: August 5, 2005

Related CR Transmittal Number: 640

Effective Date: October 1, 2005

Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 640, CR 3972

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**Hurricane Katrina Waiver for Three-day Hospital Stay Requirements**

**B**ecause of the disruptions in hospital care resulting from Hurricane Katrina, hospitals serving disaster areas may need to discharge less critically ill beneficiaries to a skilled nursing facility (SNF) sooner than usual due to overcrowding. Because of the three-day hospital rule, such an early discharge would unfairly disadvantage beneficiaries who would, under normal circumstances, qualify for Medicare coverage of their SNF care. There may also be cases in which skilled care is needed, and there is no available hospital bed due to the disaster. Again, applying the three-day requirement could deny beneficiaries coverage to which they would have been entitled absent the disaster.

Therefore, the three -day prior hospital stay requirement will be waived for any Medicare beneficiary:

- evacuated from a nursing home in the emergency area
- discharged from a hospital (in the emergency or receiving locations) in order to provide care to more seriously ill patients

- who needs SNF care as a result of the emergency, regardless of whether that individual was in a hospital or nursing home prior to the hurricane.

You should follow the instructions shown below when submitting SNF claims for services furnished as a result of hurricane Katrina and its aftermath:

- The receiving provider must document in the medical record both the medical need for the SNF admission and how the admission was related to the crisis created by hurricane Katrina and its aftermath.
- For verification/tracking purposes, the receiving provider should indicate “Hurricane Katrina” in the remarks section of the bill.
- The receiving provider should use condition code 58, which will bypass the three-day stay requirement. The occurrence span code 70 and date need not be reported. ❖

Source: CMS Joint Signature Memorandum 05510, September 10, 2005

# HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

## Additional Guidelines Regarding HCPCS Codes G0297 and G0337

An article addressing correction to the termination date for HCPCS codes G0297 and G0337 was published in the Fourth Quarter 2005 *Medicare A Bulletin* (page 87). Since then, the Centers for Medicare & Medicaid Services (CMS) has provided fiscal intermediaries with new guidance affecting HCPCS code G0297.

### Background

Change Request 3871, Transmittal 572, issued June 1, 2005, stated that the following HCPCS codes would be terminated with an effective date of January 28, 2005. The termination date for these HCPCS codes as indicated in the July 2005 release of the outpatient prospective payment system (OPPS) outpatient code editor (OCE) was an error.

On July 7, 2005, CMS issued direction to pay claims containing HCPCS code G0297 and/or G0337 outside of the OCE until the October 2005 update to the OPPS OCE is implemented based on the following criteria:

- G0297, Insertion of single chamber pacing cardioverter defibrillator pulse generator  
This is a valid code that is recognized under the OPPS.
- G0337, Hospice evaluation and counseling services, pre-election.  
This is not paid under the OPPS, but may be payable when submitted to regional home health intermediaries by hospice providers.

As mandated by CMS, FIs had implemented a workaround to allow payment on claims that contain

HCPCS codes G0337 with dates of service **on or after January 28 2005**. Beginning with the successful implementation of the October 2005 OCE release, FIs will discontinue this workaround.

### Action Required by Providers Submitting Claims with HCPCS Code G0297

First Coast Service Options, Inc. (FCSO), your fiscal intermediary (FI), is currently holding claims with dates of service **on or after January 28, 2005**, that contain HCPCS code G0297.

If you have not previously submitted claims within this timeframe, you may submit the claim omitting the service indicated by HCPCS code G0297 to receive payment for the other provided services. After the October 2005 OPPS OCE update, scheduled for implementation on October 3, 2005, you can adjust the original claim and add the services for HCPCS code G0297. Please note that the timely filing requirements apply also to adjusted claims.

If you have submitted your claims with HCPCS code G0297 prior to this notification, your claims are being held in the fiscal intermediary shared system (FISS) in the status and location S/MJSMP until the October 2005 OPPS OCE update. After the implementation of the OPPS OCE update, the FI will release your claims for processing and the appropriate interest guideline will be applied accordingly. ❖

Source: CMS Joint Signature Memorandum 05443, August 1, 2005

## New Guidance Regarding Healthcare Common Procedure Coding System Code G0297

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

### Provider Types Affected

All providers billing outpatient services to Medicare fiscal intermediaries (FIs) that are paid under the outpatient prospective payment system (OPPS)

### Provider Action Needed

#### STOP – Impact to You

HCPCS codes **G0297**, insertion of single chamber pacing cardioverter defibrillator pulse generator, and **G0337**, hospice evaluation and counseling services, pre-election, were **incorrectly listed as terminated** January 28, 2005 in the July 2005 Release (V6.2) of the OPPS outpatient code editor (OCE).

#### CAUTION – What You Need to Know

**G0297** is a **valid code** recognized under outpatient prospective payment system (OPPS) outpatient code editor (OCE) edit 69.

**G0337** is not paid under OPPS but **may be payable**

**when submitted to regional home health intermediaries by hospice providers.**

### GO – What You Need to Do

Read the guidelines listed below regarding claims containing HCPCS codes G0297 and G0337.

### Background

On August 1, 2005 the Centers for Medicare & Medicaid Services (CMS) is providing new guidelines to Medicare FIs for paying HCPCS code G0297 and G0337. Those instructions roll back the edit published on June 1, 2005, Change Request (CR) 3871, Transmittal 572, which assigned OPPS OCE edit “69” (services provided outside the approval period) to the HCPCS codes G0297 and G0337 and listed them, incorrectly, as terminated on January 28, 2005.

On July 7, 2005 CMS issued direction to pay claims with the above HCPCS codes outside the OCE. The new



## *New Guidance Regarding Healthcare Common Procedure Coding System Code G0297 (continued)*

guidelines for HCPCS codes G0297 and G0337 are listed below.

### **HCPCS Code G0297**

- Providers should note that FIs will hold claims dated on or after January 28, 2005, containing this code until the October 2005 implementation of the OCE and then the FIs will process the claims for payment.
- If affected providers furnished additional services on the same claim with HCPCS code G0297, they may remove the charges for HCPCS code G0297 from the claim and submit for the remaining services.
- After October 2005 providers may submit an adjustment claim reflecting code G0297 in order to receive payment.
- Providers must be timely when filing for adjustment claims.

**Note:** After the successful implementation of the October 2005 OCE, FIs will release held claims for payment.

### **HCPCS Code G0337**

- Effective immediately, FIs must allow payment on all claims that contain HCPCS code G0337 beginning with dates of service of January 28, 2005 and later.

### **Additional Information**

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

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

Source: CMS Special Edition Medlearn Article SE0553

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## **October 2005 Outpatient Prospective Payment System Outpatient Code Editor Specifications—Version 6.3**

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

### **Provider Types Affected**

All providers billing outpatient services to Medicare fiscal intermediaries (FIs) that are paid under the outpatient prospective payment system (OPPS)

### **Provider Action Needed**

This article is based on change request (CR) 4007, which informs your FI that the July 2005 outpatient PPS outpatient code editor (OCE) specifications have been updated with new additions, deletions, and changes.

### **Background**

This article is based on information contained in CR 4007, which provides the revised OPPS OCE instructions and specifications that will be utilized, effective October 1, 2005, under the OPPS for hospital outpatient departments, community mental health centers (CMHCs), and for limited services as defined below when provided in a:

- Comprehensive outpatient rehabilitation facility (CORF);
- Home health agency (HHA) not under the home health prospective payment system; or to a
- Hospice patient for the treatment of a non-terminal illness.

Full details about version 6.3 of the OPPS OCE are contained in CR4007 and will not be repeated in this article, especially since many of the details are not changing, and providers paid under the OPPS are likely to be familiar with these details.

The modifications of the OCE for the October version of the revised OPPS OCE (Version 6.3) are summarized in

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Appendix L of CR 4007. Another key aspect of CR is Attachment B (Final Summary of Data Changes), which details all the revised APC/HCPCS/CPT changes and other changes.

### **Implementation**

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

### **Additional Information**

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

From that Web page, look for CR 4007 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 4007  
 Related CR Release Date: September 22, 2005  
 Related CR Transmittal Number: 683  
 Effective Date: October 1, 2005  
 Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 683, CR 4007

## Billing for Devices Under Hospital Outpatient Prospective Payment System

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

### Provider Types Affected

Providers billing services to Medicare Fiscal Intermediaries that are paid under the outpatient prospective payment system (OPPS)

### Provider Action Needed

#### STOP – Impact to You

This article is based on information from change request (CR) 4017 which revises language found in the *Medicare Claims Processing Manual, Pub 100-04, Chapter 4, Section 61*, entitled “Billing for Devices under the OPPS.” The changes delete incorrect and obsolete tables of device codes and outpatient code editor (OCE) edits and refer the reader to the Centers for Medicare & Medicaid Services (CMS) websites with correct tables of Healthcare Common Procedure Coding System (HCPCS) codes for devices and OCE edits that apply when procedures that require devices are billed under the OPPS.

#### CAUTION – What You Need to Know

To identify codes for devices that must be billed by hospitals for services paid under OPPS, see the CMS website at <http://www.cms.hhs.gov/medicare/HCPCS>.

To identify the device codes that must be reported *with* specific procedure codes for a claim to be accepted by OCE, use the CMS website at <http://www.cms.hhs.gov/providers/hopps>.

Send questions about the device code requirements on the CMS Website to [outpatientpps@CMS.hhs.gov](mailto:outpatientpps@CMS.hhs.gov).

#### GO – What You Need to Do

Please see the *Background* section of this article for further details.

### Background

Medicare intermediaries and providers subject to the OPPS are advised by CR 4017 to refer to CMS websites that contain the correct tables of HCPCS device codes and OCE edits that apply when procedures that require devices are billed under the OPPS. Under the OPPS, CMS bundles payment for an implantable device into the ambulatory payment classification (APC) groups for the procedure performed to insert the device.

Because the pass-through status of many device categories expired at the end of calendar year (CY) 2002, CMS discontinued the HCPCS C-codes that had been established to report pass-through devices in CY 2003.

However, CMS found that the claims used to set payment rates for APCs that require devices (“device-dependent” APCs) frequently have packaged costs that are much lower than the cost of the devices associated with the procedures. CMS attributes this anomalous cost data in part to variable hospital billing practices.

To improve the specificity of claims data, CMS reestablished device C-codes and encouraged hospitals (on a voluntary basis) to report device codes and charges on claims for services associated with devices in CY 2004.

For CY 2005, CMS required hospitals to report device C-codes for devices used in procedures on their claims if

appropriate device codes exist. The goal is to capture the costs of all devices utilized in procedures in the hospital claims data used to develop APC payment rates. Specifically with respect to device-dependent APCs paid under the OPPS, the objective is to base payment on single-bill claims data, without adjustment for erratic data.

On December 17, 2004, CR 3606 (transmittal 403) was issued, which announced that, effective April 1, 2005, CMS would edit for the presence of specified device codes when hospitals billed certain procedure codes under the OPPS.

**The following tables contained in CR 3606 (Transmittal 403) are incorrect and obsolete:**

- HCPCS Codes for Devices
- Procedure Code to Device Code Edits.

CR 4017 points out the CMS website locations that contain the correct and timely information. The website information will be updated as needed, and any changes will be effective on the calendar quarter.

#### Requirement that Hospitals Report Device Codes on Claims on Which They Report Specified Procedures

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

Current HCPCS codes for devices may be found on the CMS website at <http://www.cms.hhs.gov/medicare/HCPCS>.

#### Edits for Claims on Which Specified Procedures Are To Be Reported with Device Codes

The OCE will return to the provider any claim that:

- Reports an HCPCS code for a procedure listed in the table of device edits; and
- Does not also report at least one device HCPCS code required for that procedure.

The HCPCS codes for procedures listed in the table of device code edits may be found on the CMS website at <http://www.cms.hhs.gov/providers/hopps/>.

The table of device code edits shows the effective date for each edit. If the claim is returned to the provider for failure to pass the edits, the hospital will need to modify the claim by either correcting the procedure code or ensuring that one of the required device codes is on the claim before resubmission. While all devices that have device HCPCS codes (and that were used in a given procedure) should be reported on the claim, if more than one device code is listed (for a given procedure code), then only one of the possible device codes is required to be on the claim for payment to be made (unless otherwise specified).

Device edits do not apply to the specified procedure code if the provider reports one of the following modifiers with the procedure code:

## Billing for Devices Under Hospital Outpatient Prospective Payment System (continued)

### Modifier and Description

**52 Reduced Services** – Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician’s discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

**73 Discontinued outpatient procedure prior to anesthesia administration** – Due to extenuating circumstances or those that threaten the well being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient’s surgical preparation, including sedation when provided, and being taken to the room where the procedure is to be performed, but prior to the administration of anesthesia (local, regional block(s), or general).

**74 Discontinued outpatient procedure after anesthesia administration** – Due to extenuating circumstances or those that threaten the well being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc).

#### Where:

- A procedure that normally requires a device is interrupted (either before or after the administration of anesthesia if anesthesia is required or at any point if anesthesia is not required), **and**
- The device is not used, **then**

- Hospitals should report modifier 52, 73, or 74 (listed in previously) as applicable.

The device edits are not applied in these cases. Effective **October 1, 2005**, hospitals paid under the OPPTS (bill types 12x and 13x) must:

- Use the specific HCPCS codes for devices as shown on the CMS website on claims for procedures that use the devices; and
- Look to the CMS website for the OCE procedure code to device code edits that apply.

### Implementation

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

### Additional Information

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

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

From that Web page, look for CR 4017 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 4017

Related CR Release Date: August 26, 2005

Related CR Transmittal Number: 658

Effective Date: October 1, 2005

Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 658, CR 4017

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## Dateline Extension on Adjustments for Certain Surgical Procedure Claims

Instructions related to “July 2005 Update to the Hospital Outpatient Prospective Payment System” were published in the Fourth Quarter 2005 Medicare A Bulletin (pages 85-87). The section titled “Reprocessing of OPPTS Claims Containing Certain Surgical Procedures” notified providers that CMS had discovered an error in the 2005 OPPTS PRICER that miscalculated certain outlier payments. The error was corrected in the July 2005 version of the OPPTS PRICER and fiscal intermediaries were given a deadline of September 15, 2005, to complete all mass adjustments. The Centers for Medicare & Medicaid Services (CMS) has extended the September 15, 2005, deadline to **December 31, 2005**.

### No Action Required by Providers Regarding Mass Adjustments

As mandated by CMS, First Coast Service Option, Inc has been adjusting the affected claims that meet **all** of the

following criteria using the July 2005 OPPTS PRICER:

1. Claims processed using the January or April 2005 OPPTS PRICER that were processed to payment prior to the installation of the July 2005 OPPTS PRICER.
2. Claims with one or more surgical procedure lines (lines with a status indicator of “T” (any HCPCS) or “S” with HCPCS codes greater than 09999 and less than 70000) that contain no surgical procedure lines with charges less than \$1.01.
3. Claims with dates of service January 1, 2003, or greater.

This project is scheduled for completion by December 31, 2005. ❖

Source: CMS Joint Signature Memorandum 05480, August 19, 2005

## October 2005 Update of the Hospital Outpatient Prospective Payment System

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

### Provider Types Affected

Physicians billing Medicare fiscal intermediaries (FIs) or regional home health intermediaries (RHHIs) for Part B drugs, and providers billing Medicare FIs for services paid under the OPSS

### Provider Action Needed

#### STOP – Impact to You

This article is based on information contained in Change Request (CR) 4035, which describes changes to the OPSS to be implemented in the October 2005 OPSS update and changes to payment policy and billing procedures under the OPSS.

#### CAUTION – What You Need to Know

Unless otherwise noted, all changes addressed in CR 4035 are effective for services furnished on or after October 1, 2005.

#### GO – What You Need to Do

Please see the *Background* and *Additional Information* sections of this article for further details regarding the October 2005 OPSS update.

### Background

This article describes changes to the OPSS to be implemented in the October 2005 OPSS update. The October 2005 OPSS outpatient code editor (OCE) and OPSS PRICER will reflect additions, changes, and deletions to the following:

- The Healthcare Common Procedure Coding System (HCPCS)
- Ambulatory payment classification (APC)
- HCPCS modifiers
- Revenue codes.

Key OPSS changes for October 2005 (unless another date is specified) are described below.

**Note:** October 2005 revisions to the OPSS OCE data files, instructions, and specifications are provided in CR 4007, “October 2005 Outpatient Prospective Payment System Code Editor (OPSS OCE) Specifications Version 6.3”. A Medlearn Matters article (MM4007) addressing those changes is available on the CMS website at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM4007.pdf>.

#### 1. Expansion of the Device Dependent Edits

The Centers for Medicare & Medicaid Services (CMS) implemented the first phase of device edits in the OCE, effective April 1, 2005. These edits return claims for services to providers when:

- There is an HCPCS code for the device.
- The provider failed to include a code for a major device necessary to perform the procedure.

CMS is expanding device edits to apply to more procedure codes for which the use of a device is essential to the performance of the procedure (effective October 1, 2005).

See CR 4017, “Billing for Devices Under the Hospital Outpatient Prospective Payment System (OPSS),” on the CMS website at [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp).

At that page, look for CR 4017 in the CR NUM field on the right. Device edits may be found on the CMS website at <http://www.cms.hhs.gov/providers/hopps/default.asp>.

They have been posted and open to public comment since the issuance of the 2005 OPSS final rule on November 1, 2004, and CMS incorporated many of the comments received into the device edits for implementation on October 1, 2005.

Please note that there are some HCPCS codes for procedures that require a device but for which there are no device edits. This is *not* an oversight. In some cases:

- The device codes that exist do not describe all possible devices that could be used in the procedure. Therefore, an edit could return a claim that properly coded the procedure, *but* omitted the device *because* there is not an appropriate code for the device that was used.
- The procedure is not on the list of procedures that have received adjusted payment and special scrutiny in the past. Therefore, no device editing is being applied at this time.

CMS may expand the device edits in the future. Comments or questions about the content of the edits should be directed to [Outpatientpps@cms.hhs.gov](mailto:Outpatientpps@cms.hhs.gov). The person making the comment should:

- Identify the writer and the HCPCS code involved.
- Include the rationale for why the person believes that the edit of concern should be revised.

Claim-specific questions should be directed to your fiscal intermediary.

**2. No Cost Device Billing Clarification**

In CR3915 (Transmittal 585, dated June 17, 2005), CMS provided directions for reporting devices for which the hospital incurs no cost. That CR stated that if hospitals paid under the OPSS surgically implant a device furnished at no cost to the hospital, the hospital must:

- Report a charge of zero for the device; or
- Submit a token charge (e.g. \$1.00) on the line with the device code if the hospital’s billing system requires that a charge be entered.

However, since the Fiscal Intermediary Standard System (FISS) will only accept a zero for lines reflecting a surgical procedure, hospitals should submit a token charge (e.g., \$1.00) on the line with the device code and **not report a zero charge as previously stated in CR3915.**

**3. New Service**

The following new service is assigned for payment under the OPSS:

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment	Minimum Adjusted Copayment
C9725	10/01/05	S	1507	Place endorectal app	Placement of endorectal intracavity applicator for high intensity brachytherapy	\$550.00	\$110.00

**4. Payment for New Brachytherapy Sources**

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 621(b)) 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, dated March 30, 2004) provided instructions regarding the change to billing and payment for brachytherapy sources and identified the applicable codes that became effective for this payment as of January 1, 2004. CR3154 can be found on the CMS website at: [http://www.cms.hhs.gov/manuals/pm\\_trans/R132CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R132CP.pdf).

The following table lists one new code that may be reported for payment as a brachytherapy source under the OPSS:

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor
C2637	10/01/05	H	2637	Brachytx, Ytterbium – 169	Brachytherapy source, Ytterbium-169, per source

**5. Drugs and Biologicals**

**a. Drugs with Payments Based on Average Sales Price (ASP) Effective October 1, 2005**

The table below lists the drugs and biologicals whose payments under the OPSS will be established in accordance with the average sales price (ASP) methodology that is used to calculate payment for drugs and biologicals in the physician office setting. In the 2005 OPSS final rule (*Federal Register*, Volume 9, Number 219, page 65777 (69 FR 65777)), it was stated that payments for drugs and biologicals based on ASP will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary, CMS will:

- Incorporate changes to the payment rates in the appropriate quarterly release of the OPSS PRICER.
- Not publish the updated payment rates in the program instructions implementing the associated quarterly update of the OPSS.

However, the updated payment rates will be available in the October 2005 update of OPSS Addendum A and Addendum

B. These may be found on the CMS website at <http://www.cms.hhs.gov/providers/hopps/>.

Single-indication orphan drugs payable under OPSS are also listed below. The methodology used to establish payment rates for these drugs is discussed in the 2005 OPSS final rule, published in the *Federal Register* (Volume 69, Number 219, page 65807 (69 FR 65807)) on November 15, 2004. It can be reviewed on the CMS website at <http://www.cms.hhs.gov/providers/hopps/2005fc/1427fc.asp>.

**HCPCS APC Long Description**

C9123	9123	Human fibroblast derived temporary skin substitute, per 247 square centimeters
C9127	9127	Injection, paclitaxel protein-bound particles, per 1 mg
C9128	9128	Injection, pegaptamib sodium, per 0.3 mg
C9129	9129	Injection, Clofarabine, per 1 mg
C9203	9203	Injection, Perflexane lipid microspheres, per single use vial
C9205	9205	Injection, Oxaliplatin, per 5 mg
C9206	9206	Collagen-glycosaminoglycan bilayer matrix, per cm2

# OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

C9211	9211	Injection, Alefacept, for intravenous use per 7.5 mg
C9212	9212	Injection , Alefacept, for intramuscular use per 7.5 mg
C9218	9218	Injection, azacitidine, 1 mg
C9220	9220	Sodium hyaluronate per 30 mg dose, for intra-articular injection
C9221	9221	Acellular dermal tissue matrix, per 16cm <sup>2</sup>
C9222	9222	Decellularized soft tissue scaffold, per 1 cc
C9224	9224	Injection, Galsulfase, per 5 mg
C9225	9225	Injection, Fluocinolone acetonide intravitreal implant, per 0.59 mg
C9226	9226	Injection, Ziconotide for intrathecal infusion, per 5 mcg
J0128	9216	Abarelix for injectable suspension, per 10 mg
J0135	1083	Injection, adalimumab, 20 mg
J0180	9208	Injection, IV, Agalsidase beta, per 1 mg
J0205	900	Injection, Alglucerase, per 10 units
J0256	901	Alpha 1 proteinase inhibitor-human, 10 mg
J0595	703	Injection, Butorphanol tartrate 1 mg
J0878	9124	Injection, daptomycin per 1 mg
J1457	1085	Injection, gallium nitrate, 1 mg
J1785	916	Injection imiglucerase, per unit
J1931	9209	Injection, laronidase, 0.1 mg
J2185	729	Injection, meropenem, 100 mg
J2280	1046	Injection, moxifloxacin 100 mg
J2355	7011	Oprelvekin injection, 5 mg
J2357	9300	Injection, omalizumab, per 5 mg
J2469	9210	Injection, palonosetron HCl, 25 mcg
J2783	738	Injection, rasburicase, 0.5 mg
J2794	9125	Injection, risperidone, long acting, 0.5 mg
J3240	9108	Injection Thyrotropin Alpha , 0.9 mg, provided in 1.1 mg vial
J3411	1049	Injection, Thiamine HCL 100 mg
J3415	1050	Injection, Pyridoxine HCL 100 mg
J3465	1052	Injection, voriconazole, 10 mg
J3486	9204	Injection, Ziprasidone mesylate, per 10 mg
J7308	7308	Aminolevulinic acid HCL for topical administration, 20%, single unit dosage form (354mg)
J7513	1612	Daclizumab, parenteral, 25 mg
J7518	9219	Mycophenolic acid, oral, per 180 mg
J7674	867	Methacholine chloride administered as inhalation solution through a nebulizer, per 1mg
J8501	868	Aprepitant, oral, 5 mg
J9010	9110	Alemtuzumab, 10 mg
J9015	807	Aldesleukin, per single use vial
J9017	9012	Arsenic trioxide, 1 mg
J9035	9214	Injection, Bevacizumab, per 10 mg
J9041	9207	Injection, Bortezomib, 0.1 mg
J9055	9215	Injection, Cetuximab, per 10 mg
J9160	1084	Denileukin diftitox, 300 mcg
J9216	838	Interferon gamma 1-b, 3 million units
J9300	9004	Gemtuzumab ozogamicin, 5 mg
J9305	9213	Injection, Pemetrexed, per 10 mg
Q2019	1615	Injection, Basiliximab, 20 mg
Q4075	1062	Injection, Acyclovir, 5 mg
Q4076	1070	Injection, Dopamine HCL, 40 mg
Q4077	1082	Injection, Treprostinil, 1 mg
Q4079	9126	Injection, Natalizumab, per 1 mg

## b. Updated Payment Rates for Certain Drugs and Biologicals, Effective July 1, 2005, through September 30, 2005

The payment rates for the drugs and biologicals listed in the following table were **incorrect** in the July 2005 OPSS PRICER. The corrected payment rates will be installed in the October 2005 OPSS PRICER, effective for services furnished on July 1, 2005, through implementation of the October 2005 update. The FISS maintainer will mass-adjust claims that were processed incorrectly as a result of the incorrect rates in the July PRICER.

HCPCS	APC	Short Description	Corrected Payment Rate	Corrected Minimum Adjusted Copayment
C9129	9129	Inj clofarabine	\$29.21	\$5.84
C9211	9211	Inj, alefacept, IV	\$593.60	\$118.72
J0595	0703	Butorphanol tartrate 1 mg	\$0.94	\$0.19
Q4075	1062	Acyclovir, 5 mg	\$0.03	\$0.01

**c. Newly Approved Drugs and Biologicals Eligible for Pass-Through Status**

The following drugs and biologicals have been designated as eligible for pass-through status under the OPPTS, effective October 1, 2005. Payment rates for these items will be available in the October 2005 update of OPPTS Addendum A and Addendum B on the CMS website at <http://www.cms.hhs.gov/providers/hopps/>.

HCPCS	APC	SI	Long Description
C9225	9225	G	Injection, fluocinolone acetonide intravitreal implant, per 0.59 mg
C9226	9226	G	Injection, ziconotide for intrathecal infusion, per 5 mcg

**d. Payment for Drugs and Biologicals Recently Approved by the FDA**

CR3287 (Transmittal 188, dated May 28, 2004) explains how hospitals may report new drugs and biologicals after the Food and Drug Administration (FDA) approval but before assignment of product specific HCPCS codes. CR3287 can be found on the CMS website at [http://www.cms.hhs.gov/manuals/pm\\_trans/R188CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R188CP.pdf).

Beginning in 2004, the MMA required that payment for new drugs and biologicals (after FDA approval but before assignment of product-specific HCPCS codes) be equal to 95 percent of average wholesale price (AWP). CMS is assigning the following product-specific HCPCS code for billing a biological that was approved by the FDA on May 31, 2005. The payment rate for this item can be found in the October 2005 update of OPPTS Addendum A and Addendum B on the CMS website.

HCPCS	SI	APC	Short Descriptor	Long Descriptor	Effective Date
C9224	K	9224	Injection, galsulfase	Injection, galsulfase, per 5 mg	5/31/2005

Hospitals should bill for this biological using the following codes:

- **HCPCS code C9399** (Unclassified drug or biological) for claims submitted prior to successful implementation of the October 2005 OPPTS OCE (in accordance with CR 3287, Transmittal 188, dated May 28, 2004).
- **HCPCS code C9224** for claims submitted on or after implementation of the October 2005 OPPTS OCE. Note that claims submitted with C9399 after October 3, 2005, will be returned to the provider.

**e. Change in the Effective Date of HCPCS Code J8501 (Aprepitant, oral, 5 mg)**

CMS stated in the July 2005 update of the OPPTS that *pass-through status* for HCPCS code J8501 (aprepitant, oral, 5mg) was approved effective April 6, 2005. However, a national coverage decision (NCD) announced that oral aprepitant (HCPCS code J8501) had an effective date of **April 4, 2005**.

Therefore, in CR 4035, CMS changes the pass-through status for J8501 (aprepitant, oral, 5mg) to an effective date of **April 4, 2005**.

CMS further instructs in CR 4035 that on or after the implementation of the October 2005 OPPTS OCE, your Medicare intermediary will mass-adjust claims containing HCPCS code J8501 with date of service April 4, 2005, or April 5, 2005, processed prior to installment of the October 2005 OPPTS PRICER.

**6. Coverage Determinations**

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

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

**Implementation**

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

**Additional Information**

Hospital outpatient prospective payment system-related information may be found on the CMS website at <http://www.cms.hhs.gov/providers/hopps/default.asp>.

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

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

From that Web page, look for CR 4035 in the CR NUM column on the right, and click on the file for that CR.

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

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

Related Change Request (CR) Number: 4035  
 Related CR Release Date: September 30, 2005  
 Related CR Transmittal Number: 691  
 Effective Date: October 1, 2005  
 Implementation Date: October 3, 2005

Source: CMS Pub. 100-4, Transmittal 691, CR 4035

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# **PROVIDER AUDIT ISSUES**

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## **New Versions of the Intern and Resident Information System Software Available**

The Office of Financial Management will post two IRIS programs (version 3.1 of IRISV3 and version 1.1 of IRISEDV3) on the CMS website during September 2005 for downloading by Medicare providers.

The Web page address for downloading these programs is: <http://www.cms.hhs.gov/providers/IRIS>. ❖

Source: CMS Joint Signature Memorandum 05529, September 19, 2005

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## **HIGLAS Federal Holidays for 2005 and 2006**

On September 6, 2005, First Coast Service Options, Inc. (FCSO) transitioned to the Healthcare Integrated General Ledger Accounting System (HIGLAS). As a result of this change, FCSO will no longer issue payments or execute the financial payment cycle on federal holidays.

Monday, October 10, 2005 was a federal holiday (Columbus Day) and therefore, a financial payment cycle was not generated. Payments that would have otherwise been generated on Monday October 10, 2005, were processed in Wednesday's financial cycle. Friday's financial cycle contained normal volumes.

**Note:** The financial cycle generated on Friday, October 7, 2005, produced payments and remittance advices that were dated Wednesday, October 12, 2005. This is a one-day variance in payment and is the result of the Monday holiday.

Below is a list of the remaining 2005 and upcoming 2006 federal holidays:

### **2005 Federal Holidays**

Friday, November 11	Veterans Day
Thursday, November 24	Thanksgiving Day
Monday, December 26	Christmas Day

### **2006 Federal Holidays**

Monday, January 2	New Year's Day
Monday, January 16	Martin Luther King, Jr.'s Birthday
Monday, February 20	Washington's Birthday
Monday, May 29	Memorial Day
Tuesday, July 4	Independence Day
Monday, September 4	Labor Day
Monday, October 9	Columbus Day
Friday, November 10	Veterans Day
Thursday, November 23	Thanksgiving Day
Monday, December 25	Christmas Day ❖



# THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

## Medicare Announces End of HIPAA Contingency Plan for Claim Submissions

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

### Provider Types Affected

All Medicare physicians, providers, and suppliers who continue to submit electronic claims in non-compliant HIPAA formats

### Impact on Providers STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is ending its contingency plan that allowed providers to submit claims formats electronically that were not in the format required by the Health Insurance Portability and Accountability Act (HIPAA). As of October 1, 2005, all providers must use the HIPAA compliant format for claims submitted to Medicare. **In June 2005, over 99 percent of claims submitted to Medicare were in HIPAA compliant formats.**

### CAUTION – What You Need to Know

Non-compliant claims submitted to Medicare **on or after October 1, 2005**, will be rejected and returned to the provider.

### GO – What You Need to Do

To assure that your claims are processed timely and that your cash flow is not interrupted, be sure to submit HIPAA compliant claims as of October 1, 2005.

### Background

The Health Insurance Portability and Accountability Act (HIPAA) regulation required claims be submitted electronically effective October 16, 2003, in a format adopted for national use. To allow additional time for entities to become compliant, CMS established a contingency plan to continue Medicare fee-for-service (FFS) payments beyond October 16, 2003 based on non-compliant formats.

In a measured step toward full compliance, CMS announced that effective July 1, 2004, non-compliant electronic claims would be paid after 27 days (the same as paper claims). Further information on the contingency plan may be found in Medlearn Matters articles MM2981 and SE0414 at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM2981.pdf> and <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0414.pdf> respectively.

These articles also provided important information to assist those few remaining providers who need to begin sending HIPAA compliant claims.

Through provider outreach activities, CMS has seen a steady decrease in the number of non-HIPAA compliant

providers. In June 2005, fewer than **four percent** of Medicare FFS billing providers submitted electronic non-HIPAA compliant claims.

Considering the number of all active Medicare providers, it is clear that the Medicare provider community at large has done an outstanding job of adopting the HIPAA claims formats.

CMS believes that the industry has surpassed critical mass in both the total number of compliant claims and number of providers capable of sending compliant claims. Therefore, Medicare will end its HIPAA contingency plan for claims submission on October 1, 2005.

Claims that are not compliant as of October 1, 2005 will be returned to the provider for submission as a compliant claim. But, prior to October 1, 2005, if you are not submitting HIPAA compliant claims your Medicare carrier, durable medical equipment regional carrier (DMERC), or intermediary will contact you directly regarding the need to become compliant to offer further assistance.

CMS expects to end the contingency plan for other transactions in the near future. The remittance advice (835) is our next target to end the full contingency. We will continue to monitor progress toward use of the HIPAA standards to guide in that decision.

### Additional Information

As previously mentioned, further information on the contingency plan and on help in becoming compliant may be found in Medlearn Matters articles MM2981 and SE0414 at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM2981.pdf>

and

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0414.pdf> respectively.

As Medlearn Matters article MM2981 indicates Medicare carriers and intermediaries can provide free/low cost software that will enable submission of HIPAA compliant claims electronically. If you need such software, contact your carrier or intermediary at their special EDI telephone number. Your carrier/intermediary will also have a list of vendors who may assist you in submitting compliant claims. For those billing Medicare Part A (including hospital outpatient services), a list of these carrier/intermediary numbers by state is available at:

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

For those billing Medicare Part B, you may find those numbers listed by State at:

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

## Medicare Announces End of HIPAA Contingency Plan for Claims Submissions (continued)

For additional information on HIPAA, visit the CMS Web site at: <http://www.cms.hhs.gov/hipaa/hipaa2/default.asp>.

To view the revised manual chapter for the claims receipt rules, see Chapter 1, Section 80.2.1.2, which can be found in Pub 100-04, the Medicare Claims Processing Manual. This may be found at: [http://www.cms.hhs.gov/manuals/104\\_claims/clm104index.asp](http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp).

Related Change Request (CR) Number: 3956

Related CR Release Date: August 4, 2005

Related CR Transmittal Number: 171

Effective Date: October 1, 2005

Implementation Date: October 3, 2005

Source: CMS Pub. 100-20, Transmittal 171, CR 3956

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## Mandatory Electronic Submission of Medicare Claims Questions & Answers

### 1Q. Must I submit Medicare claims electronically?

1A. Yes. All initial claims for reimbursement under Medicare must be submitted electronically, with limited exceptions.

### 2Q. When must I begin submitting Medicare claims electronically?

2A. The Administrative Simplification Compliance Act (ASCA) provision was effective for initial claims submitted on or after October 16, 2003. Submission of a paper claim constitutes an attestation by the provider that at least one of the paper claim exception criteria apply at the time of submission.

### 3Q. What are the exceptions to the electronic claim submission requirement?

- 3A. The electronic claim submission exceptions include:
1. Intermediary small providers – To qualify, a provider required to submit claims to Medicare must have fewer than 25 full-time equivalent employees (FTEs). Carrier small providers – To qualify, a physician, practitioner, or supplier that bills Medicare must have fewer than ten FTEs.
  2. Dentists.
  3. Participants in a Medicare demonstration project when paper claim filing is required by that demonstration project due to the inability of the applicable implementation guide adopted under HIPAA to report data essential for the demonstration
  4. Providers that conduct mass inoculations, such as flu injections, that may be permitted to submit paper roster bills and who do not have a contract in place for submission of claims for more than one state to a single Medicare contractor that commits them to electronic submission of flu shot claims.
  5. Providers that submit claims when more than one other payer is responsible for payment prior to Medicare payment.
  6. Providers that only furnish services outside of the United States.

7. Providers experiencing a disruption in their electricity and communication connection that is outside of their control.

8. Providers that can establish that an “unusual circumstance” exists that preclude submission of claims electronically.

### 4Q. Who determines if a provider meets the electronic claim submission exception criteria?

4A. Providers are to **self-assess** to determine if they meet the exception criteria. If the provider determines he/she meets an exception that qualifies for submission of paper claims, no further action is needed at that time. If a provider is selected for enforcement review, the provider will receive a ‘Review of Paper Claims Submission Practices’ letter and will need to follow the instructions in that letter.

### 5Q. What is considered an “unusual circumstance”?

5A. The Centers for Medicare & Medicaid Services (CMS) interprets an “unusual circumstance” to be a temporary or long-term situation outside of a provider’s control that precludes submission of claims electronically and therefore, it would be against equity and good conscience for CMS to require claims affected by the circumstance to be submitted electronically. Examples of “unusual circumstances” include:

- a. Limited temporary situations when a Medicare contractor’s claim system would reject a particular type of electronically submitted claim, pending system modifications (individual Medicare claims processing contractors notify their providers of these situations if they apply).
- b. Providers that submit fewer than 10 claims a month to a Medicare contractor on average.
- c. Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims
- d. Entities that can demonstrate that information necessary for adjudication of a Medicare claim, other than a medical record or other claim

*Mandatory Electronic Submission of Medicare Claims Questions & Answers (continued)*

attachment, cannot be submitted electronically using the claims formats adopted under the Health Insurance Portability and Accountability Act (HIPAA).

- e. Other circumstances documented by a provider, generally in rare cases, where a provider can establish that, due to conditions outside of the provider's control, it would be against equity and good conscience for CMS to enforce the electronic claim submission requirement.

**6Q. Can I request a waiver of the electronic claim submission requirement?**

**6A.** A provider may submit a waiver request if an "unusual circumstance" applies under c, d, or e above. Such requests are subject to Medicare contractor and CMS approval. If provider self-assessment indicates that an exception condition, other than c, d, or e is met, the provider is automatically waived from the electronic claim submission requirement for either the indicated claim type or the period when an "unusual circumstance" exists.

**7Q. Where do I submit an "unusual circumstance" waiver?**

**7A.** "Unusual Circumstance" waiver requests related to condition c, d, or e above should be submitted to:

Attention: ASCA Waiver  
 Medicare EDI  
 P.O. Box 44071  
 Jacksonville, FL 32231-44071

Be sure to include documentation appropriate to establish the validity of the waiver request. A waiver request should include the organizational name of the provider, address, contact person, the reason for the waiver, and why the provider considers enforcement of the electronic billing requirement to be against equity and good conscience.

**8Q. Can I submit an "unusual circumstance" waiver to CMS?**

**8A.** No. Providers are not to submit such requests directly to CMS. CMS has directed Medicare

contractors to review such requests and if they agree the waiver request has merit, they will forward it to CMS with an explanation as to why contractor staff recommends CMS approval of the waiver request. If the contractor does not consider an "unusual circumstance" to be met, they will issue a "denial of an unusual circumstance waiver request" letter".

**9Q. How do I submit a claim that for adjudication purposes requires a medical record or other claim attachment?**

**9A.** Submit the initial claim electronically. If documentation is required, a development letter request will be sent to you requesting the needed documentation. Remember, the existence of an attachment is not an approved exception to the ASCA requirement for electronic submission of claims.

**10Q. What if I do not have software to submit claims electronically?**

**10A.** You have a number of alternatives to consider for electronic submission of your claims to Medicare. This office can supply you with HIPAA-compliant free billing software for submission of Medicare claims. Information regarding this free billing software, PC-ACE Pro32®, and the necessary forms to obtain the software can be found on our website at: <http://www.fcso.com/customers/providers.shtml>.

There is also commercial billing software, billing agent, and clearinghouse services available on the open market that often include services other than Medicare billing and may better meet your needs. A list of HIPAA vendors, as well as information to assist providers in choosing a software vendor, is available in the EDI section of our website at: <http://www.floridamedicare.com>.

If you have questions about electronic claim submission, you may contact us at (904) 791-8767, option 1.

Source: CMS Pub. 100-4, Transmittal 615, CR 3875  
 CMS Joint Signature Memorandum 05455,  
 August 9, 2005

**National Provider Identification Submission Instructions for Medicare Part A Electronic Transactions**

Effective January 1, 2006, First Coast Service Options will begin acceptance of the National Provider Identification (NPI) when submitted on an ASC X12N ANSI 837 or 276 version 4010A1 if the Medicare legacy provider number (for the same provider) is also present.

**Background**

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required issuance of a unique National Provider Identifier (NPI) to each physician, supplier and other provider of health care. CMS began to accept applications for NPI's via Internet and by mail on May 23, 2005. A number of articles have been issued in recent months to educate and remind physicians, suppliers and other provid-

ers on the NPI and the application process. If you have not applied for an NPI, you may do so via the Internet at <https://nppes.cms.hhs.gov>.

One of the articles indicated that providers should not begin to submit their NPIs on claims or other health care transactions until notified by particular payers that they have completed system changes as needed to eliminate the possibility that transactions with NPIs could be rejected. Medicare, as well as other health benefit payers, needs to make system changes to accept and process transactions using the NPI in lieu of those identifiers previously used to identify providers. Those prior identifiers are frequently referred to as "legacy identifiers."

## National Provider Identification Submission Instructions for Medicare Part A Electronic Transactions (continued)

### Impacts

The following requirements must be met if you choose to submit an NPI beginning January 1, 2006 on either the ASC X12N ANSI 837 (electronic claim) or the ASC X12N ANSI 276 transaction (claim status).

Please note: When submitting an NPI in either the ASC X12N ANSI 837 or the 276 transaction, the provider's legacy number (Medicare provider number) must be submitted for the same provider in the same loop or else the transaction will be rejected.

### X12 837 Version 4010A1 NPI Edits

- The NPI may be submitted on the X12 837 version 4010A1 claim in the following provider loops: 2010AA, 2010AB, 2310A, B, C, or E, or 2420A, B or C.
- When submitting an NPI, the NM108 must contain the XX qualifier and the NM109 of that same segment must contain a 10-byte numeric identifier (containing no special or alpha characters).
- When the NPI is submitted in either the billing loop (2010AA) or pay-to-provider loop (2010AB), two REF segments must be submitted. One to indicate the legacy provider identifier and one to indicate the Employee Identification Number (EIN.)
  - ♦ When submitting the legacy provider number, the REF01 must contain the 1C qualifier and the REF02 must contain the legacy provider identifier.
  - ♦ When indicating the EIN, the REF01 must contain the E1 qualifier and the REF02 must contain the EIN.
- If the NPI is submitted in any loops other than 2010AA or 2010AB, then only one REF segment is required for the reporting of the legacy provider identifier.
  - ♦ REF01 must contain either the 1C or the 1G qualifier (when the provider is a physician and depending on the loop) and the REF02 must contain the legacy provider identifier.

Any 837-version 4010A1 claim submitted on or after January 1, 2006 not meeting the above specified requirements will be rejected by the standard system.

### X12 276 Version 4010A1 NPI Edits

- The NPI must be submitted on the X12 276 version 4010A1 claim status request in the 2100C loop.
- When submitting an NPI, the 276 must contain two iterations of the 2100C loop. One each to house the NPI and one to house the Medicare legacy number (Medicare provider number).
  - ♦ Within the first 2100C loop, NM108 must contain the XX qualifier and the NM109 of that same segment must contain a 10-byte numeric identifier (containing no special or alpha characters).
  - ♦ Within the second 2100C loop, NM108 must contain the SV qualifier and NM109 must contain the Medicare legacy number.
- Both the NPI and the provider legacy identifier submitted in a 276 version 4010A1 claim status request transaction will be reported back on the 277 version 4010A1 response transaction.

Any 276 version 4010A1 claim status request submitted on or after January 1, 2006 not meeting the above specified requirements will be rejected. Additionally, if a 276 is submitted with more than two iterations of the 2100C loop, or entry of the same qualifier (XX, SV or FI) more than once in NM108 of the 2100C loop iterations, it will be rejected by the standard system.

If you have additional questions please contact Medicare Part A EDI at 1-904-791-8131, option 2. Office hours are 8:00 a. m. to 4:30 p.m. Monday through Thursday and 12:30 p.m. to 4:30 p.m. on Friday. ❖

Source: CMS Pub. 100-20, Transmittal 180, CR 4004

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## Clarification on Termination of the Incoming Claim Health Insurance Portability and Accountability Act Contingency Plan

The Centers for Medicare & Medicaid Services (CMS) has received a number of inquiries about the impact of termination of the contingency plan for incoming claims on October 1, 2005, on submission of Medicare Secondary Payer (MSP) claims. The Health Insurance Portability and Accountability Act (HIPAA) is furnishing the following information to clarify the Medicare requirements for submission of compliant MSP claims as required.

On August 4, 2005, CMS announced that the HIPAA contingency period for claims sent to Medicare would end on October 1, 2005. This termination does not apply to claims that Medicare sends outbound to other payers that have signed a coordination of benefits (COB) trading partner agreement for the transfer of claims by Medicare. It does apply to claims sent to Medicare for secondary payment following processing by a primary payer, however. Therefore, effective October 1, 2005, electronic MSP claims must comply with all X12 837 version 4010A1 implementation guide requirements, and include standard claim adjustment

reason (CAS) codes to describe adjustments that a primary payer made during adjudication, or they will be rejected.

CMS is aware of provider concerns that primary payers frequently send paper explanations of benefits or 835 transactions that contain local messages or codes rather than standard CAS codes. HIPAA does not require that standard CAS codes be reported in paper explanations of benefits, and payers that still have an X12 835 HIPAA contingency plan in effect may not yet be able to report standard CAS codes. HIPAA does require health care benefit payers to send providers X12 835 version 4010A1 transactions if requested by providers, and those 835 transactions must contain standard CAS codes by the end of each payer's 835 contingency period.

CMS is working with the HIPAA standards committee that maintains the CAS codes to develop a simplified means to translate non-standard messages and codes into standard CAS codes. We expect this process to be approved and implemented quickly. However, until an alternate solution is

**Clarification on Termination of the Incoming Claim HIPAA Contingency Plan (continued)**

approved for use, electronic MSP claims sent to Medicare are required to contain standard CAS codes, along with other loops, segments, and data elements that apply. It is the provider's responsibility to convert local adjustment reason codes or messages into the appropriate standard CAS codes prior to transmission of an 837 version 4010A1 claim to Medicare for secondary payment. ❖

Source: CMS Joint Signature Memorandum 05512, September 13, 2005

**Claim Status Code/Claim Status Category Code Update**

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

**Provider Types Affected**

All providers submitting health care claim status transactions to Medicare carriers, including durable medical equipment carriers (DMERCs), and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs)

**Provider Action Needed**

This is a reminder item regarding the periodic update of certain code sets used as a result of the Health Insurance Portability and Accountability Act (HIPAA). Effective January 1, 2006, the Medicare claims processing system will update its lists of health care claims status codes and health care claims status category codes with all applicable code changes posted online with the "new as of 10/05" and prior date designations.

**Background**

Under HIPAA, code sets that characterize a general administrative situation, rather than a medical condition or service, are referred to as non-clinical or non-medical code sets.

Claim status category codes and claim status codes are used in the health care claim status inquiry and response (276/277) transactions:

- Claim status category codes indicate the general payment status of the claim.
- Claim status codes provide more detail about the status communicated in the general claim status category codes.

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

These codes are available online at:

<http://www.wpc-edi.com/codes/Codes.asp>.

**Additional Information**

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

From that Web page, look for CR 3960 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your Medicare carrier/DMERC/FI/RHHI 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: 3960

Related CR Release Date: July 29, 2005

Related CR Transmittal Number: 631

Effective Date: January 1, 2006

Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 631, CR 3960

**Completion of Attestation for All 270/271 Transactions**

The Centers for Medicare and Medicaid Services (CMS) is making changes to its information technology infrastructure to address standards for Medicare beneficiary eligibility inquiries. This approach will create the necessary database and infrastructure to provide a centralized Health Insurance Portability and Accountability Act (HIPAA) compliant 270/271 health care eligibility inquiry and response in real-time.

Providers are reminded that an attestation form must be completed prior to accessing the real-time eligibility application. This attestation form is available online on the CMS website at <http://www.cms.hhs.gov/it>. ❖

Source: CMS Pub. 100-04, Transmittal 700, CR 4093

This material provides a basic overview of the consumer privacy protection rules adopted by the United States Department of Health and Human Services in conformance with the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996. This material does not interpret these rules or attempt to apply the rules to your particular circumstances. The information provided is (1) for your information only, (2) subject to change without notice, and (3) provided "as is" without warranty of any kind, expressed or implied. FIRST COAST SERVICE OPTIONS, INC. DISCLAIMS RESPONSIBILITY FOR ANY CONSEQUENCES OR LIABILITY ATTRIBUTABLE TO OR RELATED TO ANY USE, NON-USE, OR INTERPRETATION OF INFORMATION CONTAINED OR NOT CONTAINED IN THIS MATERIAL. FIRST COAST SERVICE OPTIONS, INC. DISCLAIMS ANY LIABILITY FOR ANY DIRECT, SPECIAL, INDIRECT, INCIDENTAL, OR CONSEQUENTIAL LOSSES OR DAMAGES RELATED TO THE ACCURACY OR COMPLETENESS OF THIS MATERIAL. The information provided is no substitute for your own review and analysis of the relevant law.

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## EDUCATIONAL RESOURCES

### CMS Quarterly Provider Update

The October 2005 *Quarterly Provider Update* is now available on the Centers for Medicare & Medicaid Services (CMS) website.

The *Quarterly Provider Update* is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all nonregulatory changes to Medicare including program memoranda, manual changes and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update. The purpose of the *Quarterly Provider Update* is to:

- Inform providers about new developments in the Medicare program.
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions.
- Ensure that providers have time to react and prepare for new requirements.

- Announce new or changing Medicare requirements on a predictable schedule.
- Communicate the specific days that CMS business will be published in the *Federal Register*:

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the *Quarterly Provider Update* listserv (electronic mailing list at <http://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1>).

The *Quarterly Provider Update* may be accessed at <http://www.cms.gov/providerupdate/main.asp>.

To view past issues of the QPU, visit <http://www.cms.hhs.gov/providerupdate/archive/>.

We encourage you to bookmark this website and visit it often for this valuable information. ❖

Source: CMS Transmittal AB-03-075, CR 2686

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

### Medicare Guide to Rural Health Services Information for Providers, Suppliers and Physicians

The Division of Provider Information Planning & Development at the Centers for Medicare & Medicaid Services (CMS) recently developed the “Medicare Guide to Rural Health Services Information for Providers, Suppliers and Physicians” which offers rural health information and resources in a single source.

The guide is available in electronic downloadable format on the CMS website at <http://www.cms.hhs.gov/medlearn/MedRuralGuide.pdf>.

Print and CD-ROM versions of the guide will be available in late November free of charge from the Medicare Learning Network’s Web page on the CMS website at <http://www.cms.hhs.gov/medlearn/default.asp?link=products>. ❖

Source: Provider Education Resources Listserv, Message 200510-03

## MEDICARE PREVENTIVE SERVICES

### Preventive Services Guide now Available

The Centers for Medicare & Medicaid Services (CSM) is pleased to announce that the “*Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals*” is now available to order. This comprehensive guide to Medicare-covered preventive services and screenings is intended to give physicians, providers, suppliers, and other health care professionals that bill Medicare fee-for-service contractors information on coverage, coding, billing, and reimbursement to help them file claims effectively, while also giving providers information that will enable them to encourage utilization of these benefits as appropriate. A downloadable PDF version of the guide is available on the CMS website at <http://www.cms.hhs.gov/medlearn/preventiveservices.asp>.

The Guide is also one of the resources included in the Medicare Preventive Services Resources CD ROM for health care professionals. Copies of both the Guide and the CD ROM may be ordered, free of charge, through the Medicare Learning Network’s Medlearn home page on the Web at <http://www.cms.hhs.gov/medlearn>.

Order your copies today! ❖

Source: Provider Education Resources Listserv, Message 200508-10

## Informational and Educational Materials for the New Preventive Services

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

### Provider Types Affected

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

### Introduction

This special edition article provides an overview of the many informational and educational products developed by the Centers for Medicare & Medicaid Services (CMS) to inform and educate physicians, providers, suppliers, and other health care professionals, including nonphysician practitioners, about the array of Medicare-covered preventive services and screenings available. These include the following three new services that became effective January 1, 2005:

- Diabetes screening tests
- Cardiovascular screening blood tests
- The initial preventive physical examination (IPPE)

(For the purpose of this article, non-physician practitioners are physician assistants, nurse practitioners, or clinical nurse specialists.)

**Note:** It is important to emphasize that the diabetes screening tests and cardiovascular screening blood tests are each stand alone billable services separate from the IPPE or "Welcome to Medicare" Physical Exam. The IPPE is a unique benefit for beneficiaries new to the Medicare program. This benefit must be received in the first six months after the effective date of the beneficiary's first Part B coverage period, which must begin on or after January 1, 2005.

To ensure that your Medicare patients receive the best possible health care, it is important to be aware of the preventive benefits available for these patients.

### Diabetes Screening Tests

Section 613 of the MMA provides for coverage, under Medicare Part B, of diabetes screening tests, effective for services furnished on or after January 1, 2005, for beneficiaries at risk for diabetes (see eligibility below) or those diagnosed with pre-diabetes.

Medicare provides coverage for the following diabetes screening blood tests:

- A fasting blood glucose test; and
- A post-glucose challenge test:
  - ♦ An oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults; or
  - ♦♦ A two-hour post-glucose challenge test alone.

### Who Is Eligible?

To be eligible for the diabetes screening tests, beneficiaries must have any of the risk factors or at least two of the characteristics discussed below.

### Risk Factors

Individuals who have **any** of the following risk factors are eligible for diabetes screening:

- Hypertension
- Dyslipidemia
- Obesity (with a body mass index greater than or equal to 30 kg/m<sup>2</sup>)
- Previous identification of elevated impaired fasting glucose or glucose tolerance.

### Characteristics

Alternatively, individuals who have a risk factor consisting of at least two of the following characteristics are eligible for diabetes screening:

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

### Frequency of Screening Tests

Effective for services performed on or after January 1, 2005, Medicare provides coverage for diabetes screening tests with the following frequency:

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

### Nationally Noncovered Indications

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

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

**Diabetes:** diabetes mellitus, a condition of abnormal glucose metabolism diagnosed from a fasting blood sugar > 126 mg/dL on two different occasions; a 2-hour post-glucose challenge > 200 mg/dL on two different occasions; or a random glucose test > 200 mg/dL for an individual with symptoms of uncontrolled diabetes.

**Pre-diabetes:** abnormal glucose metabolism diagnosed from a previous fasting glucose level of 100 to 125 mg/dL, or a 2-hour post-glucose challenge of 140 to 199 mg/dL. The term "pre-diabetes" includes impaired fasting glucose and impaired glucose tolerance.

**Post-glucose challenge test:** an oral glucose tolerance test with a glucose challenge of 75 gms of glucose for non-pregnant adults, or a 2-hour post-glucose challenge test alone.

### Reimbursement

Reimbursement for the diabetes screening tests is made under the Medicare clinical laboratory fee schedule. There is no deductible or co-payment for this benefit.

## Informational and Educational Materials for the New Preventive Services (continued)

**Note:** For detailed instructions regarding types of bills (TOBs) to use, including special instructions for Maryland hospitals and critical access hospitals (CAHs), see CR 3637 (Transmittal 446, Re-issued on January 21, 2005, “MMA – Diabetes Screening Tests”) on the CMS website at [http://www.cms.hhs.gov/manuals/pm\\_trans/R446CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R446CP.pdf).

There is a related Medlearn Matters article (MM3637) on the CMS website at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3637.pdf>.

### Cardiovascular Screening Blood Tests

Section 612 of the MMA provides for coverage, under Medicare Part B, of cardiovascular screening blood tests (tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk for that disease) effective for services performed on or after January 1, 2005.

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

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

Other cardiovascular screening tests for which CMS has not specifically indicated national coverage continue to be noncovered.

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

Under Part B, Medicare provides coverage for each of these three cardiovascular screening blood tests once every five years (i.e., 59 months after the last covered screening tests). The physician who is treating the beneficiary for the purpose of early detection of cardiovascular disease in individuals without apparent signs or symptoms must order these tests.

### Reimbursement

Reimbursement for the cardiovascular screening blood tests is made under the Medicare clinical laboratory fee schedule. There is no deductible or co-payment for this benefit.

**Note:** Details regarding HCPCS/CPT codes and diagnosis codes, and how carriers and intermediaries will treat claims, are described in CR 3411 (Transmittal 408, dated December 17, 2004, “MMA – Cardiovascular Screening Blood Tests,” which may be found on the CMS website at [http://www.cms.hhs.gov/manuals/pm\\_trans/R408CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R408CP.pdf).

In addition, there is a related Medlearn Matters article (MM3411) on the CMS website at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3411.pdf>.

### The Initial Preventive Physical Examination

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

### Once in a Lifetime Benefit

The IPPE is a once-a-lifetime benefit that must be performed within six months after the effective date of the beneficiary’s first Part B coverage, but only if such Part B coverage begins on or after January 1, 2005. An IPPE furnished on January 10, 2005, for example, to a beneficiary whose Medicare Part B coverage was effective initially on December 1, 2004, would not be covered under this benefit. If a beneficiary is first covered by Part B on January 1, 2005, however, then a physical provided on January 10, 2005 *would* be covered by this new benefit.

This provision provides for payment for an IPPE to be performed in various provider settings by physicians, or qualified non-physician practitioners (NPPs). However, coverage is provided for only one IPPE per beneficiary lifetime.

### Services Included in the IPPE Visit

The complete IPPE visit consists of all of the following services furnished to a beneficiary with the goal of health promotion and disease detection:

#### 1) Review of an individual’s medical and social history, with attention to modifiable risk factors for disease detection

This review includes at a minimum past medical and surgical history, such as experiences with illnesses, hospital stays, operations, allergies, injuries and treatments, current medication and supplements (including calcium and vitamins), family history (including diseases that may be hereditary by the physician who is treating the beneficiary for the purpose of early detection of cardiovascular disease in individuals without apparent signs or symptoms).

#### 2) Review of an individual’s potential (risk factors) for depression

This review includes current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression. The physician or other qualified NPP may select a screening instrument from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations.

#### 3) Review of the individual’s functional ability and level of safety

This review is based on the use of appropriate screening questions or a screening questionnaire, which the physician or other qualified NPP may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations. The review must include, at a minimum, a review of hearing impairment, activities of daily living, risk of falls, and home safety.



*Informational and Educational Materials for the New Preventive Services (continued)*

**4) An examination**

This examination includes measurement of the individual's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the physician or qualified NPP, based on the individual's medical and social history (refer to service element 1) and current clinical standards.

**5) Performance and interpretation of an EKG**

As required by statute, the IPPE benefit always includes a screening EKG. If the primary physician or qualified NPP is not able to perform the EKG during the IPPE visit, arrangements should be made for the beneficiary to be referred to another physician or entity to perform and interpret the EKG. The primary physician or qualified NPP must document the results of the screening EKG in the beneficiary's medical record to complete and bill for the IPPE benefit. Both the IPPE and the screening EKG must be performed and interpreted before the physician, qualified NPP, and/or entity can submit the claims.

**6) Education, counseling, and referral**

These will be conducted, as deemed appropriate, by the physician or qualified NPP, based on the results of the review and evaluation services described in the previous five elements.

**7) Education, counseling, and referral for other preventive services**

Education, counseling, and referral including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining the appropriate screening and other preventive services, which are covered separately under Medicare Part B. These services include the following:

- Pneumococcal, influenza, and hepatitis B vaccines and their administration
- Screening mammography
- Screening Pap smear and screening pelvic examinations
- Prostate cancer screening tests
- Colorectal cancer screening tests
- Diabetes outpatient self-management training services
- Bone mass measurements
- Screening for glaucoma
- Medical nutrition therapy for individuals with diabetes or renal disease
- Cardiovascular screening blood tests
- Diabetes screening tests.

**Note:** The MMA did not make any provision for the waiver of Medicare coinsurance and Part B deductible for the IPPE. Payment for this service would be subject to the required deductible, which is \$110 for calendar year 2005, if the deductible has not been met, with the exception of federally qualified health centers (FQHCs). In addition, the usual coinsurance provisions would apply. For more detailed instructions regarding HCPCS codes to use, including special instructions for rural

health clinics/federally qualified health centers (RHCs)/FQHCs, Maryland hospitals, critical access hospitals (CAHs), and Indian health service (IHS) hospitals, review Change Request (CR) 3638 (Transmittal 417, dated December 22, 2004, "MMA – Initial Preventive Physical Examination") on the CMS website at [http://www.cms.hhs.gov/manuals/pm\\_trans/R417CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R417CP.pdf).

You can also view the related Medlearn Matters article (MM3638) on the CMS website at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3638.pdf>.

**Preventive Services Informational and Educational Products**

CMS has developed a variety of informational and educational products for health care professionals to:

- Increase your awareness about Medicare's coverage for disease prevention and early detection
- Provide you with important information about Medicare coverage, coding, billing, and reimbursement
- Help you file preventive services claims effectively
- Give you information that will equip you to encourage utilization of these benefits.

The *Additional Information* section of this Special Edition article will tell you where you can find informational/educational products specifically for Medicare beneficiaries.

The following informational and educational products have been developed especially for you, the Medicare fee-for-service physician, provider, supplier, and health care professional.

**The Preventive Services Educational Resource Web Guide**

CMS has developed a Medlearn Web page where Medicare fee-for-service providers can find links to all provider/supplier specific informational and educational related preventive services products and resources. The web page is located on the CMS website at <http://www.cms.hhs.gov/medlearn/preventiveservices.asp>.

Access to products discussed in this special edition article may be found on this Web page.

**The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals**

This comprehensive guidebook to Medicare-covered preventive services and screenings is intended to provide physicians, providers, suppliers, and other health care professionals that bill Medicare fee-for service contractors with information on coverage, coding, billing, and reimbursement to help them file claims effectively.

It also gives providers information that will enable them to encourage utilization of these benefits as appropriate. You may order a print copy of *The Guide* or download, view, and print a copy by going to the CMS website at <http://www.cms.hhs.gov/medlearn/preventive/pguide.asp>.

## Informational and Educational Materials for the New Preventive Services (continued)

### Brochures

Five two-sided, tri-fold brochures provide an overview of the coverage information for each preventive service covered by Medicare. These brochures may be ordered through the Medlearn product ordering system, or they may be downloaded, viewed and printed on the CMS website at <http://www.cms.hhs.gov/medlearn/preventiveservices.asp>.

### Expanded Benefits

The *Expanded Benefits* brochure provides Medicare fee-for-service physicians, providers, suppliers, and other health care professionals with an overview of Medicare's coverage for the three new preventive services and screenings (the IPPE, cardiovascular screening blood tests, and diabetes screening tests), as well as other covered diabetes benefits. This brochure can be found on the CMS website at [http://www.cms.hhs.gov/medlearn/expanded\\_benefits\\_06-08-05.pdf](http://www.cms.hhs.gov/medlearn/expanded_benefits_06-08-05.pdf).

### Cancer Screenings

The *Cancer Screenings* brochure provides Medicare fee-for-service physicians, providers, suppliers, and other health care professionals with an overview of Medicare's coverage for screening mammography, screening Pap test, pelvic examination, colorectal cancer screening, and prostate cancer screening benefits. This brochure can be found on the CMS website at [http://www.cms.hhs.gov/medlearn/cancer\\_screening\\_06-08-05.pdf](http://www.cms.hhs.gov/medlearn/cancer_screening_06-08-05.pdf).

### Adult Immunizations

The *Adult Immunizations* brochure provides Medicare fee-for-service physicians, providers, suppliers, and other health care professionals with an overview of Medicare's coverage for influenza, hepatitis B, and pneumococcal polysaccharide vaccines and their administration. This brochure may be found on the CMS website at [http://www.cms.hhs.gov/medlearn/adult\\_immunization\\_06-08-05.pdf](http://www.cms.hhs.gov/medlearn/adult_immunization_06-08-05.pdf).

### Glaucoma Screening

The *Glaucoma Screening* brochure provides Medicare fee-for-service physicians, providers, suppliers, and other health care professionals with an overview of Medicare's coverage for the glaucoma screening benefit. This brochure may be found on the CMS website at [http://www.cms.hhs.gov/medlearn/glaucoma\\_06-08-05.pdf](http://www.cms.hhs.gov/medlearn/glaucoma_06-08-05.pdf).

### Bone Mass Measurements

The *Bone Mass Measurements* brochure provides Medicare fee-for-service physicians, providers, suppliers, and other health care professionals with an overview of Medicare's coverage for the bone mass measurements (bone density studies) benefit. The *Bone Mass Measurements* brochure is available on the CMS website at [http://www.cms.hhs.gov/medlearn/bone\\_mass\\_06-08-05.pdf](http://www.cms.hhs.gov/medlearn/bone_mass_06-08-05.pdf).

The above brochures may be ordered or downloaded, viewed, and printed by going to the CMS website at <http://www.cms.hhs.gov/medlearn/preventiveservices.asp>.

### Quick Reference Information: Medicare Preventive Services

This two-sided laminated chart gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings. It identifies coding requirements,

eligibility, frequency parameters, and co-payment/coinsurance and deductible information for each benefit. You may order copies of the *Quick Reference Chart* or download, view, and print a copy by going to the CMS website <http://www.cms.hhs.gov/medlearn/preventiveservices.asp>.

### Medicare Preventive Services Resources for Physicians, Providers, Suppliers, and Other Health Care Professionals (CD ROM)

CMS has created a special CD ROM titled *Medicare Preventive Services Resources for Physicians, Providers, Suppliers, and Other Health Care Professionals* that contains useful preventive services resources for Medicare fee-for-service physicians, providers, suppliers, and other health care professionals who bill Medicare fee-for-service contractors (FIs and carriers). These resources include:

- The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals
- The Quick Reference Information: Medicare Preventive Services chart
- The following five brochures (described above):
  - ♦ Expanded Benefits
  - ♦ Cancer Screenings
  - ♦ Adult Immunizations
  - ♦ Glaucoma Screenings
  - ♦ Bone Mass Measurements

To order the *Medicare Preventive Services Resources for Physicians, Providers Suppliers, and Other Health Care Professionals* CD ROM, go to the CMS website at [http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5).

### Preventive Services Web-Based Training (WBT) Courses

The current WBT course, Medicare Preventive Services: Osteoporosis, Diabetes, and Prostate Cancer, is being expanded to include the new MMA benefits, and will be renamed Medicare Preventive Services Series: Part 3 Expanded Benefits. The Medicare Preventive Services Series: Part 1 Adult Immunizations WBT is being updated to include hepatitis B, and the Medicare Preventive Services Series: Part 2 Women's Health WBT is also being updated.

These updated products will be available later in 2005. To access the preventive services web-based training courses, see the Provider Education section of the Preventive Services Educations Resource Web Guide on the CMS website at <http://www.cms.hhs.gov/medlearn/preventiveservices.asp>.

### Preventive Services Medlearn Matters Articles

CMS issued the following *Medlearn Matters* articles in January 2005 for each new preventive service as corresponding implementing instructions were released:

- The Initial Preventive Physical Examination (MM3638) at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3638.pdf>

*Informational and Educational Materials for the New Preventive Services (continued)*

- Cardiovascular Screening Blood Tests (MM3411) at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3411.pdf>
- Diabetes Screening Tests (MM3637) at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3637.pdf>.

**Coming Soon! An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals (Video and Audio programs)**

This educational video and audio program will provide an overview of Medicare’s coverage for preventive services and screenings, including the new MMA services. The program will also discuss risk factors associated with various diseases and highlight the importance of disease prevention and early detection. The video will be available in three formats, VHS, DVD, and CD to accommodate changing technological demands of the provider community, and the audio will be available in CD format. You will be able to order these in late 2005.

**Summary**

In addition to helping you file your claims more effectively, these new products will help you increase your awareness about Medicare’s coverage for disease prevention and early detection so you are better prepared to:

- Talk to your Medicare patients about the new services
- Encourage their utilization of Medicare-covered preventive services and screenings for which they may be eligible.

We encourage you to order and use these products; however, provider-specific products are not meant for distribution to Medicare beneficiaries. They have been developed for you, the Medicare physician, provider, and supplier.

**Additional Information For Medicare Beneficiaries**

In addition to the variety of products for Medicare providers, CMS has also developed resources that can be used by physicians, partners, and beneficiary advocates to educate beneficiaries about Medicare covered preventive screenings and services. A few of the many products available include:

**2005 Prevention ToolKit**

CMS joined forces with the American Cancer Society (ACS), the American Diabetes Association (ADA), and the American Heart Association (AHA) to develop materials that you can use as a reference and to educate beneficiaries in your community about the new preventive benefits. These resources including brochures, fact sheets, FAQs, a poster, and booklets can be downloaded, viewed and printed on the CMS website at <http://www.cms.hhs.gov/partnerships/tools/2005preventive/toolkit/default.asp>.

**Guide to Medicare’s Preventive Services Booklet**

This guide is available on the CMS website at <http://www.medicare.gov/Publications/Pubs/pdf/10110.pdf>.

**The “Staying Healthy” Website**

This website is located at <http://www.medicare.gov/health/overview.asp>.

The goal of this website is to provide information about preventive services that are available to people with Medicare. The site includes the following information:

Diabetes Screening, Supplies, and Self  
<http://www.medicare.gov/health/diabetes.asp>

Management Training Cardiovascular Screening  
<http://www.medicare.gov/health/cardio.asp>

One-time “Welcome to Medicare”  
<http://www.medicare.gov/health/physicalexam.asp>

Physical Exam Cancer Tests  
<http://www.medicare.gov/health/cancer.asp>

Breast Cancer Screening (Mammograms)  
<http://www.medicare.gov/health/mammography.asp>

Cervical and Vaginal Cancer Screening  
<http://www.medicare.gov/health/cervical.asp>

(Pap Test and Pelvic Exam) Colon Cancer Screening (Colorectal)  
<http://www.medicare.gov/health/coloncancer.asp>

Prostate Cancer Screening (PSA)  
<http://www.medicare.gov/health/prostate.asp>

Shots  
<http://www.medicare.gov/health/shots.asp>

Flu  
<http://www.medicare.gov/health/flu.asp>

Pneumococcal  
<http://www.medicare.gov/health/pneumococcal.asp>

Hepatitis B  
<http://www.medicare.gov/health/hepatitis.asp>

Bone Mass Measurements  
<http://www.medicare.gov/health/osteoporosis.asp>

Glaucoma Tests  
<http://www.medicare.gov/health/glaucoma.asp>

Patient publications may be ordered online at <http://www.medicare.gov> or by calling 1-800-MEDICARE (1-800-633-4227).

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

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

Related CR: N/A

Release Date: N/A

Source: Special Edition Medlearn Matters Article SE0556

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## Medicare Preventive Services Resource CD now Available

The Division of Provider Information Planning & Development (DPIPD) staff of CMS Provider Communication Group is pleased to announce the availability of the following new educational product for providers:

The Medicare preventive services resources for physicians, providers, suppliers, and other health care providers CD ROM contains:

- a. *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Providers*
- b. Five brochures:
  - ♦ *Expanded Benefits*
  - ♦ *Glaucoma Screenings*
  - ♦ *Cancer Screenings*

- ♦ *Bone Mass Measurements*
- ♦ *Adult Immunizations*

- c. *Quick Reference Information: Medicare Preventive Services* chart.

These resources are useful for Medicare fee-for service (FFS) physicians, providers, suppliers, and other health care professionals that bill Medicare FFS contractors (fiscal intermediaries and carriers). This new product may be ordered, free of charge, from the Medicare Learning Network's Medlearn product ordering system on the CMS website at: <http://www.cms.hhs.gov/medlearn>. ❖

Source: Provider Education Resources Listserv, Message 200508-3

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## PRESCRIPTION DRUG COVERAGE

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### New Products on Medicare Drug Coverage for Health Care Professionals

The Centers for Medicare & Medicaid Services (CSM) has developed two new PowerPoint® educational products for health care professionals and others who want to learn more details about the Medicare Prescription Drug Coverage program. These products are available on CMS website at

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

These PowerPoint slides are available in two versions:

- 1.) a comprehensive version that contains detailed information.
- 2.) an abbreviated version that is suitable for short presentations or a quick overview.

These PowerPoint slides may be used for presentations or for individuals to review to learn more about the Medicare Drug Coverage program. The shorter version is suitable for "Lunch and Learn" sessions, short seminars/lectures, or as part of "grand rounds."

CMS is currently marketing these materials to entities who accredit educational products with the suggestion that they make this information available to health care professionals for continuing education credit. As CMS becomes aware of entities that pick up this product and offer it for CME, their Web links will be posted to CMS Medlearn drug coverage Web page. ❖

Source: Provider Education Resources Listserv, Message 200509-2

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### Prescription Drug Coverage Resources Available

The Centers for Medicare & Medicaid Services (CMS) has developed public service announcements (PSAs) for the provider community to increase awareness of the new prescription drug coverage and the resources available to assist people with Medicare. There are two versions of the PSAs. The only difference between the two is the graphics and orientation (horizontal versus vertical). The PSAs are posted on the CMS website under the heading, "Basic Information for Health Care Professionals."

The Web page address is: <http://www.cms.hhs.gov/medlearn/drugcoverage.asp>. ❖

Source: Provider Education Resources Listserv, Message 200509-08

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### What Do You Say when Asked About the New Medicare Prescription Drug Coverage

The Centers for Medicare & Medicaid Services has updated the public service announcements (PSAs) for health care professional.

The PSAs are designed to give health care professionals additional resources should their patients ask about the Medicare prescription drug coverage. The PSAs are posted on the CMS website under the heading, "Public Service Announcements (PSAs) for Health Care Professionals" at: [http://www.cms.hhs.gov/medlearn/psa\\_vert\\_92305.pdf](http://www.cms.hhs.gov/medlearn/psa_vert_92305.pdf) and [http://www.cms.hhs.gov/medlearn/psa\\_horz\\_92305.pdf](http://www.cms.hhs.gov/medlearn/psa_horz_92305.pdf)

Please note that both versions contain the same content; one is a vertical orientation and the other is a horizontal orientation. ❖

Source: CMS Joint Signature Memorandum 05541, September 29, 2005  
Provider Education Resources Listserv, Message 200509-11

## Medicare Prescription Drug Coverage—Clarification on Part D and Fee-For-Service Providers, New Web-based Educational Products

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

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

### Provider Types Affected

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

### Important Points to Remember

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

### Clarifying Information for Fee-for-Service (FFS) Medicare Providers

#### Billing for Drugs Covered Under Part D

There has been some confusion among FFS providers regarding their ability to bill drugs covered under Part D, commonly referred to as “Medicare Prescription Drug Coverage.” In short, being an enrolled provider in the FFS program does not impart Part D-related billing privileges. Medicare Part B covers a limited number of prescription drugs and biologicals. Currently, covered Medicare drugs generally fall into three categories:

- Drugs furnished incident to a physician’s service.
- Drugs furnished through a Medicare Part B covered item of durable medical equipment (DME).
- Drugs specifically covered by statute (for example, oral immunosuppressive drugs).

These drugs continue to be covered and paid for under the FFS Medicare program (i.e., Part B) and FFS providers (e.g., physicians, hospitals, and pharmacies) will continue to bill their carriers, fiscal intermediaries, and durable medical equipment regional carriers (DMERCs) for these drugs. This coverage under Part B continues after the January 1, 2006 effective date for Part D. (For a more detailed discussion of Medicare Part B covered drugs, access CMS website at <http://www.cms.hhs.gov/providers/drugs/>.)

#### How Medicare Prescription Drug Coverage Will be Administered

Medicare prescription drug coverage under Part D will be administered through Medicare Advantage Prescription Drug plans (MA-PDs) and Prescription Drug plans (PDPs).

For a person with Medicare who joins an MA or a PDP, their provider must have a contractual relationship with that MA-PD or PDP to bill and receive payment from the MA-PDP or PDP for that individual’s covered prescription drugs. This is true regardless of whether or not the provider is enrolled in the FFS Medicare program and billing FFS Medicare for Medicare Part B covered drugs.

**Example:** Suppose a pharmacy is currently receiving payment under Medicare Part B for an individual’s Medicare Part B covered drug, albuterol, delivered through a nebulizer, which is considered to be DME. The pharmacy would, as they do today, bill the local DMERC for this drug. The same individual has joined a PDP and has coverage of albuterol delivered through a metered dose inhaler (which is not considered DME under Part B). The pharmacy can only bill the MA-PD or PDP for covered albuterol delivered through a metered dose inhaler if the pharmacy has a contractual relationship with that MA-PD or PDP.

### New Information on Medicare Prescription Drug Coverage Information for Providers Web Page

The following new information may be found on the Medicare Prescription Drug Coverage Information for Providers Web page on the CMS website at <http://www.cms.hhs.gov/medlearn/drugcoverage.asp>.

#### Toolkit for Health Professionals: Medicare Prescription Drug Coverage

The Centers for Medicare & Medicaid Services (CMS) has released the Toolkit for Health Care Professionals: Medicare Prescription Drug Coverage, available as an Adobe PDF file (860Kb) on the CMS website at <http://www.cms.hhs.gov/medlearn/provtoolkit.pdf>.

This toolkit includes downloadable educational materials specifically for physicians and other health care professionals and their staff to learn the basics about Medicare Prescription Drug Coverage. It also includes materials that can be distributed to Medicare patients. The kit contains reproducible artwork, a letter from the CMS Administrator, a fact sheet (English and Spanish), a brochure, an article, and a list of other resources. You may add your logo and business information to these materials and copy freely.

#### Limited Income? SSA Can Help - Posters to Display in Health Care Settings

Flat wall posters directing people with Medicare who have limited income to a number they can call to find out if they are eligible for help with prescription drug costs are available now. Posters are suitable for display in a physician’s, provider’s or supplier’s office, a pharmacy, or other health care setting where people with Medicare will see this information. Easel posters are no longer available. To order, visit the Medlearn Product Ordering Page on the

**Prescription Drug Coverage—Clarification on Part D and Fee-For-Service Providers, ... (continued)**

CMS website at [http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5).

**New Fact Sheets Available On the Medicare Website**

The following fact sheets are now available at <http://www.medicare.gov>.

These can help your patients better understand Medicare's new prescription drug coverage:

**Quick Facts about Medicare's New Coverage for Prescription Drugs for People Who Have Coverage from an Employer or Union (Publication Number 11107)**

Basic information about Medicare's new prescription drug coverage for people who have prescription coverage from an employer or union. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11107.pdf>.

**Quick Facts about Medicare's New Coverage for Prescription Drugs for People with a Medicare approved Drug Discount Card (Publication Number 11104)**

Basic information about Medicare's new prescription drug coverage for a person with a Medicare-approved drug discount card. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11104.pdf>.

**New Medicare Prescription Drug Coverage—Who Can Help Me Apply and Enroll? (Publication Number 11125)**

Explains who can help people with Medicare apply for extra help in paying for prescription drug costs and join a Medicare prescription drug plan. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11125.pdf>.

**Quick Facts about Medicare's New Coverage for Prescription Drugs for People in a Medicare Health Plan with Drug Coverage (Publication Number 11135)**

Basic information about Medicare's new prescription drug coverage for people with a Medicare health plan with prescription drug coverage. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11135.pdf>.

**New Medicare Prescription Drug Coverage: A Message for People Who Care for Someone with Medicare (Publication Number 11126)**

Explains Medicare's new prescription drug coverage to those who make health care decisions for people with Medicare. (4 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11126.pdf>.

**Quick Facts about Medicare's New Coverage for Prescription Drugs for Alaskans with Limited Income and Resources (Publication Number 11105\_AK)**

Basic information about Medicare's new prescription drug coverage for a person with limited income and resources in Alaska. (2 pages) [http://www.medicare.gov/Publications/Pubs/pdf/11105\\_AK.pdf](http://www.medicare.gov/Publications/Pubs/pdf/11105_AK.pdf).

**Quick Facts about Medicare's New Coverage for Prescription Drugs for Hawaiians with Limited Income and Resources (Publication Number 11105\_HI)**

Basic information about Medicare's new prescription drug coverage for a person with limited income and resources in Hawaii. (2 pages) [http://www.medicare.gov/Publications/Pubs/pdf/11105\\_HI.pdf](http://www.medicare.gov/Publications/Pubs/pdf/11105_HI.pdf).

**Quick Facts About Medicare Prescription Drug Coverage and Protecting Your Personal Information (Publication Number 11147)**

Information about how people with Medicare can protect their personal information when dealing with plans and others about Medicare prescription drug coverage. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11147.pdf>.

**New Publications Available on the CMS Website**

The following new publications are available by going to <http://www.cms.hhs.gov/medicarereform/factsheets.asp> on the CMS website and clicking on the appropriate links described below:

**Basic Questions and Answers About Prescription Drug Coverage**

We encourage you to use these basic questions and answers to respond to inquiries from people with Medicare: <http://www.cms.hhs.gov/partnerships/news/mma/qsandas.pdf>.

**What Medicare Prescription Drug Coverage Means to You: A Guide to Getting Started**

A new brochure available to explain the basics of prescription drug coverage: [http://www.cms.hhs.gov/medicarereform/91007\\_MedicareBrochure.pdf](http://www.cms.hhs.gov/medicarereform/91007_MedicareBrochure.pdf).

**Additional Information**

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

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

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

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

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

Source: CMS Special Edition Medlearn Article SE0557

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## New Educational Products Available on Medicare Prescription Drug Coverage

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

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

Medicare prescription drug coverage under Part D will be administered through Medicare Advantage Prescription Drug plans (MA-PDs) and Prescription Drug plans (PDPs). For Medicare beneficiaries who join a MA-PD or a PDP, their provider must have a contractual relationship with that MA-PD or PDP to bill and receive payment from the plans for that individual’s covered prescription drugs. FFS providers cannot bill Medicare fiscal intermediaries (FIs) or carriers for Part D covered drugs. Our next article in this series will provide further information on Part B versus Part D billing.

### Provider Types Affected

Physicians, health care professionals, providers, suppliers, and staff who provide service to people with Medicare

### Important Points to Remember

- On January 1, 2006, new prescription drug coverage will be available to all people with Medicare.
- It will cover brand name and generic drugs.
- Drugs that are currently covered by Medicare Part B will continue to be covered by Part B.
- This new drug coverage is not automatic – all people with Medicare will need to make a decision this fall. Since you’re a trusted source, your patients may turn to you for information about this new coverage. Therefore, we’re looking to you and your staff to take advantage of this “teachable moment” and help your Medicare patients learn more about this new coverage.
- You should encourage all your Medicare patients to learn more about the new prescription drug coverage because it may save them money on prescription drugs. There is extra help available for people with limited income and resources.
- If your Medicare patients ask you questions about the new coverage, you can refer them to 1-800-MEDICARE and to <http://www.medicare.gov> for additional information and assistance.

### New Products Available on <http://www.cms.hhs.gov/medlearn/drugcoverage.asp>

New products are available to download at the *Medicare Prescription Drug Coverage Information for Providers* web page. This page is dedicated to providing the latest drug coverage information for fee-for-service (FFS) Medicare providers. The new products include the following:

#### Medicare Rx Training Course: Important Information for Health Care Professionals – Earn CME Credit

This training course covers important information about Medicare prescription drug coverage, including the fundamental components of the program, types of drug plans available, resources for people with Medicare and health care professionals, and important dates in 2005 and 2006.

The University of Kansas Medical Center (KUMC) is offering continuing education credit for this course in

coordination with the Centers for Medicare & Medicaid Services (CMS):

- **Doctors:** 1.5 CME Category 1 Credit
- **Nurses:** 1.8 CNE Contact Hours
- **Other Health Care Professionals:** 1.5 Credit Hours

Once you complete the course and receive a passing score on the post-assessment, you will be provided with a link to KUMC. KUMC will charge a nominal fee for credit courses.

#### Physician Brochure

This publication explains the new Medicare prescription drug coverage for physicians and their staff.

#### Physician Tear-off Sheet

This resource is appropriate for distribution in physicians’ offices and other clinical settings. It contains basic information on the new coverage, as well as contact numbers for each state’s State Health Insurance Assistance Program (SHIP). The SHIPs will direct people with Medicare to resources for individual counseling.

#### “Have Limited Income? SSA Can Help” - Posters for Your Office or Clinic

These posters direct people with Medicare who have limited income and resources to sources for help with prescription drug costs. The posters are suitable for display in healthcare settings where people with Medicare and their caregivers will see the information. To view and order the posters, go to the CMS website at <http://www.cms.hhs.gov/medlearn/drugcoverage.asp>.

#### New Beneficiary Publications Available

New publications for people with Medicare that explain various aspects of the new coverage are available on the CMS website at <http://www.cms.hhs.gov/medlearn/drugcoveragepubs.asp>.

#### Additional Information

To find Medicare Prescription Drug plans available in each state, visit the *Landscape of Local Plans* on the Medicare website for a complete listing.

You can use the new *Medicare Prescription Drug Plan Finder* to help people with Medicare learn about the new Medicare prescription drug coverage, find and compare prescription drug plans that meet personal needs, and enroll in the prescription drug plan that is right for him/her.

The new *Formulary Finder* on the Medicare website will help people with Medicare find plans in each state that match their required drug lists.

Bookmark the Medicare Prescription Drug Coverage Information for Providers page <http://www.cms.hhs.gov/medlearn/drugcoverage.asp>, for the latest information and educational resources.

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal Number: N/A

Implementation Date: N/A

Source: Special Edition Medlearn Matters Article SE0559

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**Posters Now Available!**

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

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

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

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

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

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

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**Coming in 2006! – Medicare Prescription Drug Coverage**

Beginning January 1, 2006, Medicare prescription drug coverage will be available to people with Medicare. Health care professionals can find information about this new coverage at <http://www.cms.hhs.gov/medlearn/drugcoverage.asp>, on the CMS website. ❖

Source: CMS Joint Signature Memorandum 05541, September 22, 2005



**ORDER FORM - PART A MATERIALS**

The following materials are available for purchase. To order, please complete and submit this form along with your check/money order (PAYABLE TO: BCBSFL-FCSO, account number 700284).

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
	<p><b>Medicare A Bulletin Subscriptions</b> – The <i>Medicare A Bulletin</i> is available free of charge online at <a href="http://www.floridamedicare.com">http://www.floridamedicare.com</a>. Hardcopy or CD-ROM distribution is limited to one copy per medical facility who has billed at least one Part A claim to the fiscal intermediary in Florida for processing during the twelve months prior to the release of each issue.</p> <p><b>Beginning with publications issued after June 1, 2003</b>, providers who meet these criteria must register to receive the <i>Bulletin</i> in hardcopy or CD-ROM format. Qualifying providers will be eligible to receive one hardcopy or CD-ROM of each issue, if a valid reason can be shown why the electronic publication available free of charge on the Internet cannot be used.</p> <p>Non-providers (e.g., billing agencies, consultants, software vendors, etc.) or providers who need additional copies at other office facility locations may purchase an annual subscription. This subscription includes all Medicare bulletins published during calendar year 2006 (back issues sent upon receipt of the order). Please check here if this will be a:</p> <p><input type="checkbox"/> Subscription Renewal or  <input type="checkbox"/> New Subscription</p>	700284	<p>\$250.00 (Hardcopy)</p> <p>\$20.00 (CD-ROM)</p>

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Total \$ \_\_\_\_\_

**Mail this form with payment to:**  
**First Coast Service Options, Inc.**  
**Medicare Publications - ROC 10T**  
**P.O. Box 45280**  
**Jacksonville, FL 32232-5280**

Facility Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Attention: \_\_\_\_\_ Area Code/Telephone Number: \_\_\_\_\_

**Please make check/money order payable to: BCBSFL- FCSO Account #700284**  
**(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)**

**ALL ORDERS MUST BE PREPAID -**  
**DO NOT FAX - PLEASE PRINT**

*NOTE: The Medicare A Bulletin is available free of charge online at [www.floridamedicare.com](http://www.floridamedicare.com).*

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## Addresses

### **CLAIMS STATUS**

#### **Coverage Guidelines**

#### **Billing Issues Regarding**

#### **Outpatient Services, CORE, ORF, PHP**

Medicare Part A Customer Service  
P. O. Box 2711  
Jacksonville, FL 32231-0021

### **PART A REDETERMINATION**

Medicare Part A Redetermination and Appeals  
P. O. Box 45053  
Jacksonville, FL 32232-5053

### **MEDICARE SECONDARY PAYER (MSP)**

#### **Information on Hospital Protocols**

#### **Admission Questionnaires**

#### **Audits**

Medicare Secondary Payer  
Hospital Review  
P. O. Box 45267  
Jacksonville, FL 32232-5267

#### **General MSP Information**

#### **Completion of UB-92 (MSP Related)**

#### **Conditional Payment**

Medicare Secondary Payer  
P. O. Box 2711  
Jacksonville, FL 32231-0021

#### **Automobile Accident Cases**

#### **Settlements/Lawsuits**

#### **Other Liabilities**

Auto/Liability Department – 17T  
P. O. Box 44179  
Jacksonville, FL 32231-4179

### **PROVIDER EDUCATION**

Medicare Education and Outreach  
P. O. Box 45157  
Jacksonville, FL 32232-5157

#### **Seminar Registration Hotline**

1-904-791-8103

### **ELECTRONIC CLAIM FILING “DDE Startup”**

Direct Data Entry (DDE)  
P. O. Box 44071  
Jacksonville, FL 32231-4071

### **FRAUD AND ABUSE**

Complaint Processing Unit  
P. O. Box 45087  
Jacksonville, FL 32232-5087

### **PART A RECONSIDERATION**

#### **Claims Denied at the Redetermination Level**

MAXIMUS  
QIC Part A East Project  
Eastgate Square  
50 Square Drive  
Victor, NY 14564-1099

### **OVERPAYMENT COLLECTIONS**

#### **Repayment Plans for Part A Participating Providers**

#### **Cost Reports (original and amended)**

#### **Receipts and Acceptances**

#### **Tentative Settlement Determinations**

#### **Provider Statistical and Reimbursement (PS&R) Reports**

#### **Cost Report Settlement (payments due to provider or Program)**

#### **Interim Rate Determinations**

#### **TEFRA Target Limit and Skilled Nursing Facility Routine Cost Limit Exceptions**

#### **Freedom of Information Act Requests (relative to cost reports and audits)**

Provider Audit and Reimbursement Department (PARD)  
P.O. Box 45268  
Jacksonville, FL 32232-5268  
1-904-791-8430

### **MEDICARE REGISTRATION**

#### **American Diabetes Association**

#### **Certificates**

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

## Telephone Numbers

### **PROVIDERS**

Customer Service Center Toll-Free  
1-877-602-8816  
Speech and Hearing Impaired  
1-877-660-1759

### **BENEFICIARY**

Customer Service Center Toll-Free  
1-800-MEDICARE  
1-800-633-4227  
Speech and Hearing Impaired  
1-800-754-7820

### **ELECTRONIC MEDIA CLAIMS**

EMC Start-Up  
1-904-791-8767, option 4

Electronic Eligibility  
1-904-791-8131

Electronic Remittance Advice  
1-904-791-6865

Direct Data Entry (DDE) Support  
1-904-791-8131

PC-ACE Support  
1-904-355-0313

Testing  
1-904-791-6865

Help Desk  
(Confirmation/Transmission)  
1-904-905-8880

## Medicare Websites

### **PROVIDERS**

Florida Medicare Contractor  
[www.floridamedicare.com](http://www.floridamedicare.com)  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)

### **BENEFICIARIES**

Centers for Medicare & Medicaid Services  
[www.medicare.gov](http://www.medicare.gov)

## Other Important Addresses

### **REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY**

#### **Home Health Agency Claims Hospice Claims**

Palmetto Government Benefit Administrators – Gulf Coast  
34650 US Highway 19 North, Suite 202  
Palm Harbour, FL 34684-2156

### **RAILROAD MEDICARE**

#### **Railroad Retiree Medical Claims**

Palmetto Government Benefit Administrators  
P. O. Box 10066  
Augusta, GA 30999-0001

### **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)**

#### **Durable Medical Equipment Claims Orthotic and Prosthetic Device Claims Take Home Supplies**

#### **Oral Anti-Cancer Drugs**

Palmetto Government Benefit Administrators  
P. O. Box 100141  
Columbia, SC 29202-3141



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***MEDICARE A BULLETIN***

*FIRST COAST SERVICE OPTIONS, INC. ❖ P.O. Box 2078 ❖ JACKSONVILLE, FL 32231-0048*

**\* ATTENTION BILLING MANAGER \***

