

# 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

### Medicare Part B Coverage of Drugs and Biologicals – Special Focus on the Unlabeled Use of Anti-Cancer Drugs

Medicare Part B covers medically reasonable and necessary outpatient drugs that are furnished “incident to” a physician’s service provided that the drugs are not usually self-administered by the patients who take them. With few exceptions, Medicare Part B does generally not reimburse for drugs that can be self-administered, such as those in pill form, or are used for self-injection. This is not to be confused with the new Medicare Part D benefit.



The “incident to” provision requires that the drug or biologic must be of a form that is not usually self-administered, must be furnished by a physician, and must be administered by the physician, or by auxiliary personnel employed by the physician or by the same entity by which the physician is employed and under the physician’s personal supervision. CMS has provided instructions how to establish whether a drug is usually self-administered by the patient. Based on these, this contractor posts a “List of Excluded Self-Administered Injectable Drugs Incident to a Physician’s Service” that are usually self-administered and thus not covered under Medicare Part B

([http://www.floridamedicare.com/partb\\_sad\\_FLB%20-%20List%20of%20Excluded%20Injectable%20Drugs.pdf](http://www.floridamedicare.com/partb_sad_FLB%20-%20List%20of%20Excluded%20Injectable%20Drugs.pdf)).

In order to be covered under Medicare, use of a drug or biological must be safe and effective and otherwise reasonable and medically necessary. Drugs or biologicals approved for marketing by the FDA are considered safe and effective for purposes of this requirement when used for approved indications as specified on the labeling. Medical necessity is, however, determined by the carrier at the local level. Unless stated otherwise in a national or local coverage determination, drugs and biologicals would be generally covered for their FDA-approved (labeled) indications.

An unlabeled use of a drug is a use that is not included as an indication on the drug’s label as approved by the FDA. Under certain circumstances, FDA-approved drugs used for indications other than listed on the official label may be covered under Medicare. In the case of the coverage of unlabeled drugs used in an anti-cancer chemotherapeutic regimen, CMS has established certain evidentiary criteria that are essentially based on support in accepted compendia, high phase clinical trials, and supportive evidence in reputable peer reviewed literature. The resulting payment decisions would be made on a case-by-case basis.

Until now, it was reasonable to assume that an FDA approved anti-cancer drug was covered only for its FDA-approved indications and the unlabeled indications as specifically listed in an NCD or LCD. Conversely, an assumption of noncoverage should have been made for any unlabeled indication not supported in an LCD or NCD. Such local and national positive coverage statements may not be readily available, especially in the case of newer agents. The publishing of new policies may take many months.

In the absence of a LCD or NCD, services are evaluated individually. This may lead to many pre- and/or post-payment reviews and numerous appeals without certainty of payment. Any time there is uncertainty whether Medicare’s medical reasonableness and necessity criteria would be met, an advance beneficiary notice (ABN) is required. Furthermore, the individual review process is time consuming and is associated with possibly delayed access to care, paper work, and cash flow issues. This is magnified by the fact that the unlabeled use of anti-cancer drugs is not an uncommon practice.

After careful review of Medicare’s rules and regulations, First Coast Service Options, Inc. (FCSO) is piloting a process that we hope will alleviate the above problems and reduce the bureaucratic and other burdens on all parties involved.

Effective March 1, 2006, an anti-cancer drug that meets all general program requirements may be considered medically reasonable and necessary for its FDA-approved indications and its “off-label” indications, as supported by the CMS approved compendia, unless there is a national or local statement to the contrary. This approach, in essence, accepts the endorsement of the editorial panels of the approved compendia as expert opinion and as a proxy for the review of clinical research that appears in peer-reviewed medical literature. It will result in the automated payment of most claims for unlabeled indications of FDA approved anti-cancer drugs, as long as these indications are supported in the compendia approved by CMS and as long as there is no local or national statement to the contrary. An article outlining the details of this provision has been posted on our website: [http://www.floridamedicare.com/parta\\_articles\\_Medicare%20Coverage%20of%20Anti-Cancer%20Drugs.asp](http://www.floridamedicare.com/parta_articles_Medicare%20Coverage%20of%20Anti-Cancer%20Drugs.asp).

This applies only to the labeled and unlabeled uses of anti-cancer drugs for the treatment of malignant neoplastic conditions. Other drugs and biologicals and/or the use of anti-cancer drugs for non-cancerous conditions are outside the scope of this publication.

This is a local project without claiming any validity on the national level and without an attempt to set a precedent. We hope that it will create a win-win situation for the patients, providers, and the Medicare program in our jurisdiction.

Eugene J. Winter, M.D.  
Medical Director

**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
<b>Second Quarter 2006</b>	<b>Mid-February 2006</b>	<b>April 1, 2006</b>
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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# GENERAL INFORMATION

## Payment Window Edit Corrections within the Common Working File

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

### Provider Types Affected

Hospitals (not including critical access hospitals)

### Provider Action Needed

#### STOP – Impact to You

This article is based on CR 4089, which is correcting some edits in Medicare's claims processing systems related to the payment window that precedes a beneficiary's admittance as an inpatient to a hospital.

#### CAUTION – What You Need to Know

Medicare has, by law, a payment window that requires certain outpatient services provided immediately prior to a beneficiary's inpatient admission to be bundled into the billing for the inpatient stay. That is, some of those services provided prior to the admission are not separately billable to Medicare.

#### GO – What You Need to Do

CR4089 corrects certain edits related to this payment window. Specifically, those edits relate to whether services involving revenue code 048X (cardiology) are bundled.

In addition, certain provider number edits are being modified. Finally, CR4089 makes certain clarifications and adjustments to the *Medicare Claims Processing Manual*, though these adjustments represent updates to the manual that have already been announced via prior Change Requests. Please see the *Additional Information* section of this article for more details on the edit changes.

#### Background

The payment window policy is long standing Medicare policy. Section 1886(a)(4) of the Social Security Act and the regulations at 42 CFR 412.2(c)(5) and 413.40(c)(2) define the operating costs of inpatient services under the prospective payment system to include certain preadmission services furnished by the admitting hospital (or by any entity wholly owned or wholly operated by the admitting hospital or by another entity under arrangements with the admitting hospital). Maryland hospitals are also subject to the payment window rules.

*Wholly owned* means that the hospital is the sole owner or operator, and has exclusive responsibility for implementing facility policies such as routine operations. A hospital does not have to exercise administrative control or make the policies to be the sole operator.

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### Additional Information

As stated earlier, Medicare is modifying some system edits that enforce this payment window provision.

Specifically, the edits are changing as follows:

- Services associated with revenue code 048x will only be bundled when the 048x code is present with **one** of the following HCPCS:
 

93015	93307	93308	93320	93501
93503	93505	93510	93526	93541
93542	93543	93544-93552		93561
- In terms of the one-day payment window, services provided the day immediately prior to admission will be bundled where the third digit of the provider number contains an "S," "T," "R," or "M" on the inpatient claim.

### Related Links

The official instruction issued to your FI regarding this change may be found by going to the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R714CP.pdf>.

Attached to CR 4089, you will find the revised Section 40.3 of Chapter 3 of the *Medicare Claims Processing Manual*.

Please refer to your local fiscal intermediary if you have questions about this issue. To find the toll free phone number, go to the CMS website at <http://www.cms.hhs.gov/apps/contacts/>.

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

Medlearn Matters Number: MM4089  
 Related Change Request (CR) Number: 4089  
 Related CR Release Date: October 21, 2005  
 Related CR Transmittal Number: 714  
 Effective Date: April 1, 2006  
 Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 714, CR 4089

**Clinical Diagnostic Laboratory Date of Service for Archived Specimens**

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

**Provider Types Affected**

Suppliers and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for clinical diagnostic laboratory services.

**Provider Action Needed**

This article is based on change request (CR) 4156, which is being issued to define the date of service (DOS) policy for laboratory tests on archived specimens, to clarify what is/ or is not an archived specimen, and to revise the policy regarding a laboratory test that requires a specimen obtained from storage.

**Background**

The Centers for Medicare & Medicaid Services published a proposed rule on November 23, 2001 in the *Federal Register* (66 FR 58792, [http://www.access.gpo.gov/su\\_docs/fedreg/a011123c.html](http://www.access.gpo.gov/su_docs/fedreg/a011123c.html)) that clarified the date of service (DOS) for clinical diagnostic laboratory services, and CR 2383 (Transmittal AB-02-134, dated October 4, 2002) was issued but did not define archived specimens.

**Note:** CR 2383 (Transmittal AB-02-134, dated October 4, 2002, subject: Questions and Answers Related to Implementation of National Coverage Determinations (NCDs) for Clinical Diagnostic Laboratory Services) can be found on the CMS website at <http://www.cms.hhs.gov/Transmittals/downloads/AB02134.pdf>.

CMS has since developed a definition of an archived specimen through its rulemaking process and issued a revised DOS policy in the *Federal Register* notice dated February 25, 2005 (70 FR 9357, which may be viewed at [http://www.access.gpo.gov/su\\_docs/fedreg/a050225c.html](http://www.access.gpo.gov/su_docs/fedreg/a050225c.html)).

CR 4156 implements this revised DOS policy for laboratory tests, and it clarifies what is/ or is not an archived

specimen. As a general rule, the DOS of a test is the date the specimen was collected, except as shown in the following table:

Specimen Description	Date of Service (DOS)
Specimen collected over a period spanning two calendar days (unless collected from archive).	Date the specimen collection ended.
Specimen stored for more than 30 calendar days before testing, (otherwise known as “an archived specimen”).	Date the specimen was obtained from storage

**Implementation**

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

**Additional Information**

For complete details, 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/Transmittals/downloads/R800CP.pdf>.

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/apps/contacts/>.

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

Medlearn Matters Number: MM4156  
 Related Change Request (CR) Number: 4156  
 Related CR Release Date: December 30, 2005  
 Effective Date: April 3, 2006  
 Related CR Transmittal Number: R800CP  
 Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 800, CR 4156

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**Healthcare Provider Taxonomy Codes Update**

*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 Part A and Part B services.

**Provider Action Needed**

**STOP – Impact to You**

This article is based on change request (CR) 4254 which informs Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs) and regional home health intermediaries (RHHIs)) to obtain the most recent healthcare provider taxonomy codes (HPTC) and use it to update their internal HPTC tables.

*Healthcare Provider Taxonomy Codes Update (continued)***CAUTION – What You Need to Know**

HIPAA requires that submitted data, which is part of a named code set, be valid data from that code set. Claims accepted with invalid data are non-compliant. Because health care provider taxonomy is a named code set in the 837 Institutional and Professional implementation guides, Medicare must validate the inbound taxonomy codes against their internal HPTC tables.

**GO – What You Need to Do**

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

**Background**

The HPTC set is an external non-medical data code set designed for use in classifying health care providers according to provider type or practitioner specialty in an electronic environment (specifically within the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) health care claim transaction).

HPTCs are scheduled for update twice per year (April and October). The HPTC list is available from the Washington Publishing Company at <http://www.wpcedi.com/codes/taxonomy> in two forms:

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

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

**Implementation**

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

**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/Transmittals/downloads/R815CP.pdf>.

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/apps/contacts/>.

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

Medlearn Matters Number: MM4254  
Related Change Request (CR) Number: 4254  
Related CR Release Date: January 20, 2006  
Effective Date: April 1, 2006  
Related CR Transmittal Number: R815CP  
Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 815, CR 4254

**Redefined Type of Bill 14x for Nonpatient Laboratory Specimens**

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

**Provider Types Affected**

All hospitals billing for non-patient lab specimens, but particularly Maryland Hospitals billing Medicare fiscal intermediaries (FIs) for laboratory services for their outpatients and for non-patients and critical access hospitals (CAHs) billing FIs for laboratory services for their outpatients and for non-patients

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

Affected providers must stop using type of bill (TOB) 14x when billing for referred diagnostic tests and reserve the use of TOB 14x for non-patient laboratory specimens.

**CAUTION – What You Need to Know**

Be aware of the redefinition of TOB 14x for use in billing tests for non-patient laboratory specimens, which Medicare pays for based on the clinical diagnostic laboratory fee schedule. When the lab tests are provided in **Maryland**, services to a hospital’s own outpatients are paid under the **state cost containment system**. **When tests are performed on non-patient specimens, they are** categorized as “non-patient specimen only lab tests.” The same distinction applies to CAHs. When the lab tests are performed for the CAH’s own outpatients there are paid based on cost. When they are performed on non-patient specimens the tests are paid based on the lab fee schedule.

**GO – What You Need to Do**

Use the redefined TOB 14x for non-patient laboratory specimens as discussed in this article.

**Background**

While 85x TOB is still used for lab tests, it is **only** valid if the patient is an **outpatient** of the CAH and **physically present** at the time the specimen is collected. A CAH cannot seek reasonable cost reimbursement for tests provided to individuals in locations such as a rural health clinic, a provider-based home health agency, the individual’s home, or a physician’s office. Individuals in these locations are non-patients of the CAH and their lab tests are categorized as “non-patient specimen only lab tests.” For these non-patients, use TOB 14x and Medicare’s payment will be made under the lab fee schedule.

In the early 1990s, the definition of 14x was changed to be “all referred diagnostic services” and, subsequently, there was no adequate method to distinguish the non-patient specimens. The changed definition of TOB 14x was confusing to both providers and FIs.

Due to this lack of clarity, and the need to pay both Maryland hospitals and CAHs on the lab fee schedule when only the specimen is received and the need to distinguish for certain pathology tests, the Centers for Medicare & Medic-

## *Redefined Type of Bill 14x for Nonpatient Laboratory Specimens (continued)*

aid Services (CMS) is introducing a revised definition of TOB 14x for non-patient specimens. These specimens will be paid on the clinical diagnostic lab fee schedule, as opposed to on the basis of reasonable cost or percent of charges.

### Implementation

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

### Additional Information

The official instruction issued to your FI regarding this change may be found by going to the CMS website <http://www.cms.hhs.gov/transmittals/downloads/R734CP.pdf>.

For additional information relating to this issue, please refer to your FI. To find their toll free phone number, go to the CMS website <http://www.cms.hhs.gov/apps/contacts/>.

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

Medlearn Matters Number: MM3835  
Related Change Request (CR) Number: 3835  
Related CR Release Date: October 28, 2005  
Related CR Transmittal Number: 734  
Effective Date: October 1, 2004  
Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 734, CR 3835

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## New Condition Codes 49 and 50

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

### Provider Types Affected

Providers who bill fiscal intermediaries (FIs) or regional home health intermediaries (RHHIs)

### Provider Action Needed

#### STOP – Impact to You

These new condition codes are to be used to describe an item that is provided without cost because it is under warranty, replaced, recalled, or was defective.

#### CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) intends to use these codes for tracking purposes initially as they need to be able to track replacements given to Medicare beneficiaries.

#### GO – What You Need to Do

Use the new codes in form locator 24-30 field on the claim Form CMS-1450 or its electronic equivalent as follows:

#### Code 49: Product Replacement within Product

**Lifecycle** – Replacement of product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly—warranty.

#### Code 50: Product Replacement for Known Recall of a

**Product** – The manufacturer or the Food and Drug Administration (FDA) has identified the product for recall and therefore replacement.

### Background

CMS requested and received new condition codes from the National Uniform Billing Committee to describe situations when a provider receives a product without cost. This could happen because the item was recalled for any of the reasons mentioned above, and it is important for CMS to track recall/replacement items.

### Implementation

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

### Additional Information

The official instructions issued to the intermediary/RHHI regarding this change can 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 CR4058. Click on the links to open and view the files for those CRs.

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/apps/contacts/>.

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

Medlearn Matters Number: MM4058  
Related Change Request (CR) Number: 4058  
Related CR Release Date: November 4, 2005  
Related CR Transmittal Number: 741  
Effective Date: April 1, 2006  
Implementation Date: April 3, 2006

Source: CMS Pub. 100-04, Transmittal 741, CR 4058,

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## Eliminate the Use of Surrogate Unique Physician Identification Numbers on Medicare Claims

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), using surrogate unique physician identification numbers (UPINs)

### Provider Action Needed

This article is based on change request (CR) 4177, which directs your carrier or DMERC to no longer accept the surrogate UPIN OTH000 to identify ordering or referring physicians on claims submitted by billers, suppliers, physicians, and nonphysician practitioners. (Beneficiary submitted claims and mass immunization claims are excluded.)

### Background

The Social Security Act (Section 1833(q)) requires that all physicians who meet the definition of a physician (Section 1861(r)) must have a UPIN, and that all claims for services ordered or referred by one of these physicians include the name and UPIN of the ordering/referring physician.

Currently, suppliers, physicians, and non-physician practitioners are allowed to bill for diagnostic, radiology, consultation services, and equipment with the use of surrogate UPIN OTH000. Surrogate UPINs were intended to be used during an interim period when a UPIN has been requested but has not yet been received.

CR4177 announces that CMS will no longer accept the Surrogate UPIN OTH000 to identify the ordering or referring physicians on claims submitted by billers, suppliers, physicians, and non-physician practitioners, effective for dates of service April 1, 2006, and later: (Beneficiary submitted claims and mass immunization claims are excluded.)

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*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.*

- Durable medical equipment (DME) suppliers, physicians, non-physician practitioners, and billers must submit the UPIN assigned to the ordering or referring physician; and
- Medicare carriers, DMERCs, and FIs will return, as unprocessable, all claims submitted with surrogate UPIN OTH000.

### Implementation

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

### Additional Information

For complete details, please see the official instruction issued to your contractor regarding this change. That instruction may be viewed on the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R752CP.pdf>.

If you need to obtain another physician's UPIN for billing purposes, you may find that UPIN by going to <http://www.upinregistry.com>.

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

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

Medlearn Matters Number: MM4177  
 Related Change Request (CR) Number: 4177  
 Related CR Release Date: November 10, 2005  
 Related CR Transmittal Number: 752  
 Effective Date: April 1, 2006  
 Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 752, CR 4177

## Medicare Supplemental Payments to Federally Qualified Health Centers under Contract with Medicare Advantage Plans

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

### Provider Types Affected

FQHCs under contract with Medicare Advantage (MA) plans

### Provider Action Needed

FQHCs should be aware of the **instructions for calculating and billing the new supplemental payments due to FQHCs** who contract with the MA program effective for services furnished on or after January 1, 2006.

### Background

This article and related CR 3886 provide details regarding the calendar year (CY) 2006 supplemental payments that augment the direct payments made by the MA organization to FQHCs for all covered FQHC services. Title II of the Medicare Modernization Act (MMA) established the MA program. The MA program replaces the Medicare + Choice (M+C) program established under Part C. The MA program retains many of the key features of the M+C program and includes **several new features, such as the introduction of regional MA plans that will be organized as preferred provider organizations.**

### *Medicare Supplemental Payments to FQHCs under Contract with Medicare Advantage Plans (continued)*

Section 237 of the MMA requires the Centers for Medicare & Medicaid Services (CMS) to provide supplemental payments to FQHCs that contract with MA organizations to cover the difference, if any, between the payment received by the FQHC for treating MA enrollees and the payment to which the FQHC would be entitled to receive under the cost-based all-inclusive payment rate as set forth in 42 CFR, Part 405, Subpart X.

The Medicare all-inclusive payment, which continues to be made for all covered FQHC services furnished to Medicare beneficiaries participating in the original Medicare program, is based on the FQHC's unique cost-per-visit as calculated by the Medicare fiscal intermediary (FI) based on the Medicare cost report. **FQHC's seeking payment under Section 237 of the MMA must submit to their FI copies of their contracts under each MA plan.**

To implement this new supplemental payment provision, CMS must determine if the Medicare cost-based payments that the FQHC would be entitled to exceed the amount of payments received by the FQHC from the MA organization and, if so, pay the difference to the FQHC at least quarterly. In determining the supplemental payment, the statute also excludes in the calculation of the supplemental payments any financial incentives provided to FQHCs under their MA arrangements, such as risk pool payments, bonuses, or withholds.

Following are the basic instructions for calculating the supplemental payments for FQHCs under contract with MA Plans.

- The FQHC supplemental payment is based on the per visit calculation, subject to a yearly reconciliation.
  - Supplemental payments are calculated by determining the difference between 100 percent of the FQHC's all inclusive cost-based per visit rate and the average per visit rate received by the FQHC from the MA organization for payment under the MA Plan, less the co-pay the FQHC charges the MA enrollees. Also, the FI will not apply the original Medicare deductible and coinsurance in calculating the interim supplemental payment rate.
  - Each eligible FQHC seeking the supplemental payment is required to submit (for the first two rate years) to the FI an estimate of the average MA payments (per visit basis) for covered FQHC services.
  - Every eligible FQHC seeking the supplemental payment is required to submit a documented estimate of their average per visit payment for their MA enrollees for each MA plan they contracted with and any other information as may be required to enable the FI to accurately establish an interim supplemental payment.
  - Expected payments from the MA organization will be used until actual MA revenue and visits collected on the FQHC's cost report can determine the amount of the supplemental payment.
- Effective January 1, 2006, eligible FQHCs will report actual MA revenue and visits on their cost reports. At the end of each cost reporting period the FI will use actual MA revenue and visit data along with the FQHC's final all-inclusive payment rate, to determine the FQHC's final actual supplemental per visit payment. This amount (per visit basis) will serve as the interim rate for the subsequent rate year. Actual aggregated supplemental payments will then be reconciled with aggregated interim supplemental payments, and any underpayment or overpayment will then be accounted for in determining final Medicare FQHC program liability at cost settlement.
  - An FQHC is only eligible to receive this supplemental payment when FQHC services are provided during a face-to-face encounter between an MA enrollee and one or more of the following FQHC covered core practitioners: physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, or clinical social workers. The supplemental payment is made directly to each qualified FQHC through the FI.
  - Each FQHC seeking the supplemental payment is responsible for submitting a claim for each qualifying visit to the FI on type of bill 73x with revenue code 0519. Also, FQHCs must not report revenue codes 0520 and/or 0900 on the same claim that contained revenue code 0519 when submitting claims for these qualifying visits by MA enrollees. Healthcare Common Procedure Coding System (HCPCS) coding is not required.

#### **Implementation**

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

#### **Additional Information**

The official instruction issued to your intermediary regarding this change may be found by going to CMS website at <http://new.cms.hhs.gov/transmittals/downloads/R773CP.pdf>.

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/apps/contacts/>.

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

Medlearn Matters Number: MM3886  
Related Change Request (CR) Number: 3886  
Related CR Release Date: December 2, 2005  
Related CR Transmittal Number: 773  
Effective Date: April 1, 2006  
Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 794, CR 3886

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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.

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 25, 2006, to reflect changes made to CR 4104. The CR was changed to show that this inquiry is only available to providers who bill intermediaries. This article was originally published in the [First Quarter 2006 Medicare A Bulletin \(page 13\)](#).

### Provider Affected

Providers billing Medicare fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), 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

CR 3929, 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.

### Additional Information

For complete details, please see the official instruction issued to FI/RHHI regarding this change. That instruction may be found by going to the CMS website <http://www.cms.hhs.gov/transmittals/downloads/R818CP.pdf>.

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

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 – Revised  
Related Change Request (CR) Number: 4104  
Related CR Release Date: January 24, 2006  
Related CR Transmittal Number: R818CP  
Effective Date: April 1, 2006  
Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 818, CR 4104

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## October 2004 Quarterly Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 20, 2006, to provide new Web addresses that reflect changes in the new CMS website. All other information remains the same. This article was originally published in the First Quarter 2005 Medicare A Bulletin (pages 12-13).

### Provider Types Affected

Physicians, providers, and suppliers

### Provider Action Needed

This instruction provides information for updating and implementing the October quarterly 2004 fee schedule amounts for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). It implements fee schedule amounts for new codes and revises any fee schedule amounts for existing codes that were calculated in error.

### Background

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings (Social Security Act, Sections 1834(a), (h), and (i)). In addition, payment on a fee schedule basis is required for parenteral and enteral nutrition

(PEN) by regulations contained in 42 CFR 414.102.

This instruction implements fee schedule amounts for new codes, deletes certain codes, and revises any fee schedule amounts for existing codes that were calculated in error in prior updates. Specifically, the changes for this update are as follows:

- Codes A4363, E1400 thru E1404, K0137 thru K0139, K0168 thru K0181, K0190 thru K0192, K0277 thru K0279, K0284, K0400, K0417, K0419 thru K0439, and K0530 were deleted from the Healthcare Common Procedure Coding System (HCPCS) effective December 31, 1999. These codes were inadvertently included in the 2004 fee schedule file, and they are being removed with this update.
- Codes E1019 and E1021 are also being removed, as they are not valid 2004 HCPCS codes.

## October 2004 Quarterly Update for DMEPOS Fee Schedule (continued)

- The 2004 Puerto Rico schedule amounts for codes A4351 and A4352 were based on incorrect pricing information. The durable medical equipment regional carriers (DMERCs) must revise the base fee schedule amounts for these codes as part of the October quarterly update.
- Codes K0630 thru K0649, representing lumbar sacral orthosis products were added to the HCPCS effective April 1, 2004, and their fee schedule amounts were implemented on July 1, 2004. However, the Centers for Medicare & Medicaid Services has determined that the fee schedule amounts for codes K0630, K0631, K0632, K0634, K0635, K0636, K0637, K0639, K0640, K0642, K0644, K0645, and K0646 were based on incorrect pricing information and has recalculated those fee schedule amounts. The revised amounts will be implemented on October 4, 2004, as part of this update.
- Codes K0650 thru K0669 were added to the HCPCS effective July 1, 2004. Because data is not yet available, implementation of the fee schedule amounts for these items will be delayed until the January 2005 update.

### Implementation

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

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### Additional Information

To view the official instruction issued to your DMERC or intermediary on this issue, please see on CMS website: <http://www.cms.hhs.gov/Transmittals/downloads/R272CP.pdf>.

Also, the quarterly update process for the DMEPOS fee schedule is located in Section 60 of Chapter 23 of the Medicare Claims Processing Manual, which may be found on CMS website at: <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>.

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

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

Medlearn Matters Number: MM3377 – Revised  
Related Change Request (CR) Number: 3377  
Related CR Release Date: August 10, 2004  
Related CR Transmittal Number: 272  
Effective Date: January 1, 2004 for revised 2004 fee schedule amounts  
Implementation Date: October 4, 2004

Source: CMS Pub 100-4 Transmittal 272, CR 3377

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

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 13, 2006, to provide new Web addresses that reflect changes in the new CMS website. All other information remains the same. This article was originally published in the January 2005 Medicare A Bulletin Special Issue (page 17).

### Provider Types Affected

All providers

### Provider Action Needed

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

### Background

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

Thus, beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

### Exceptions

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

1. The payment allowance limits for blood and blood products, with certain exceptions such as blood clotting factors, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.
2. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005 will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003 regardless of whether or not the durable medical equipment is implanted. The payment allowance limits will not be updated in 2005.
3. The payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent



*January 2005 Quarterly Average Sale Price Medicare Part B Drug Pricing (continued)*

of the AWP as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.

- The payment allowance limits for drugs not included in the ASP Medicare Part B Drug Pricing File are based on the published wholesale acquisition cost (WAC) or invoice pricing.

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

### Implementation

The implementation date is January 3, 2005.

### Additional Information

The official instruction issued to your carrier/intermediary regarding this change may be found on CMS website at: <http://www.cms.hhs.gov/Transmittals/downloads/R348CP.pdf>.

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

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

Medlearn Matters Number: MM3539 – Revised  
Related Change Request (CR) Number: 3539  
Related CR Release Date: October 29, 2004  
Related CR Transmittal Number: 348  
Effective Date: January 1, 2005  
Implementation Date: January 3, 2005

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

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## Consolidation of Claim Crossover Process: Additional Common Working File Functionality

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 17, 2006, to provide new Web addresses that reflect changes in the new CMS website. All other information remains the same. This article was originally published in the Third Quarter 2004 Medicare A Bulletin (pages 19-21).

### Provider Types Affected

All Medicare providers.

### Provider Action Needed

Medicare physicians, suppliers, and providers should note that this instruction communicates changes to the existing Medicare claims crossover process. CMS is implementing a new initiative known as the “Coordination of Benefits Agreement (COBA) consolidated crossover process.” This article provides guidance on the new COBA crossover strategy, including a new claim-based Medigap and Medicaid crossover process to be implemented by Medicare carriers and DMERCs on October 4, 2004. It is especially important to understand that the new claim-based COBA IDs being issued by CMS to Medigap insurers and state Medicaid agencies must be submitted on incoming claims in certain defined instances, as explained later in this article.

### Background

The Centers for Medicare & Medicaid Services (CMS) Coordination of Benefits (COB) program identifies the health benefits available to a Medicare beneficiary and coordinates the payment process to ensure appropriate payment of Medicare benefits. The program offers an automatic crossover service to other insurers, or trading partners, that may pay benefits after the Medicare claim has been processed. The trading partner is charged a fee-per-claim that is crossed by Medicare. COB trading partners include:

- Medicare supplemental insurers (i.e., non-Medigap plans),
- Title XIX State Medicaid Agencies, and
- Medigap insurers.

In order to better service its customers, CMS is streamlining the claims crossover process and is consolidating the claims crossover function under one contractor, the Medicare Coordination of Benefits Contractor (COBC).

As part of this streamlined process, COB trading partners, who are eligible to receive Medicare paid claims directly from CMS for purposes of calculating their secondary liability, will no longer have to sign separate agreements with individual Medicare carriers and intermediaries. Instead, each COB trading partner will:

- Enter into one national Coordination of Benefits Agreement (COBA) with CMS’ COBC, and
- No longer need to prepare and send separate eligibility files to Medicare intermediaries or carriers, nor receive numerous crossover files. They will instead submit one eligibility file periodically and will regularly receive a consolidated file of claims data for those eligibles.

These changes are the result of input from affected stakeholders in the health insurance industry and will result in a more effective implementation of the COBA process and more effective processes for Medicare providers to receive claim payments that are secondary to Medicare benefits. In addition, the revised COBA process will ensure

### *Consolidation of Claim Crossover Process: Additional CWF Functionality (continued)*

that CMS fulfills the requirements imposed by the HIPAA ANSI-X12 835 (electronic remittance advice [ERA]) Implementation Guide with respect to communication of crossover information to its Medicare providers and suppliers.

#### **Eligibility-Based Crossover Process**

As previously mentioned, national COBAs will now be executed with the COBC by the trading partners, and trading partners will send COB eligibility files to the COBC. Trading partners that provide eligibility files will be assigned COBA IDs to facilitate the crossover process.

For an eligibility file-based crossover, the COBA ID of the trading partner, along with all other eligibility file data elements associated to an individual beneficiary, will be stored in Medicare's common working file (CWF) in the recently established beneficiary other insurance (BOI) auxiliary record. CWF will also house the COBA insurance file that will contain specific information associated to the trading partner that is identified on the BOI auxiliary record. As Medicare claims are processed, CWF will be equipped to apply each COB trading partner's claims selection criteria against the Medicare claims and provide information to the Medicare carrier or intermediary to enable those entities to place appropriate crossover claims information on the HIPAA ANSI X12N 835 Electronic Remittance Advice sent to providers and suppliers.

#### **Claim-Based Crossover Process**

For those Medigap and Medicaid insurers that do not provide COB eligibility files identifying beneficiaries that are insured by their plans, a claim-based crossover process will be implemented by October 4, 2004. Unique five-digit COBA IDs will be assigned by the COBC to Medigap and Medicaid insurers that do not provide eligibility files to the COBC.

Medicare providers and suppliers will receive a listing of all Medigap and Medicaid insurers that have been assigned unique claim-based COBA IDs and will be responsible for entering the unique claim-based COBA IDs on each claim submitted to Medicare to initiate the crossing over of claims to the Medigap or Medicaid insurer for supplemental payment to the provider or supplier.

Through this instruction, Medicare claims processing systems will also be modified to house Medigap and Medicaid claim-based COBA IDs and the associated Medigap or Medicaid information necessary for the Medicare carrier or DMERC to prepare an ERA and send the claim to the COBC to cross to the Medigap or Medicaid insurer. The Part B or DME provider or supplier is required to include a claim-based COBA ID on incoming Medicare claims where:

- The beneficiary presents (or has presented) some evidence of his/her coverage under a Medigap plan or eligibility for Medicaid benefits and a corresponding

COBA ID for the identified Medigap insurer or State Medicaid Agency can be located on CMS' COBA claim-based ID listing;

- The provider or supplier participates in the Medicare Program. Note that this condition applies both to Medigap and Medicaid claim-based crossover; and
- The beneficiary assigns (or has assigned) his/her Medigap benefits to the provider or supplier.

#### **Implementation**

The implementation date for this instruction is July 6, 2004.

Because of this instruction's impact on providers and suppliers, carriers and DMERCs will not be required to implement the COBA claim-based crossover requirements described in this instruction until October 4, 2004. Effective October 4, 2004, all participating Part B and DME providers and suppliers will cease including the carrier or DMERC-issued Medigap or Medicaid ID on incoming claims. Instead, they will begin to include the claim-based COBA ID, which will be assigned by Medicare's COBC, on incoming claims. When Part B or DME providers or suppliers check the claim-based COBA ID listing and locate the beneficiary's identified Medigap plan, they shall include the Medigap claim-based COBA ID on the incoming claim if: 1) the provider or supplier participates in the Medicare Program; and 2) the beneficiary assigns (or has assigned) his/her rights to benefits to the provider or supplier. When Part B or DME providers or suppliers that participate in the Medicare Program check the claim-based COBA ID listing and locate the State Medicaid Agency that pays benefits for the beneficiary, they shall include the Medicaid claim-based COBA ID on the incoming claim.

As of October 4, 2004, CMS will require participating Part B and DME providers and suppliers to include the CMS-issued Medigap or Medicaid claim-based COBA ID on their submitted claims to Medicare if they wish to have their patients' Medicare claims crossed over to the Medigap or Medicaid insurer that does not supply an eligibility file for their insureds. (Section 70.6 of Chapter 28 of the Medicare Claims Processing Manual [Pub 100-04] has complete details concerning this requirement, as well as other coordination of benefits procedures.)

#### **Additional Information**

You can find the CMS program manuals index on the CMS website at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>.

Medlearn Matters Number: MM3109 – Revised  
Related Change Request (CR) Number: 3109  
Related CR Release Date: February 6, 2004  
Related CR Transmittal Number: R98CP  
Effective Date: July 1, 2004  
Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 98, CR 3109

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## Medicare Secondary Payer Application to Former Spouses and Certain Family Members with Coverage under the Federal Employees Health Benefits Program

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 17 2006, to provide new Web addresses that reflect changes in the new CMS website. All other information remains the same. This article was originally published in the First Quarter 2005 Medicare A Bulletin (page 21).

### Provider Types Affected

All Medicare providers

### Provider Action Needed

This is an informational article to alert providers that former spouses of certain federal employees, former employees, or annuitants, may qualify to enroll in a health benefits plan under the Federal Employees Health Benefit Plan (FEHB) and the correct order of payment.

A determination has been made that Medicare will be the primary payer for such former spouses, once they are entitled to Medicare based on age or disability.

### Background

Certain former spouses of people who have Federal Employees Health Benefits are entitled to coverage under the Spouse Equity Act because their divorce decree gives them the right to a portion of a future retirement annuity and/or to a survivor annuity, and because their former spouse is either an active worker, someone who is entitled to a future annuity, or is an annuitant.

The Medicare law in Section 1862 (b)(1)(A) of the Social Security Act, states that Medicare is secondary payer for individuals age 65 or over who have group health coverage by virtue of their own or a spouse’s current employment status. The question was raised as to whether FEHB coverage provided to former spouses under the Spouse Equity Act is secondary to Medicare under this provision. Also, the question has been raised as to whether FEHB coverage provided to the spouse and family members under the Spouse Equity Act is secondary to Medicare under the disability provision.

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Under the Spouse Equity Act, the individual is no longer on the former spouse’s policy. The coverage is considered to be a separate, self-only policy, i.e., not dependent coverage but a policy separate from the former spouse. The employer makes no contributions to the coverage. Since the language in the Spouse Equity Act gives the former spouse the right to enroll in FEHB whether or not the spouse himself or herself is enrolled, the FEHB former spouse coverage is not considered employment based. Consequently, Medicare is the primary payer for the former spouse, once they are entitled to Medicare under the working aged provision. Under the Medicare secondary for the disabled provision, Medicare would be primary for the former spouse as well as any covered family members since the coverage is not considered employment based.

### 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/Transmittals/downloads/R18MSP.pdf>.

Medlearn Matters Number MM3120 – Revised  
Related Change Request (CR) Number: 3120  
Related CR Release Date: August 27, 2004  
Related CR Transmittal Number: R18MSP  
Effective Date: November 29, 2004  
Implementation Date: November 29, 2004

Source: CMS Pub 100-5 Transmittal 18, CR 3120

## Explanation of Systems Used by Medicare to Process Your Claims

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

### Provider Types Affected

All physicians, providers, and suppliers who submit claims to Medicare

### Introduction

This special edition article provides a high-level overview of the software systems Medicare uses to process your claims. Frequently, *Medlearn Matters* articles reference Medicare systems and this article will help explain briefly what those systems are.

Sometimes, you may see documents from the Centers for Medicare & Medicaid Services (CMS) that reference the “shared systems,” or system acronyms, such as FISS, MCS, or CWF. The purpose of this special edition article is to provide you with some understanding of these systems and how they are used to process your claims.

### Overview

When a beneficiary visits a physician, hospital, or other supplier of health care services, a claim is sent by the provider of the service to a Medicare fiscal intermediary (FI) or carrier, including durable medical equipment regional carriers (DMERCs) and regional home health intermediaries (RHHIs). Collectively, the carriers and FIs, DMERCs, and RHHIs are referred to as Medicare contractors.

## *Explanation of Systems Used by Medicare to Process Your Claims (continued)*

Using certain systems, known within CMS as “shared systems,” the Medicare contractors perform traditional claims processing services, and send claims to another Medicare system, known as the common working file (CWF) system for verification, validation, and payment authorization.

Responses are returned from the CWF concerning payments to the FI, RHHI, DMERC, or carrier, who subsequently pays for the service, if appropriate. Only CMS and the Medicare contractors have direct communication with the CWF System. CWF provides an interface between CMS and its contractors.

The Medicare claims flow diagram on the last page of this article illustrates the claims processing flow. In brief, the various systems that process Medicare claims are described as follows:

### **Shared Systems**

There are three “shared systems” that process Medicare claims:

- One processes Medicare claims submitted to FIs and RHHIs
- Another processes claims submitted to carriers
- The third processes claims submitted to DMERCs.

All three of the “shared systems” interface with the CWF, which is addressed below. These systems apply certain edits to claims received. Claims that do not pass those edits are returned to the provider (RTP) and are often referred to as RTP claims. Examples of claims that may be RTP’ed include those where an invalid health insurance claim number (HICN) or an invalid provider number is supplied on the initial claim.

### **Fiscal Intermediary Standard System (FISS)**

FISS is a mainframe system that FIs and RHHIs use to process Medicare Part A claims nationwide, including outpatient claims submitted under Part B. Within FISS, claims are entered, corrected, adjusted, or canceled. Inquiries for status of claims, for additional development requests, or for eligibility and various codes are processed.

### **Multi-Carrier System (MCS)**

MCS is a mainframe system that Medicare Part B carriers use to process Medicare Part B Claims nationwide. It processes claims for physician care, durable medical equipment, and other outpatient services. Like its Part A counterpart, claims are entered, corrected, adjusted, or canceled. Inquiries for status of claims, for additional development requests, or for eligibility and various codes are processed.

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### **VMS Shared System**

This system has some of the same characteristics as the MCS, but processes claims submitted by suppliers to the Medicare DMERCs.

### **CMS-Supplied Modules and Pricing/Coding Files**

In addition to the “shared systems,” CMS supplies other uniform modules to FIs, RHHIs, DMERCs, and carriers, and these modules are used by the shared systems in processing Medicare claims. By and large, these modules establish rates (or prices) and processing logic according to type of service.

These modules or programs include the following:

- Those referred to as the PRICERs (there are several PRICERs, such as an inpatient PRICER, an outpatient PRICER, and so on).
- OCE (outpatient code editor)
- MCE (inpatient code editor)
- GROUPER, which translates variables such as age, diagnosis, and surgical codes into a diagnosis related group (DRG).

In addition, fee schedules and codes are supplied by CMS in the form of downloadable files, which are used by the shared systems in processing Medicare claims.

Some of these files include: MPFSDB (Medicare physician fee schedule) and its various forms; DMEPOS (durable medical equipment, prosthetics, orthotics, and supplies schedule); ambulance fee schedule; and HCPCS (Health Care Common Procedure Codes).

### **Common Working File (CWF)**

The CWF contains information about all Medicare beneficiaries. The shared systems interface with the CWF to verify beneficiaries’ entitlement to Medicare, deductible status, and benefits available, such as lifetime reserve days. The CWF actually approves payment of each claim. Under CWF, Part A and Part B data for each beneficiary is combined into a single, common working file.

Medlearn Matters Number: SE0605

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

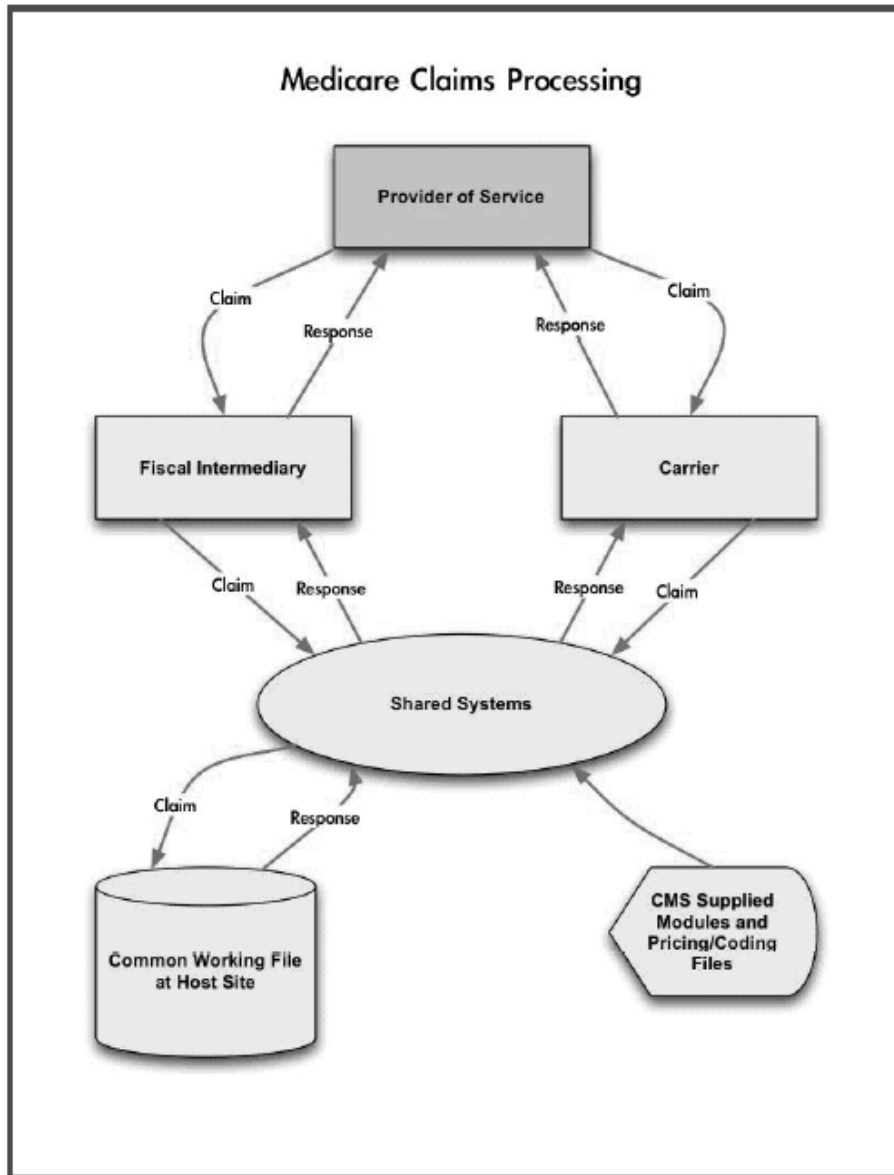
Effective Date: N/A

Related CR Transmittal Number: N/A

Implementation Date: N/A

Source: Special Edition Medlearn Matters Article SE0605



*Explanation of Systems Used by Medicare to Process Your Claims (continued)*

## NATIONAL PROVIDER IDENTIFIER

### NPI Information for Medicare Organization Provider Subparts

The National Provider Identifier (NPI) final rule requires health care providers who are organizations and who are covered entities under HIPAA to determine if they have “subparts” that should be assigned NPIs. The NPI final rule provides guidance to those health care providers in making those determinations.

The Centers for Medicare & Medicaid Services (CMS) has communicated to the Provider Enrollment staff at the carriers and fiscal intermediaries the Medicare program’s expectations concerning the determination of subparts for NPI assignment purposes. CMS has posted a document describing the subpart concept and its relationship to the way in which Medicare enrolls its organization providers at [http://www.cms.hhs.gov/NationalProvIdentStand/06\\_implementation.asp#TopOfPage](http://www.cms.hhs.gov/NationalProvIdentStand/06_implementation.asp#TopOfPage).

This document will be helpful to providers in understanding the issue of subparts and how subpart determination could be done in a way that helps to promote smoother and more efficient Medicare claims processing during the implementation of the NPI in the Medicare program.

The health care industry in general has expressed an interest in being informed of this type of information. CMS is making this information available on the CMS website so that it is easily available to interested parties. ❖

Source: Provider Education Resources Listserv, Message 200601-11

## Redesigned of the National Provider Identifier Web Page

Announcing the redesigned CMS Web page dedicated to providing all the latest National Provider Identifier (NPI) news for health care providers. Visit the Web page <http://www.cms.hhs.gov/NationalProvIdentStand/>.

This page also contains a section for Medicare fee-for-service (FFS) providers with helpful information on the Medicare NPI implementation. A new fact sheet with answers to questions that health care providers may have regarding the NPI is now available on the web page; bookmark this page as new information and resources will continue to be posted.

For more information on private industry NPI outreach, visit the Workgroup for Electronic Data Interchange (WEDI) NPI Outreach Initiative website at <http://www.wedi.org/npioi/index.shtml>.

Source: CMS Joint Signature Memorandum 06184, January 23, 2006

## Requirements for Use and Editing of National Provider Identifier Numbers

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

### Provider Types Affected

Physicians, providers, and suppliers who submit claims for services to Medicare carriers, including durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs), to include regional home health intermediaries (RHHIs)

### Provider Action Needed

The requirements for stage 2 apply to all transactions that are first processed by Medicare systems on or after October 2, 2006, and are not based on the date of receipt of a transaction, unless otherwise stated in a business requirement.

Please note that the effective and implementation dates shown above reflect the dates that Medicare systems will be ready, but the key date for providers regarding the use of the NPI in stage 2 is October 1, 2006.

### Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414)).

To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began to accept applications for, and to issue NPIs, on May 23, 2005.

Applications may be made by mail and also online at <https://nppes.cms.hhs.gov>.

### NPI and Legacy Identifiers

The NPI is a ten-position, intelligence-free numeric identifier (ten-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. **Beginning May 23, 2007 (May 23, 2008, for small health plans), the NPI must be used in lieu of legacy provider identifiers.**

Legacy provider identifiers include:

- Online survey certification and reporting (OSCAR) system numbers
- National supplier clearinghouse (NSC) numbers

- Provider identification numbers (PINs)
- Unique physician identification numbers (UPINs) used by Medicare.

They **do not** include taxpayer identifier numbers (TINs) or such as:

- Employer identification numbers (EINs)
- Social security numbers (SSNs).

### Primary and Secondary Providers

Providers are categorized as either "primary" or "secondary" providers:

- **Primary providers** include billing, pay-to, rendering, or performing providers. In the DMERCs, primary providers include ordering providers.
- **Secondary providers** include supervising physicians, operating physicians, referring providers, and so on.

### Crosswalk

During stage 2, Medicare will utilize a crosswalk between NPIs and legacy identifiers to validate NPIs received in transactions, assist with population of NPIs in Medicare data center provider files, and report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions. Key elements of this crosswalk include the following:

- Each primary provider's NPI reported on an inbound claim or claim status query will be cross-walked to the Medicare legacy identifier that applies to the owner of that NPI.
- The Crosswalk will be able to do a two-directional search, from a Medicare legacy identifier to NPI, and from NPI to a legacy identifier.
- The Medicare Crosswalk will be updated daily to reflect new provider registrations.

### NPI Transition Plans for Medicare FFS Providers

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

*Requirements for Use and Editing of National Provider Identifier Numbers (continued)*

<b>Stage</b>	<b>Medicare Implementation</b>
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.
October 2, 2006 – May 22, 2007 <i>(This is stage 2, the subject of CR4023)</i>	<p>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.</p> <p><i>Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.</i></p> <p>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.</p>
May 23, 2007 – Forward	CMS systems will only accept NPI numbers. Coordination of benefit transactions sent to small health plans will continue to carry legacy identifiers, if requested by such a plan, through May 22, 2007.

**Claim Rejection**

Claims will be rejected if:

- The NPI included in a claim or claim status request does not meet the content criteria requirements for a valid NPI; this affects:
  - ♦ X12 837 and Direct Data Entry (DDE) screen claims (DDE claims are submitted to Medicare intermediaries only)
  - ♦ National Council of Prescription Drug Plan (NCPDP) claims (submitted to Medicare DMERCs only)
  - ♦ Claims submitted using Medicare’s free billing software
  - ♦ Electronic claim status request received via X12 276 or DDE screen
  - ♦ Non-X12 electronic claim status queries
- An NPI reported cannot be located in Medicare files.
- The NPI is located, but a legacy identifier reported for the same provider in the transaction does not match the legacy identifier in the Medicare file for that NPI.
- Claims include the NPI but do not have a taxpayer identification number (TIN) reported for the billing or pay-to provider in electronic claims received via X12 837, DDE screen (FISS only), or Medicare’s free billing software.

**Note:** If only provider legacy identifiers are reported on an inbound transaction prior to May 23, 2007, pre-NPI provider legacy number edit rules will be applied to those legacy identifiers.

**Additional Information**

**X12 837 Incoming Claims and COB**

During stage 2, an X12 837 claim may technically be submitted with only an NPI for a provider, **but you are strongly encouraged to also submit the corresponding Medicare legacy identifier for each NPI** in X12 837 Medicare claims.

Use of both numbers could facilitate investigation of errors if one identifier or the other cannot be located in the Medicare validation file. When an NPI is reported in a claim for a billing or pay-to provider, a TIN must also be submitted in addition to the provider’s legacy identifier as required by the claim implementation guide.

**National Council of Prescription Drug Plans (NCPDP) Claims**

The NCPDP format was designed to permit a prescription drug claim to be submitted with either **an NPI or a legacy identifier, but not more than one identifier** for the same retail pharmacy or prescribing physician. The NCPDP did provide qualifiers, including one for NPIs, to be used to identify the type of provider identifier being reported.

- For stage 1, retail pharmacies were directed to continue filing their NCPDP claims with their individual NSC number and to report the UPIN of the prescribing physician.
- During stage 2, retail pharmacies will be allowed to report their NPI, and/or the NPI of the prescribing physician (if they have the prescribing physician’s NPI) in their claims.

## Requirements for Use and Editing of National Provider Identifier Numbers (continued)

When an NPI is submitted in an NCPDP claim, it will be edited in the same way as an NPI submitted in an X12 837 version 4010A1 claim. The retail pharmacy will be considered the primary provider and the prescribing physician as the secondary provider for NPI editing purposes.

### Paper Claim Forms

The transition period for the revised CMS-1500 is currently scheduled to begin October 1, 2006 and end February 28, 2007. The transition period for the UB-04 is currently scheduled for March 1, 2007 - May 22, 2007.

Pending the start of submission of the revised CMS-1500 and the UB-04, providers must continue to report legacy identifiers, and not NPIs, when submitting claims on the non-revised CMS-1500 and the UB-92 paper claim forms.

Provider identifiers reported on those claim forms are presumed to be legacy identifiers and will be edited accordingly. "Old" form paper claims, received through the end of the transition period that applies to each form, may be rejected if submitted with an NPI.

Or, if they are not rejected—since some legacy identifiers were also 10-digits in length—could be incorrectly processed, preventing payment to the provider that submitted that paper claim.

### Standard Paper Remits (SPRs)

The SPR FI and carrier/DMERC formats are being revised to allow reporting of both a provider's NPI and legacy identifier when both are available in Medicare's files. If a provider's NPI is available in the data center provider file, it will be reported on the SPR, even if the NPI was not reported for the billing/pay-to, or rendering provider on each of the claims included in that SPR. The revised FI and carrier/DMERC SPR formats are attached to CR 4023:

- CR 4023 Attachment 1: FI standard paper remit (SPR) amended format for stage 2
- CR 4023 Attachment 2: carrier/DMERC SPR amended stage 2 Format.

### Remit Print Software

The 835 PC-Print and Medicare remit easy print software will be modified by October 2, 2006, to enable either the NPI or a Medicare legacy number, or both, if included in the 835, to be printed during stage 2.

### Free Billing Software

Medicare will ensure that this software is changed as needed by October 2, 2006, to enable reporting of both an NPI and a Medicare legacy identifier for each provider for which data is furnished in a claim, and to identify whether an entered identifier is an NPI or a legacy identifier.

### In-Depth Information

Please refer to CR4023 for additional detailed NPI-related claim information about the following topics:

- Crosswalk
- X12 837 Incoming Claims and COB
- Non-HIPAA COB Claims
- NCPDP Claims
- DDE Screens
- Paper Claim Forms
- Free Billing Software
- X12 276/277 Claim Status Inquiry and Response Transactions
- 270/271 Eligibility Inquiry and Response Transactions
- 835 Payment and Remittance Advice Transactions
- Electronic Funds Transfer (EFT)
- Standard Paper Remits (SPRs)
- Remit Print Software
- Claims History
- Proprietary Error Reports
- Carrier, DMERC, and FI Local Provider Files, including EDI System Access Security Files
- Med A and Med B Translators
- Other Translators
- Stages 3 and 4

CR 4023, the official instruction issued to your FI/regional home health intermediary (RHHI) or carrier/durable medical equipment regional carrier (DMERC) regarding this change, may be found by going to CMS website <http://www.cms.hhs.gov/transmittals/downloads/R787CP.pdf>.

You may also wish to review *Medlearn Matters* article SE0555, "Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition *Medlearn Matters* Articles on NPI-Related Activities," which is available on the CMS website at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0555.pdf>.

This article contains further details on the NPI and how to obtain one.

Please refer to your local FI/RHHI or carrier/DMERC if you have questions about this issue. To find their toll free phone number, go to CMS website <http://www.cms.hhs.gov/apps/contacts/>.

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

Medlearn Matters Number: MM4023  
Related Change Request (CR) Number: 4023  
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Source: CMS Pub. 100-20, Transmittal 190, CR 4023

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# AMBULANCE SERVICES

## Terminating Ambulance HCPCS Q3019 and Q3020

Effective January 1, 2006 with implementation of the full ambulance fee schedule, temporary HCPCS Q3019, and Q3020 have been terminated. Ambulance suppliers that were previously permitted to bill separately for these services furnished incident to the ambulance transport could continue to do so until the full implementation of the ambulance fee schedule.

These codes will appear as valid on the HCPCS file, but will be updated to reflect this change in a future release.. ❖

Source: CMS Pub. 100-4, Transmittal 806, CR 4251

## Medical Condition List for Ambulance Services

The Centers for Medicare & Medicaid Services (CMS) has issued Pub. 100-04, transmittal 789, change request (CR) 4221. This document, dated December 23, 2005, includes an ambulance medical conditions list and its instructions.

The “Medical Conditions List” is intended primarily as an educational guideline. It will help ambulance providers and suppliers to communicate the patient’s condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew.

Use of the medical conditions list information does not guarantee payment of the claim or payment for a certain level of service. Ambulance providers and suppliers must retain adequate documentation of dispatch instructions, patient’s condition, and miles traveled, all of which must be available in the event the claim is selected for medical review (MR) by the Medicare contractor or other oversight authority. Medicare contractors will rely on medical record documentation to justify coverage. The Healthcare Common Procedure Coding System (HCPCS) code or the medical conditions list information by themselves are not sufficient to justify coverage.

All current Medicare ambulance policies remain in place.

CMS issued the medical conditions list as guidance via a manual revision as a result of interest expressed in the ambulance industry for this tool. While the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes are not precluded from use on ambulance claims, they are currently not required (per Health Insurance Portability and Accountability Act (HIPAA)) on most ambulance claims, and these codes generally do not trigger a payment or a denial of a claim. Some carriers and fiscal intermediaries have local coverage determinations (LCD) in place that cite ICD-9-CM that can be added to the claim to assist in documenting that the services are reasonable and necessary, but this is not common. Since ICD-9-CM codes are not required and are not consistently used, not all carriers or fiscal intermediaries edit on this field, and it is not possible to edit on the narrative field. The ICD-9-CM codes are generally not part of the edit process, although the medical conditions list is available for those who do find it helpful in justifying that services are reasonable and necessary.

The medical conditions list is set up with an initial column of primary ICD-9-CM codes, followed by an

alternative column of ICD-9-CM codes. The primary ICD-9-CM code column contains general ICD-9-CM codes that fit the transport conditions as described in the subsequent columns. Ambulance crew or billing staff with limited knowledge of ICD-9-CM coding would be expected to choose the one or one of the two ICD-9-CM codes listed in this column to describe the appropriate ambulance transport and then place the ICD-9-CM code in the space on the claim form designated for an ICD-9-CM code. The option to include other information in the narrative field always exists and can be used whenever an ambulance provider or supplier believes that the information may be useful for claims processing purposes. If an ambulance crew or billing staff member has more comprehensive clinical knowledge, then that person may select an ICD-9-CM code from the alternative ICD-9-CM code column. These ICD-9-CM codes are more specific and detailed. An ICD-9-CM code does not need to be selected from both the primary column and the alternative column. However, in several instances in the alternative ICD-9-CM code column, there is a selection of codes and the word “PLUS.” In these instances, the ambulance provider or supplier would select an ICD-9-CM code from the first part of the alternative listing (before the word “PLUS”) and at least one other ICD-9-CM code from the second part of the alternative listing (after the word “PLUS”). The ambulance claim form does provide space for the use of multiple ICD-9-CM codes. Please see the example below:

The ambulance arrives on the scene. A beneficiary is experiencing the specific abnormal vital sign of elevated blood pressure; however, the beneficiary does not normally suffer from hypertension (ICD-9-CM code 796.2 (from the alternative column on the Medical Conditions List)). In addition, the beneficiary is extremely dizzy (ICD-9-CM code 780.4 (fits the “PLUS any other code” requirement when using the alternative list for this condition (abnormal vital signs))). The ambulance crew can list these two ICD-9-CM codes on the claim form, or the general ICD-9-CM code for this condition (796.4 – Other Abnormal Clinical Findings) would work just as well. None of these ICD-9-CM codes will determine whether or not this claim will be paid; they will only assist the contractor in making a medical review determination provided all other Medicare ambulance coverage policies have been followed.

### *Medical Condition List for Ambulance Services (continued)*

While the medical conditions/ICD-9-CM code list is intended to be comprehensive, there may be unusual circumstances that warrant the need for ambulance services using ICD-9-CM codes not on this list. During the medical review process contractors may accept other relevant information from the providers or suppliers that will build the appropriate case that justifies the need for ambulance transport for a patient condition not found on the list.

Because it is critical to accurately communicate the condition of the patient during the ambulance transport, most claims will contain only the ICD-9-CM code that most closely informs the Medicare contractor why the patient required the ambulance transport. This code is intended to correspond to the description of the patient's symptoms and condition once the ambulance personnel are at the patient's side. For example, if an advanced life support (ALS) ambulance responds to a condition on the medical conditions list that warrants an ALS-level response and the patient's condition on-scene also corresponds to an ALS-level condition, the submitted claim need only include the code that most accurately reflects the on-scene condition of the patient as the reason for transport. (All claims are required to have HCPCS codes on them, and may have modifiers as well.) Similarly, if a Basic Life Support (BLS) ambulance responds to a condition on the medical conditions list that warrants a BLS-level response and the patient's condition on-scene also corresponds to a BLS-level condition, the submitted claim need only include the code that most accurately reflects the on scene condition of the patient as the reason for transport.

When a request for service is received by ambulance dispatch personnel for a condition that necessitates the skilled assessment of an advanced life support paramedic based upon the medical conditions list, an ALS-level ambulance would be appropriately sent to the scene. If upon arrival of the ambulance the actual condition encountered by the crew corresponds to a BLS-level situation, this claim would require two separate condition codes from the medical condition list to be processed correctly. The first code would correspond to the "reason for transport" or the on-scene condition of the patient. Because in this example, this code corresponds to a BLS condition, a second code that corresponds to the dispatch information would be necessary for inclusion on the claim in order to support payment at the ALS level. In these cases, when MR is performed, the Medicare contractor will analyze all claim information (including both codes) and other supplemental medical documentation to support the level of service billed on the claim.

Contractors may have (or may develop) individual local policies that indicate that some codes are not appropriate for payment in some circumstances. These continue to remain in effect.

### **Information on Appropriate Use of Transportation Indicators**

When a claim is submitted for payment, an ICD-9-CM code from the medical conditions list that best describes the patient's condition and the medical necessity for the transport may be chosen. In addition to this code, one of the transportation indicators below may be included on the

claim to indicate why it was necessary for the patient to be transported in a particular way or circumstance. The provider or supplier will place the transportation indicator in the "narrative" field on the claim.

### **Air and Ground**

- **Transportation Indicator "C1":** Transportation indicator "C1" indicates an inter-facility transport (to a higher level of care) determined necessary by the originating facility based upon EMTALA regulations and guidelines. The patient's condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list.
- **Transportation Indicator "C2":** Transportation indicator "C2" indicates a patient is being transported from one facility to another because a service or therapy required to treat the patient's condition is not available at the originating facility. The patient's condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list. In addition, the information about what service the patient requires that was not available should be included in the narrative field of the claim.
- **Transportation Indicator "C3":** Transportation indicator "C3" may be included on claims as a secondary code where a response was made to a major incident or mechanism of injury. All such responses – regardless of the type of patient or patients found once on scene – are appropriately Advanced Level Service responses. A code that describes the patient's condition found on scene should also be included on the claim, but use of this modifier is intended to indicate that the highest level of service available response was medically justified. Some examples of these types of responses would include patient(s) trapped in machinery, explosions, a building fire with persons reported inside, major incidents involving aircraft, buses, subways, trains, watercraft and victims entrapped in vehicles.
- **Transportation Indicator "C4":** Transportation indicator "C4" indicates that an ambulance provided a medically necessary transport, but the number of miles on the claim form appear to be excessive. This should be used only if the facility is on divert status or a particular service is not available at the time of transport only. The provider or supplier must have documentation on file clearly showing why the beneficiary was not transported to the nearest facility and may include this information in the narrative field.

### **Ground Only**

- **Transportation Indicator "C5":** Transportation indicator "C5" has been added for situations where a patient with an ALS-level condition is encountered, treated and transported by a BLS-level ambulance with no ALS level involvement whatsoever. This situation would occur when ALS resources are not available to respond to the patient encounter for any number of reasons, but the ambulance service is informing you that although the patient transported had an ALS-level

*Medical Condition List for Ambulance Services (continued)*

condition, the actual service rendered was through a BLS-level ambulance in a situation where an ALS-level ambulance was not available.

For example, a BLS ambulance is dispatched at the emergency level to pick up a 76-year-old beneficiary who has undergone cataract surgery at the eye surgery center. The patient is weak and dizzy with a history of high blood pressure, myocardial infarction, and insulin-dependent diabetes melitus. Therefore, the on-scene ICD-9-CM equivalent of the medical condition is 780.02 (unconscious, fainting, syncope, near syncope, weakness, or dizziness – ALS Emergency). In this case, the ICD-9-CM code 780.02 would be entered on the ambulance claim form as well as transportation indicator C5 to provide the further information that the BLS ambulance transported a patient with an ALS-level condition, but there was no intervention by an ALS service. This claim would be paid at the BLS level.

- **Transportation Indicator “C6”:** Transportation indicator “C6” has been added for situations when an ALS-level ambulance would always be the appropriate resource chosen based upon medical dispatch protocols to respond to a request for service. If once on scene, the crew determines that the patient requiring transport has a BLS-level condition, this transportation indicator should be included on the claim to indicate why the ALS-level response was indicated based upon the information obtained in the operation’s dispatch center. Claims including this transportation indicator should contain two primary codes. The first condition will indicate the BLS-level condition corresponding to the patient’s condition found on-scene and during the transport. The second condition will indicate the ALS-level condition corresponding to the information at the time of dispatch that indicated the need for an ALS-level response based upon medically appropriate dispatch protocols.

- **Transportation Indicator “C7”:** Transportation indicator “C7” is for those circumstances where IV medications were required en route. C7 is appropriately used for patients requiring ALS level transport in a nonemergent situation primarily because the patient requires monitoring of ongoing medications administered intravenously. Does not apply to self-administered medications. Does not include administration of crystalloid intravenous fluids (i.e., normal saline, lactate ringers, 5 percent dextrose in water, etc.). The patient’s condition should also be reported on the claim with a code selected from the list.

**Air Only**

**All “transportation indicators” imply a clinical benefit to the time saved with transporting a patient by an air ambulance versus a ground or water ambulance.**

- D1 Long Distance – patient’s condition requires rapid transportation over a long distance.
- D2 Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.
- D3 Time to get to the closest appropriate hospital due to the patient’s condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of-hospital time to maximize clinical benefits to the patient.
- D4 Pick up point not accessible by ground transportation.

The medical conditions list and entire text of this transmittal is available on CMS website at <http://new.cms.hhs.gov/Transmittals/Downloads/R789CP.pdf>. ❖

Source: CMS Pub. 100-4, Transmittal 789, CR 4221,

## Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
<b>Emergency Conditions - Non-Traumatic</b>						
535.50	458.9, 780.2, 787.01, 787.02, 787.03, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, 789.09, 789.60 through 789.69, or 789.40 through 789.49 PLUS any other code from 780 through 799 except 793, 794, and 795.	Severe abdominal pain	With other signs or symptoms	ALS	Nausea, vomiting, fainting, pulsatile mass, distention, rigid, tenderness on exam, guarding.	A0427/A0433
789.00	726.2, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, or 789.09.	Abdominal pain	Without other signs or symptoms	BLS		A0429
427.9	426.0, 426.3, 426.4, 426.6, 426.11, 426.13, 426.50, 426.53, 427.0, 427.1, 427.2, 427.31, 427.32, 427.41, 427.42, 427.5, 427.60, 427.61, 427.69, 427.81, 427.89, 785.0, 785.50, 785.51, 785.52, or 785.59.	Abnormal cardiac rhythm/Cardiac dysrhythmia.	Potentially life-threatening	ALS	Bradycardia, junctional and ventricular blocks, non-sinus tachycardias, PVC's >6, bi and trigeminy, ventricular tachycardia, ventricular fibrillation, atrial flutter, PEA, asystole, AICD/AED Fired	A0427/A0433
780.8	782.5 or 782.6	Abnormal skin signs		ALS	Diaphoresis, cyanosis, delayed cap refill, poor turgor, mottled.	A0427/A0433
796.4	458.9, 780.6, 785.9, 796.2, or 796.3 PLUS any other code from 780 through 799.	Abnormal vital signs (includes abnormal pulse oximetry).	With or without symptoms.	ALS		A0427/A0433



## Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
995.0	995.1, 995.2, 995.3, 995.4, 995.60, 995.61, 995.62, 995.63, 995.64, 995.65, 995.66, 995.67, 995.68, 995.69 or 995.7.	Allergic reaction	Potentially life-threatening	ALS	Other emergency conditions, rapid progression of symptoms, prior hx. Of anaphylaxis, wheezing, difficulty swallowing.	A0427/A0433
692.9	692.0, 692.1, 692.2, 692.3, 692.4, 692.5, 692.6, 692.70, 692.71, 692.72, 692.73, 692.74, 692.75, 692.76, 692.77, 692.79, 692.81, 692.82, 692.83, 692.89, 692.9, 693.0, 693.1, 693.8, 693.9, 695.9, 698.9, 708.9, 782.1.	Allergic reaction	Other	BLS	Hives, itching, rash, slow onset, local swelling, redness, erythema.	A0429
790.21	790.22, 250.02, or 250.03.	Blood glucose	Abnormal <80 or >250, with symptoms.	ALS	Altered mental status, vomiting, signs of dehydration.	A0427/A0433
799.1	786.02, 786.03, 786.04, or 786.09.	Respiratory arrest		ALS	Apnea, hypoventilation requiring ventilatory assistance and airway management.	A0427/A0433
786.05		Difficulty breathing		ALS		A0427/A0433
427.5		Cardiac arrest—Resuscitation in progress		ALS		A0427/A0433

## Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
786.50	786.51, 786.52, or 786.59.	Chest pain (non-traumatic)		ALS	Dull, severe, crushing, substernal, epigastric, left sided chest pain associated with pain of the jaw, left arm, neck, back, and nausea, vomiting, palpitations, pallor, diaphoresis, decreased LOC.	A0427/A0433
784.9	933.0 or 933.1.	Choking episode	Airway obstructed or partially obstructed	ALS		A0427/A0433
991.6		Cold exposure	Potentially life or limb threatening	ALS	Temperature< 95F, deep frost bite, other emergency conditions.	A0427/A0433
991.9	991.0, 991.1, 991.2, 991.3, or 991.4.	Cold exposure	With symptoms	BLS	Shivering, superficial frost bite, and other emergency conditions.	A0429
780.01	780.02, 780.03, or 780.09.	Altered level of consciousness (nontraumatic)		ALS	Acute condition with Glasgow Coma Scale<15.	A0427/A0433
780.39	345.00, 345.01, 345.2, 345.3, 345.10, 345.11, 345.40, 345.41, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.80, 345.81, 345.90, 345.91, or 780.31.	Convulsions, Seizures	Seizing, immediate post-seizure, postictal, or at risk of seizure & requires medical monitoring/observation.	ALS		A0427/A0433
379.90	368.11, 368.12, or 379.91.	Eye symptoms, non-traumatic	Acute vision loss and/or severe pain	BLS		A0429

## Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
437.9	784.0 PLUS 781.0, 781.1, 781.2, 781.3, 781.4, or 781.8.	Non traumatic headache	With neurologic distress conditions or sudden severe onset	ALS		A0427/A0433
785.1		Cardiac Symptoms other than chest pain.	Palpitations, skipped beats	ALS		A0427/A0433
536.2	787.01, 787.02, 787.03, 780.79, 786.8, or 786.52.	Cardiac symptoms other than chest pain.	Atypical pain or other symptoms	ALS	Persistent nausea and vomiting, weakness, hiccups, pleuritic pain, feeling of impending doom, and other emergency conditions.	A0427/A0433
992.5	992.0, 992.1, 992.3, 992.4, or 992.5.	Heat Exposure	Potentially life-threatening	ALS	Hot and dry skin, Temp>105, neurologic distress, signs of heat stroke or heat exhaustion, orthostatic vitals, other emergency conditions.	A0427/A0433
992.2	992.6, 992.7, 992.8, or 992.9.	Heat exposure	With symptoms	BLS	Muscle cramps, profuse sweating, fatigue.	A0429
459.0	569.3, 578.0, 578.1, 578.9, 596.7, 596.8, 623.8, 626.9, 637.1, 634.1, 666.00, 666.02, 666.04, 666.10, 666.12, 666.14, 666.20, 666.22, 666.24, 674.30, 674.32, 674.34, 786.3, 784.7, or 998.11.	Hemorrhage	Severe (quantity) and potentially life-threatening	ALS	Uncontrolled or significant signs of shock or other emergency conditions. Severe, active vaginal, rectal bleeding, hematemesis, hemoptysis, epistaxis, active post-surgical bleeding.	A0427/A0433

## Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
038.9	136.9, any other condition in the 001 through 139 code range which would require isolation.	Infectious diseases requiring isolation procedures / public health risk.		BLS		A0429
987.9	981, 982.0, 982.1, 982.2, 982.3, 982.4, 982.8, 983.0, 983.1, 983.2, 983.9, 984.0, 984.1, 984.8, 984.9, 985.0, 985.1, 985.2, 985.3, 985.4, 985.5, 985.6, 985.8, 985.9, 986, 987.0, 987.1, 987.2, 987.3, 987.4, 987.5, 987.6, 987.7, 987.8, 989.1, 989.2, 989.3, 989.4, 989.6, 989.7, 989.9, or 990.	Hazmat Exposure		ALS	Toxic fume or liquid exposure via inhalation, absorption, oral, radiation, smoke inhalation.	A0427/A0433
996.00	996.01, 996.02, 996.04, 996.09, 996.1, or 996.2.	Medical Device Failure	Life or limb threatening malfunction, failure, or complication.	ALS	Malfunction of ventilator, internal pacemaker, internal defibrillator, implanted drug delivery device.	A0427/A0433
996.30	996.31, 996.40, 996.41, 996.42, 996.43, 996.44, 996.45, 996.46, 996.47, 996.49, or 996.59.	Medical Device Failure	Health maintenance device failures that cannot be resolved on location.	BLS	Oxygen System supply malfunction, orthopedic device failure.	A0429
436	291.3, 293.82, 298.9, 344.9, 368.16, 369.9, 780.09, 780.4, 781.0, 781.2, 781.94, 781.99, 782.0, 784.3, 784.5, or 787.2.	Neurologic Distress	Facial drooping; loss of vision; aphasia; difficulty swallowing; numbness, tingling extremity; stupor, delirium, confusion, hallucinations; paralysis, paresis (focal weakness); abnormal movements; vertigo; unsteady gait/ balance; slurred speech, unable to speak	ALS		A0427/A0433



## Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
780.99		Pain, severe not otherwise specified in this list.	Acute onset, unable to ambulate or sit due to intensity of pain.	ALS	Pain is the reason for the transport. Use severity scale (7–10 for severe pain) or patient receiving pharmacologic intervention	A0427/A0433
724.5	724.2 or 785.9.	Back pain—non-traumatic (T and/or LS).	Suspect cardiac or vascular etiology	ALS	Other emergency conditions, absence of or decreased leg pulses, pulsatile abdominal mass, severe tearing abdominal pain.	A0427/A0433
724.9	724.2, 724.5, 847.1, or 847.2.	Back pain—non-traumatic (T and/or LS).	Sudden onset of new neurologic symptoms	ALS	Neurologic distress list.	A0427/A0433
977.9	Any code from 960 through 979.	Poisons, ingested, injected, inhaled, absorbed.	Adverse drug reaction, poison exposure by inhalation, injection or absorption.	ALS		A0427/A0433
305.0	303.00, 303.01, 303.02, 303.03, or any code from 960 through 979.	Alcohol intoxication or drug overdose (suspected).	Unable to care for self and unable to ambulate. No airway compromise.	BLS		A0429
977.3		Severe alcohol intoxication.	Airway may or may not be at risk. Pharmacological intervention or cardiac monitoring may be needed. Decreased level of consciousness resulting or potentially resulting in airway compromise.	ALS		A0427/A0433
998.9	674.10, 674.12, 674.14, 674.20, 674.22, 674.24, 997.69, 998.31, 998.32, or 998.83.	Post—operative procedure complications.	Major wound dehiscence, evisceration, or requires special handling for transport.	BLS	Non-life threatening.	A0429
650	Any code from 660 through 669 or from 630 through 767.	Pregnancy complication/ Childbirth/Labor		ALS		A0427/A0433
292.9	291.0, 291.3, 291.81, 292.0, 292.81, 292.82, 292.83, 292.84, or 292.89.	Psychiatric/Behavioral	Abnormal mental status; drug withdrawal.	ALS	Disoriented, DT's, withdrawal symptoms	A0427/A0433

## Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
298.9	300.9	Psychiatric/Behavioral	Threat to self or others, acute episode or exacerbation of paranoia, or disruptive behavior	BLS	Suicidal, homicidal, or violent.	A0429
036.9	780.6 PLUS either 784.0 or 723.5.	Sick Person - Fever	Fever with associated symptoms (headache, stiff neck, etc.). Neurological changes.	BLS	Suspected spinal meningitis.	A0429
787.01	787.02, 787.03, or 787.91.	Severe dehydration	Nausea and vomiting, diarrhea, severe and incapacitating resulting in severe side effects of dehydration.	ALS		A0427/A0433
780.02	780.2 or 780.4	Unconscious, fainting, syncope, near syncope, weakness, or dizziness.	Transient unconscious episode or found unconscious. Acute episode or exacerbation.	ALS		A0427/A0433
<b>Emergency Conditions—Trauma</b>						
959.8	800.00 through 804.99, 807.4, 807.6, 808.8, 808.9, 812.00 through 812.59, 813.00 through 813.93, 813.93, 820.00 through 821.39, 823.00 through 823.92, 851.00 through 866.13, 870.0 through 879.9, 880.00 through 887.7, or 890.0 through 897.7.	Major trauma	As defined by ACS Field Triage Decision Scheme. Trauma with one of the following: Glasgow <14; systolic BP<90; RR<10 or >29; all penetrating injuries to head, neck, torso, extremities proximal to elbow or knee; flail chest; combination of trauma and burns; pelvic fracture; 2 or more long bone fractures; open or depressed skull fracture; paralysis; severe mechanism of injury including: ejection, death of another passenger in same patient compartment, falls >20", 20" deformity in vehicle or 12" deformity of patient compartment, auto pedestrian/ bike, pedestrian thrown/run over, motorcycle accident at speeds >20 mph and rider separated from vehicle.	ALS	See "Condition Specific" Column	A0427/A0433
518.5		Other trauma	Need to monitor or maintain airway	ALS	Decreased LOC, bleeding into airway, trauma to head, face or neck.	A0427/A0433
958.2	870.0 through 879.9, 880.00 through 887.7, 890.0 through 897.7, or 900.00 through 904.9.	Other trauma	Major bleeding	ALS	Uncontrolled or significant bleeding.	A0427/A0433
829.0	805.00, 810.00 through 819.1, or 820.00 through 829.1.	Other trauma	Suspected fracture/dislocation requiring splinting/immobilization for transport.	BLS	Spinal, long bones, and joints including shoulder elbow, wrist, hip, knee, and ankle, deformity of bone or joint.	A0429

## Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
880.00	880.00 through 887.7 or 890.0 through 897.7.	Other trauma	Penetrating extremity injuries	BLS	Isolated with bleeding stopped and good CSM.	A0429
886.0 or 895.0	886.1 or 895.1.	Other trauma	Amputation—digits	BLS		A0429
887.4 or 897.4	887.0, 887.1, 887.2, 887.3, 887.6, 887.7, 897.0, 897.1, 897.2, 897.3, 897.5, 897.6, or 897.7.	Other trauma	Amputation—all other	ALS		A0427/A0433
869.0 or 869.1	511.8, 512.8, 860.2, 860.3, 860.4, 860.5, 873.8, 873.9, or 959.01.	Other trauma	Suspected internal, head, chest, or abdominal injuries.	ALS	Signs of closed head injury, open head injury, pneumothorax, hemothorax, abdominal bruising, positive abdominal signs on exam, internal bleeding criteria, evisceration.	A0427/A0433
949.3	941.30 through 941.39, 942.30 through 942.39, 943.30 through 943.39, 944.30 through 944.38, 945.30 through 945.39, or 949.3.	Burns	Major—per American Burn Association (ABA)	ALS	Partial thickness burns > 10% total body surface area (TBSA); involvement of face, hands, feet, genitalia, perineum, or major joints; third degree burns; electrical; chemical; inhalation; burns with preexisting medical disorders; burns and trauma	A0427/A0433

## Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
949.2	941.20 through 941.29, 942.20 through 942.29, 943.20 through 943.29, 944.20 through 944.28, 945.20 through 945.29, or 949.2.	Burns	Minor—per ABA	BLS	Other burns than listed above.	A0429
989.5		Animal bites, stings, envenomation	Potentially life or limb-threatening	ALS	Symptoms of specific envenomation, significant face, neck, trunk, and extremity involvement; other emergency conditions.	A0427/A0433
879.8	Any code from 870.0 through 897.7.	Animal bites/sting/envenomation	Other	BLS	Local pain and swelling or special handling considerations (not related to obesity) and patient monitoring required.	A0429
994.0		Lightning		ALS		A0427/A0433
994.8		Electrocution		ALS		A0427/A0433
994.1		Near Drowning	Airway compromised during near drowning	ALS		A0427/A0433
921.9	870.0 through 870.9, 871.0, 871.1, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7, 871.9, or 921.0 through 921.9.	Eye injuries	Acute vision loss or blurring, severe pain or chemical exposure, penetrating, severe lid lacerations.	BLS		A0429
995.83	995.53 or V71.5 PLUS any code from 925.1 through 929.9, 930.0 through 939.9, 958.0 through 958.8, or 959.01 through 959.9.	Sexual assault	With major injuries	ALS	Reference Codes 959.8, 958.2, 869.0/869.1	A0427/A0433



## Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code		Condition (General)	Condition (Specific)	Service Level	Comments and examples (not all-inclusive)	HCPCS Crosswalk
995.80	995.53 or V71.5 PLUS any code from 910.0 through 919.9, 920 through 924.9, or 959.01 through 959.9.	Sexual assault	With minor or no injuries	BLS		A0429
<b>Non-Emergency</b>						
428.9		Cardiac/hemodynamic monitoring required en route.		ALS	Expectation monitoring is needed before and after transport.	A0426
518.81 or 518.89	V46.11 or V46.12.	Advanced airway management.		ALS	Ventilator dependent, apnea monitor, possible intubation needed, deep suctioning.	A0426, A0434
293.0		Chemical restraint.		ALS		A0426
496	491.20, 491.21, 492.0 through 492.8, 493.20, 493.21, 493.22, 494.0, or 494.1.	Suctioning required en route, need for titrated O2 therapy or IV fluid management.		BLS	Per transfer instructions.	A0428
786.09		Airway control/positioning required en route.		BLS	Per transfer instructions.	A0428
492.8	491.20, 491.21, 492.0 through 492.8, 493.20, 493.21, 493.22, 494.0, or 494.1.	Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route.		BLS	Does not apply to patient capable of self-administration of portable or home O2. Patient must require oxygen therapy and be so frail as to require assistance.	A0428

## Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code		Condition (General)	Condition (Specific)	Service Level	Comments and examples (not all-inclusive)	HCPCS Crosswalk
298.9	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Danger to self or others - in restraints.		BLS	Refer to definition in 42 C.F.R Sec. 482.13(e).	A0428
293.1		Patient Safety: Danger to self or others - monitoring.		BLS	Behavioral or cognitive risk such that patient requires monitoring for safety.	A0428
298.8	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Danger to self or others - seclusion (flight risk).		BLS	Behavioral or cognitive risk such that patient requires attendant to assure patient does not try to exit the ambulance prematurely. Refer to 42 C.F.R. Sec. 482.13(f)(2) for definition	A0428
781.3	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Risk of falling off wheelchair or stretcher while in motion (not related to obesity).		BLS	Patient's physical condition is such that patient risks injury during vehicle movement despite restraints. Indirect indicators include MDS criteria.	A0428

## Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code		Condition (General)	Condition (Specific)	Service Level	Comments and examples (not all-inclusive)	HCPCS Crosswalk
041.9		Special handling en route - isolation.		BLS	Includes patients with communicable diseases or hazardous material exposure who must be isolated from public or whose medical condition must be protected from public exposure; surgical drainage complications.	A0428
907.2		Special handling en route to reduce pain - orthopedic device.		BLS	Backboard, halotraction, use of pins and traction, etc. Pain may be present.	A0428
719.45 or 719.49	718.40, 718.45, 718.49, or 907.2.	Special handling en route - positioning requires specialized handling.		BLS	Requires special handling to avoid further injury (such as with >grade 2 decubiti on buttocks). Generally does not apply to shorter transfers of <1 hour. Positioning in wheelchair or standard car seat inappropriate due to contractures or recent extremity fractures —post-op hip as an example	A0428

## Ambulance Fee Schedule - Medical Conditions List

<h1>Transportation Indicators</h1>						
Transportation Indicators Air and Ground*	Transport Category	Transportation Indicator Description		Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
C1	Interfacility Transport	EMTALA-certified inter-facility transfer to a higher level of care.	Beneficiary requires higher level of care.	BLS, ALS, SCT, FW, RW	Excludes patient-requested EMTALA transfer.	A0428, A0429, A0426, A0427, A0433, A0434
C2	Interfacility Transport	Service not available at originating facility, and must meet one or more emergency or non-emergency conditions.		BLS, ALS, SCT, FW, RW		A0428, A0429, A0426, A0427, A0433, A0434
C3	Emergency Trauma Dispatch Condition Code	Major Incident or Mechanism of Injury	<b>Major Incident-This transportation indicator is to be used ONLY as a secondary code when the on-scene encounter is a BLS-level patient.</b>	ALS	Trapped in machinery, close proximity to explosion, building fire with persons reported inside, major incident involving aircraft, bus, subway, metro, train and watercraft. Victim entrapped in vehicle.	A0427/A0433
C4	Medically necessary transport but not to the nearest facility.	BLS or ALS Response	Indicates to Carrier/Intermediary that an ambulance provided a medically necessary transport, but that the number of miles on the Medicare claim form may be excessive.	BLS/ALS	This should occur if the facility is on divert status or the particular service is not available at the time of transport only. In these instances the ambulance units should clearly document why the beneficiary was not transported to the nearest facility.	Based on transport level.
C5	BLS Transport of ALS-level Patient	ALS-Level Condition treated and transport by a BLS-level ambulance	<b>This transportation indicator is used for ALL situations where a BLS-level ambulance treats and transports a patient that presents an ALS-level condition. No ALS-level assessment or intervention occurs at all during the patient encounter.</b>	BLS		A0429



## Ambulance Fee Schedule - Medical Conditions List

Transport Description Modifiers Air and Ground*	Transport Category	Transportation Indicator Description		Service Level	Comments and Examples (not all- inclusive)	HCPCS Crosswalk
C6	ALS-level Response to BLS level Patient	ALS Response Required based upon appropriate Dispatch Protocols - BLS-level patient transport	<b>Indicates to Carrier/Intermediary that an ALS-level ambulance responded appropriately based upon the information received at the time the call was received in dispatch and after a clinically appropriate ALS-assessment was performed on scene, it was determined that the condition of the patient was at a BLS level. These claims, properly documented, should be reimbursed at an ALS-1 level based upon coverage guidelines under the Medicare Ambulance Fee Schedule.</b>	ALS		A0427
C7		IV meds required en route.	This transportation indicator is used for patients that require an ALS level transport in a non-emergent situation primarily because the patient requires monitoring of ongoing medications administered intravenously. Does not apply to self-administered medications. Does not include administration of crystalloid intravenous fluids (i.e., Normal Saline, Lactate Ringers, 5% Dextrose in Water, etc.). The patient's condition should also be reported on the claim with a code selected from the list.	ALS	Does not apply to self-administered IV medications.	A0426

## Air Ambulance Transportation Indicators

Air Ambulance Transportation Indicators		Transportation Indicator Description	Service Level	Comments and Examples (not all- inclusive)	HCPCS Crosswalk
D1		Long Distance-patient's condition requires rapid transportation over a long distance	FW, RW	If the patient's condition warrants only.	A0430, A0431
D2		Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.	FW, RW		A0430, A0431
D3		Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of-hospital time to maximize clinical benefits for the patient.	FW, RW		A0430, A0431
D4		Pick-up point not accessible by ground ambulance	FW, RW		A0430, A0431

Note: HCPCS Crosswalk to ALS1E (A0427) and ALS2 (A0433) would ultimately be determined by the number and type of ALS level services provided during transport. All medical condition codes can be crosswalked to fixed wing and rotor wing HCPCS provided the air ambulance service has documented the medical necessity for air ambulance service versus ground or water ambulance. As a result, codes A0430 (Fixed Wing) and A0431 (Rotor Wing) can be included in Column 7 for each condition listed.

# GENERAL COVERAGE

## New Requirements for Low Vision Rehabilitation Demonstration Billing

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

### Provider Types Affected

Physicians, providers, and suppliers

### Provider Action Needed

Physicians, providers and suppliers should note that the Centers for Medicare & Medicaid Services (CMS) is:

- Implementing an outpatient vision rehabilitation demonstration project in selected areas across the country to examine the impact of standardized Medicare coverage for vision rehabilitation services
- Extending coverage under Part B for the same services to provide vision rehabilitation that would otherwise be payable when provided by an occupational or physical therapist if they are now provided by a vision rehabilitation professional under the general supervision of a qualified physician.

This demonstration project will last for five years through March 31, 2011 and is limited to services provided in specific demonstration locales. These areas are New Hampshire, New York City (all five boroughs), North Carolina, Atlanta, Kansas, and Washington State.

### Background

The Secretary of the Department of Health & Human Services is directed to carry out an outpatient vision rehabilitation demonstration project as part of the FY 2004 appropriations conference report to accompany Public Law HR 2673. This demonstration project will examine the impact of standardized Medicare coverage general supervision of a physician. The services may be supplied by the following:

- Physicians
- Occupational therapists
- Certified low vision therapists
- Certified orientation and mobility specialists
- Certified vision rehabilitation therapists.

Under this low vision rehabilitation demonstration, Medicare is extending coverage under Part B for the same rehabilitation services to treat vision impairment that would otherwise be payable when provided by an occupational or physical therapist if they are now provided by a certified vision rehabilitation professional under the general supervision of a qualified physician.

This demonstration will last for five years through March 31, 2011 and is limited to services provided specifically in New Hampshire, New York City (all five boroughs), North Carolina, Atlanta, Kansas, and Washington State.

Payment for vision rehabilitation services under this demonstration may be made to:

- Either the qualified physician who is supervising the occupational therapist or certified vision rehabilitation

professional; or an occupational therapist in private practice; or

- A qualified facility, such as a rehabilitation agency or clinic that has a contractual relationship with the certified vision rehabilitation professional; and
- Where the services are furnished under the individualized written plan of care.

Payment for these services will be made under the physician fee schedule even when such services are billed by a facility. They are not subject to bundling under the outpatient prospective payment system (OPPS).

Under this low vision rehabilitation demonstration, Medicare will cover low vision rehabilitation services to people with a medical diagnosis of moderate or severe vision impairment that is not correctable by conventional methods or surgery (i.e. cataracts).

Services will be provided under an individualized, written plan of care developed by a qualified physician or qualified occupational therapist in private practice (OTPP) that is reviewed at least every 30-days by a qualified physician. The plan of care must attest that vision rehabilitation services are medically necessary and the beneficiary receiving vision rehabilitation is capable of receiving rehabilitation and deriving benefit from such services, and should include:

- An initial assessment which documents the level of visual impairment;
- Specific measurable goals to be fulfilled during rehabilitation and the criteria by which the goals will be measured
- The location of where the rehabilitation services will be conducted
- Description of specific rehabilitative services to be directed toward each goal provided during the course of rehabilitation
- A reasonable estimate of the amount of treatment necessary to reach the goals.

Rehabilitative services will be conducted within a three-month period of time, in intervals appropriate to the patient's rehabilitative needs, and will not exceed 36 units of 15 minutes each, or nine hours total.

Rehabilitation will be judged completed when the treatment goals have been attained and any subsequent services would be for maintenance of a level of functional ability, or when the patient has demonstrated no progress on two consecutive visits.

All services covered under this demonstration are one-on-one, face-to-face services. Group services will not be covered.

Vision rehabilitation services will be furnished in an appropriate setting, including the home of the individual

***New Requirements for Low Vision Rehabilitation Demonstration Billing (continued)***

receiving the services, as specified in the plan of care and can be provided by the following:

- A qualified physician as defined in the Social Security Act (Section 1861r (1) and (4)) and who is an ophthalmologist or a doctor of optometry;
- A qualified occupational therapist in private practice;
- A qualified occupational therapist who is an employee of the physician; or
- A certified vision rehabilitation professional including low vision therapists, orientation and mobility specialists, and vision rehabilitation therapists who have received certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).
- Occupational therapists employed by the physician and certified vision rehabilitation professionals may furnish services while under the general supervision of a qualified physician. General supervision means that the physician does not need to be “on premises” nor in the immediate vicinity of the rehabilitation services as would be the case with “incident to” requirements stated in Section 2050 of the Medicare Carriers Manual.
- Payment for vision rehabilitation services will be made to the qualified physician under the Medicare physician fee schedule (MPFS) or to a facility, including the following:
  - ♦ Hospitals
  - ♦ Comprehensive outpatient rehabilitation facilities (CORF)
  - ♦ Other rehabilitation agencies or clinics
  - ♦ Facilities that bill Medicare for providing

occupational therapy, through which services are furnished under an individualized, written plan of care.

Occupational therapists in private practice may also submit claims under their own provider number for providing low vision rehabilitation services. However, for occupational therapists in private practice who are participating in the low vision rehabilitation demonstration, claims submitted must contain the same information as on a physician’s claim form and must use the demonstration “G” code for occupational therapists (G9041) for the claim to be considered.

Occupational therapists in private practice may not supervise therapy assistants or certified low vision rehabilitation professions, nor may they submit claims for the services of these individuals under the demonstration.

Certified vision rehabilitation professionals provide services pursuant to a plan of care and under the general supervision of the qualified physician who develops the plan of care. However, if the certified vision rehabilitation professional has a contractual arrangement with the facility where services are furnished, the facility may submit the bill for services.

Payment to practitioners and facilities will be made using the Medicare physician fee schedule (MPFS) with jurisdictional pricing; vision services covered under the demonstration provided in a hospital outpatient setting will not be paid under the OPPS system. Payment for services under this demonstration is limited to low vision rehabilitation. E&M services are not billable under the demonstration.

Vision impairment refers to significant vision loss from disease, injury or degenerative condition that cannot be corrected by conventional means, such as medication or surgery. The impairment must be manifest by one or more of the conditions listed in the following table:

<b>Levels of Vision Impairment</b>	<b>Description</b>
Moderate Visual impairment	Best-corrected visual acuity is less than 20/60 in the better eye (including a range of 20/70 to 20/160)
Severe visual impairment (legal blindness)	Best-corrected visual acuity is less than 20/160 including 20/200 to 20/400; or visual field diameter is 20 degrees or less (largest field diameter for Goldman isopter III4e, 1/100 white test object or equivalent) in the better eye.
Profound visual impairment (moderate blindness)	Best-corrected visual acuity is less than 20/400, or visual field is 10 degrees or less.
Near-total visual impairment (severe blindness)	Best-corrected visual acuity is less than 20/1000, or visual field is 5 degrees or less.
Total visual impairment (total blindness)	No light perception

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnostic codes indicated bellow will be used to support medical necessity for coverage under the demonstration.

**ICD-9-CM CodeDescription**

368.41	Scotoma involving central area
368.45	Generalized contraction or constriction
368.46	Homonymous bilateral field defect
368.47	Heteronymous bilateral field defect
369.01	Better eye: total vision impairment lesser eye: total vision impairment

**ICD-9-CM CodeDescription**

369.03	Better eye: near-total vision impairment lesser eye: total vision impairment
369.04	Better eye: near-total vision impairment lesser eye: near-total vision impairment
369.06	Better eye: profound vision impairment lesser eye: total vision impairment
369.07	Better eye: profound vision impairment lesser eye: near-total vision impairment
369.08	Better eye: profound vision impairment lesser eye: profound vision impairment

## New Requirements for Low Vision Rehabilitation Demonstration Billing (continued)

### ICD-9-CM Code Description

369.12	Better eye: severe vision impairment lesser eye: total vision impairment
369.13	Better eye: severe vision impairment lesser eye: near-total vision impairment
369.14	Better eye: severe vision impairment lesser eye: profound vision impairment
369.16	Better eye: moderate vision impairment lesser eye: total vision impairment
369.17	Better eye: moderate vision impairment lesser eye: near-total vision impairment
369.18	Better eye: moderate vision impairment lesser eye: profound vision impairment
369.22	Better eye: severe vision impairment lesser eye: severe vision impairment
369.24	Better eye: moderate vision impairment lesser eye: severe vision impairment
369.25	Better eye: moderate vision impairment lesser eye: moderate vision impairment

Most rehabilitation is short-term and intensive, and sessions are generally conducted over a consecutive 90-day period of time with intervals appropriate to the patient's rehabilitative needs.

Patients usually receive therapy one or two times per week, and not less frequently than once every two weeks. The sessions are generally 30-60 minutes in duration.

The physician should be documented periodic follow-up and evaluation at least every 30 days during the course of the rehabilitation.

For the purposes of this demonstration, vision rehabilitation services will not be subject to physical or occupational therapy caps.

CMS established four different series of temporary demonstration, or "G", codes to accommodate rehabilitation services for low vision. Each code series will correspond to the low vision rehabilitation professional that provided the service and will be included in the official instruction issued to your carrier/intermediary.

That instruction, CR 3816, may be viewed by going to the CMS website at <http://www.cms.hhs.gov/Transmittals/2005Trans/List.asp#TopOfPage>.

From that Web page, look for CR 3816 and CR 4294, and click on the files for those CRs. **Example "G" codes** include:

- Code G9041 for services provided by a qualified occupational therapist
- Code G9042 for services provided by a certified orientation and mobility specialist
- Code G9043 for services provided by a certified low vision rehabilitation therapist
- Code G9044 for services provided by a certified vision rehabilitation therapists.

Payable places of service (POS) for Part B claims include:

- Office (11)
- Home (12)

- Assisted living facility (13)
- Group home (14)
- Custodial care facility (33)
- Independent clinic (49).

In addition, facilities that are qualified to submit claims include the following:

- Outpatient hospital clinics (TOB 13x)
- Outpatient CAH clinics (TOB 85x)
- Comprehensive outpatient rehabilitation facilities (CORFs) (TOB 75x)
- Freestanding rehabilitation clinics (TOB 74x).

Fiscal intermediaries (FIs) will use the claim related condition code 79 to indicate when services are provided outside the facility. When no condition code appears it will indicate that rehabilitation services were provided in the facility. Providers will be required to indicate either no code or code 79 on claims.

Facility claims will also use the revenue code 0949 (other rehabilitation services) in addition to the demonstration G-code, which indicates the type of professional who provided the rehabilitation service.

This will apply to all institutional settings and CAH outpatient departments. CAHs that elect to use method II billing will use revenue code 0969 or revenue code 0962, whichever is most appropriate.

Carriers will accept and process claims from qualified physicians when those claims include:

- An appropriate ICD-9-CM code that supports medical necessity
- An appropriate rehabilitation ("G") code for the demonstration
- Evidence of a written plan of care that specifies the type and duration of the rehabilitative services being furnished.

The plan of care and date can be indicated in block 19 (Reserved for Local Use) of the HCFA 1500. Facilities will use occurrence code 17 for date the plan of care was established or reviewed.

Qualified physicians, occupational therapists and low vision professionals practicing in designated demonstration areas may provide low vision rehabilitation services to eligible residents of the demonstration areas.

Approved demonstration locales are limited to the following; New Hampshire, New York City (all five boroughs), North Carolina, Atlanta, Kansas, and Washington State. Providers should note that the residence of the beneficiary receiving services and the physician or facility providing the services must be in the same approved demonstration locale (state or metropolitan area) as determined by matching primary residence and primary practice ZIP codes.

### Implementation

The implementation date for the instruction is April 3, 2006.



***New Requirements for Low Vision Rehabilitation Demonstration Billing (continued)*****Additional Information**

As previously mentioned above, CMS will establish four different series of temporary demonstration, or “G”, codes to accommodate rehabilitation services for low vision. Each code series will correspond to the low vision rehabilitation professional that provided the service and will be included in the official instruction issued to your carrier/intermediary.

You can view the official instruction issued to your carrier/intermediary for complete details regarding this change. That instruction may be viewed by going to the CMS website at <http://www.cms.hhs.gov/Transmittals/2005Trans/List.asp#TopOfPage>.

Search for 3816 and 4294 in and click on the file for those CRs.

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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/apps/contacts/>.

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

Medlearn Matters Number: MM3816  
 Related Change Request (CR) Number: 3816  
 Related CR Release Date: June 7, 2005  
 Related CR Transmittal Number: R25DEMO  
 Effective Date: April 1, 2006  
 Implementation Date: April 3, 2006

Source: CMS Pub. 100-19, Transmittal 25, CR 3816

**Pricing File Clarifications**

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 17, 2006, to provide new Web addresses that reflect changes in the new CMS website. All other information remains the same.

**Providers Affected**

All providers who bill Medicare carriers and fiscal intermediaries (FIs) for Part B services

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

Providers who previously accessed drugs and biologicals pricing files at the CMS website should be aware that corrected files have been issued.

**CAUTION – What You Need to Know**

Providers should be aware that this instruction provides corrections to the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 pricing files that were provided with Pub.100-04, Revision 54, issued on December 24, 2003.

**GO – What You Need to Do**

If you are using the files from the CMS website (listed below), be sure you have the most current version.

**Background**

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 changed the basis for payment of drugs and biologicals not paid on a cost or prospective payment basis, and furnished on or after January 1, 2004, through December 31, 2004. This instruction provides:

- Corrections to the MMA pricing files that were provided with Pub.100-04, Revision 54, issued on December 24, 2003.
- Directions to replace the MMA pricing files provided with Pub.100-04, Revision 54, with the new files available on the CMS website at [http://www.cms.hhs.gov/HistPartBDrugPricingFiles/02\\_MMA\\_Drug\\_Price.asp#TopOfPage](http://www.cms.hhs.gov/HistPartBDrugPricingFiles/02_MMA_Drug_Price.asp#TopOfPage).

(MMA Drug Payment Limits Pricing Files For Dates of Service 1/1/2004 and After – Revised). These files are for claims for drugs and biologicals not paid on a cost or prospective payment basis with dates of service on or after January 1, 2004.

Beginning January 1, 2004, MMA provides that the payment limits for most drugs and biologicals not paid on a cost or prospective payment basis are based on 85 percent of the April 1, 2003 average wholesale price (AWP) for those drugs and biologicals furnished on and after January 1, 2004.

**Exceptions**

The exceptions to this general rule and Medicare payment limits for drugs and biologicals not paid on a cost or prospective payment basis and furnished on or after January 1, 2004 through December 31, 2004, are described below:

- The payment limits for blood clotting factors are 95 percent of the AWP reflected in the published compendia as of September 1, 2003.
- The payment limits for new drugs or biologicals are 95 percent of the AWP reflected in the published compendia as of September 1, 2003. The payment limits for new drugs or biologicals without AWP listings in the published compendia as of September 1, 2003, are based on 95 percent of the AWP reflected in the published compendia as of the first of the month the payment limit for the drug or biological is determined.

For the purposes of this instruction, a new drug is an unlisted drug (not currently covered by a specific HCPCS code; i.e., a HCPCS code other than a NOC (not otherwise classified) code such as J3490, J9999, etc.) that was approved by the Food and Drugs



## Pricing File Clarifications (continued)

Administration (FDA) subsequent to April 1, 2003. A drug is not considered to be a new drug if:

- ♦ The brand or manufacturer of the drug changes;
  - ♦ A new vial size is developed; or
  - ♦ The drug receives a new indication.
- The payment limits for influenza, pneumococcal, and hepatitis B vaccines are 95 percent of the AWP reflected in the published compendia as of September 1, 2003.
  - The payment limits for certain drugs studied by the Office of the Inspector General (OIG) and the Government Accountability Office (GAO) are based on the percentages of the AWP reflected in the published compendia as of April 1, 2003 specified in Table 1 in section 20 of Chapter 17 of the Medicare Claims Processing Manual, Pub. 100-04.
  - The payment limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2004 is 95 percent of the AWP reflected in the published compendia as of October 1, 2003 regardless of whether or not the durable medical equipment is implanted.
  - The payment limits for drugs and biologicals furnished in connection with dialysis and billed by independent dialysis facilities are based on 95 percent of the AWP reflected in the published compendia as of September 1, 2003.

Drugs and biologicals not described above are paid at 85 percent of the AWP as reflected in the published compendia as of April 1, 2003.

The Medicare payment limit for drugs and biologicals not paid on a cost or prospective payment basis and furnished prior to January 1, 2004 is 95 percent of AWP.

Payment limits determined under this instruction will not be updated during 2004.

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

For any drug or biological not listed in the attached pricing files, intermediaries and carriers will determine the payment allowance in accordance with the policies described in the transmittal (R75CP).

## Implementation

The effective and implementation date of these changes was January 30, 2004.

## Additional Information

As mentioned previously, this instruction provides corrections to and directs the replacement of MMA pricing files provided with Pub.100-04, Rev.54, issued on December 24, 2003 with new files available at:

[http://www.cms.hhs.gov/HistPartBDrugPricingFiles/02\\_MMA\\_Drug\\_Price.asp#TopOfPage](http://www.cms.hhs.gov/HistPartBDrugPricingFiles/02_MMA_Drug_Price.asp#TopOfPage)

(MMA Drug Payment Limits Pricing Files For Dates of Service 1/1/2004 and After – Revised).

The Centers for Medicare & Medicaid Services (CMS) Web page furnishes drug related information to Medicare providers, physicians and other suppliers, Medicare beneficiaries and to the public.

The relevant files include the following:

- **HCPCS Drug Pricing File** – Microsoft Excel file
- **FI Specific HCPCS Drug Pricing File** – Microsoft Excel file
- **HCPCS Drug Pricing Background File** for Other than ESRD-Related or DME Infusion Drugs – Microsoft Excel file
- **HCPCS Drug Pricing Background File** for ESRD Drugs – Microsoft Excel file
- **HCPCS Drug Pricing Background File** for DME Infusion Drugs – Microsoft Excel file
- **NOC Drug Pricing** – Microsoft Excel file.

Affected providers should note that Medicare carriers and FIs have been instructed to apply these changes to new claims received and they are not automatically adjusting claims previously paid.

However, these Medicare contractors have been instructed to adjust claims that are brought to their attention by the provider. Thus, if you have been paid an incorrect amount on a previously paid claim, you can submit an adjustment to your Medicare contractor and it will be processed.

To view CR 3105, go to CMS website <http://www.cms.hhs.gov/Transmittals/downloads/R75CP.pdf>.

Medlearn Matters Number: MM3105 – Revised

Related Change Request (CR) Number: 3105

Related CR Release Date: January 30, 2004

Related CR Transmittal Number: R75CP

Effective Date: January 30, 2004

Implementation Date: January 30, 2004

Source: CMS Pub. 100-4, Transmittal 75, CR 3105

## Update for all PET Scan Services Performed in Critical Access Hospitals

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 19, 2006, to provide new Web addresses that reflect changes in the new CMS website. All other information remains the same. This article was originally published in the Second Quarter 2005 Medicare A Bulletin (pages 22).

### Provider Types Affected

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

### Provider Action Needed

#### STOP – Impact to You

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

#### CAUTION – What You Need to Know

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

#### GO – What You Need to Do

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

### Background

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

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

- The previous edit to allow HCPCS G0336 (PET imaging, brain imaging for the differential diagnosis of AD with aberrant features vs. FTD) to be billed no more than once in a beneficiary's lifetime has been removed.
- Medicare carriers and fiscal intermediaries must ensure that an appropriate diagnosis code accompanies the claim with HCPCS G0336. When submitting a claim for a FDG-PET scan, one of the following diagnosis codes must accompany the HCPCS G0336 code: 290.0, 290.10 – 290.13, 290.20 – 290.21, 290.3, 331.0, 331.11, 331.19, 331.2, 331.9, 780.93. Line items with

HCPCS code G0336 will be denied if one of the above diagnosis codes is not provided. Such denials will be reflected by claim adjustment reason code 11.

- The payment method for ALL PET scan claims submitted for services provided in critical access hospitals (CAHs) is as follows: CAHs under Method I have technical services paid at 101% of reasonable cost; CAHs under Method II have technical services paid at 101 percent of reasonable cost; and professional services are paid at 115 percent of the Medicare physician fee schedule database.

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

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

### Additional Information

The revised portion of Chapter 13, Section 60 of the Medicare Claims Processing Manual can be found as part of the official instruction issued to your carrier/intermediary regarding these changes. That instruction, CR 3640, may be found on CMS website at: <http://www.cms.hhs.gov/Transmittals/downloads/R428CP.pdf>.

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

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

Medlearn Matters Number: MM3640 – Revised  
 Related Change Request (CR) Number: 3640  
 Related CR Release Date: January 14, 2005  
 Related CR Transmittal Number: R428CP  
 Effective Date: September 15, 2004  
 Implementation Date: April 4, 2005

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

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## Autologous Blood-Derived Products for Chronic Non-Healing Wounds

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 20, 2006, to provide new Web addresses that reflect changes in the new CMS website. All other information remains the same. This article was originally published in the First Quarter 2005 Medicare A Bulletin (pages 26-27).

### Provider Types Affected

All Medicare providers

### Provider Action Needed

No action is necessary. This article is informational only. The Centers for Medicare & Medicaid Services (CMS) has determined, upon reconsideration of existing policy, that autologous blood-derived products for chronic non-healing cutaneous wounds, both platelet-derived growth factor (PDGF) in platelet-poor plasma and platelet-rich plasma (PRP), **will remain noncovered** as CMS continues to believe that the clinical effectiveness of these autologous blood-derived products is not adequately proven in scientific literature.

### Background

Patient-donated blood is centrifuged to produce an autologous gel for the treatment of chronic non-healing cutaneous wounds that persist for 30 days or longer and fail to complete the healing process properly.

Autologous blood-derived products for chronic non-healing wounds include both PDGF products, such as procuren and more recent products, and PRP products.

PRP differs from previous products because it contains whole cells, including white cells, red cells, plasma, platelets, fibrinogen, stem cells, macrophages, and fibroblasts. Physicians use PRP in clinical settings. PDGF does not contain cells and was marketed as a product to be used by patients at home.

In 1992 CMS issued a national Medicare noncoverage determination in relation to platelet-derived wound healing formulas containing growth factors in the treatment of non-healing wounds. The determination was based on a lack of sufficient published data to determine the safety and efficacy of such formulas, and a public health service technology assessment.

Recently, CMS reconsidered the 1992 decision and concluded that the clinical effectiveness of autologous PDGF products continues to be inadequately proven in

scientific literature, and it remains non-covered for treatment of chronic, non-healing cutaneous wounds. Additionally, the clinical evidence does not support a benefit in the application of autologous PRP for the treatment of chronic, non-healing wounds, and CMS has determined it is not reasonable and necessary and is nationally non-covered.

It will remain at the local contractor’s discretion whether to pay for becaplermin, a non-autologous growth factor product approved by the FDA for the treatment of chronic non-healing subcutaneous wounds. Also, the routine costs of autologous PRP products for the treatment of chronic non-healing wounds associated with category B investigational device exemption clinical trials are covered by Medicare in accordance with 42 CFR 405.201 – 405.215, 411.15, and 411.406 or section 310.1 of the National Coverage Determinations Manual.

### Additional Information

The official instruction issued to your carrier/intermediary regarding this change may be found on CMS website at: <http://www.cms.hhs.gov/Transmittals/downloads/R19NCD.pdf>.

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

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

Medlearn Matters Number: MM3384 – Revised  
Related Change Request (CR) Number: 3384  
Related CR Release Date: July 30, 2004  
Related CR Transmittal Number: R19NCD  
Effective Date: July 23, 2004  
Implementation Date: July 23, 2004

Source: CMS Pub 100-3 Transmittal 19, CR 3384

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# HOSPITAL SERVICES

## Resubmission of Inpatient Psychiatric Facility Prospective Payment System Claims with Chronic Renal Failure Comorbid Condition

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

### Provider Types Affected

Inpatient psychiatric facilities

### Provider Action Needed

Effective October 1, 2005, the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code for chronic renal failure (585) has been replaced with an expanded list of diagnosis codes: **585.1 – 585.6** and **585.9**.

The IPF PRICER uses the ICD-9-CM code 585 to provide a payment adjustment for claims with a comorbid condition of chronic renal failure, and the IPF PRICER was not updated with the expanded list of ICD-9-CM codes for 585. This article is based on change request (CR) 4164, which informs your fiscal intermediary (FI) that the IPF PRICER will have the updated list of ICD-9-CM codes for April 2006.

### Background

The inpatient psychiatric facility prospective payment system (IPF PPS) provides a comorbidity adjustment for certain comorbid conditions. Comorbidities are specific patient conditions that are secondary to the patient's primary diagnosis, and that require treatment during the stay.

The intent of the comorbidity adjustments was to recognize the increased cost associated with comorbid medical conditions by providing additional payments for certain concurrent medical and psychiatric conditions that are expensive to treat. The following are the seventeen comorbidity adjustment categories.

### Description of Comorbidity

- Developmental Disabilities
- Coagulation Factor Deficits
- Tracheotomy
- Renal Failure, Acute
- Renal Failure, Chronic
- Oncology Treatment
- Uncontrolled Diabetes-Mellitus with or without complications
- Severe Protein Calorie Malnutrition
- Eating and Conduct Disorders
- Infectious Disease
- Drug and/or Alcohol Induced Mental Disorders
- Cardiac Conditions
- Gangrene
- Chronic Obstructive Pulmonary Disease
- Artificial Openings - Digestive and Urinary
- Severe Musculoskeletal and Connective Tissue Diseases
- Poisoning

Each comorbidity grouping receives a grouping-specific adjustment, and the comorbidity category "Renal Failure, Chronic" has an adjustment factor of 1.11.

IPFs may be paid multiple comorbidity adjustments, but only one adjustment is allowed per category.

Effective October 1, 2005, the ICD-9-CM diagnosis code for chronic renal failure (585) has been replaced by the four digit coding numbers listed below. (See Medlearn Matters Article MM4005 on the CMS website at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM4005.pdf>.)

### Diagnosis Code Description

- 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

These new ICD-9-CM codes are effective for discharges occurring on or after October 1, 2005, and the IPF Pricer will be updated with the new codes, beginning April 1, 2006.

IPFs should resubmit their claims after April 1, 2006 (for discharges occurring between October 1, 2005 and March 31, 2006), if the comorbidity adjustment is applicable. Your FI will accept resubmissions of IPF claims with ICD-9-CM diagnosis codes 585.1 – 585.6 and 585.9 after April 1, 2006, so that the Chronic Renal Failure comorbidity adjustment factor of 1.11 can be applied and the claim can be paid appropriately. In the meantime, all IPF claims will continue to pay.

### Implementation

The implementation date for the instruction is April 3, 2006.

### Additional Information

Providers can view the new updated ICD-9-CM codes at the Medicare Learning Network – Coding Educational Resource Web Guide, on the CMS website at <http://www.cms.hhs.gov/medlearn/icd9code.asp>.

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/transmittals/downloads/R757CP.pdf>.

From that Web page, look for CR4164 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/apps/contacts/>.

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



## *Resubmission of IPF PPS Claims with Chronic Renal Failure Comorbid Condition (continued)*

Related Change Request (CR) Number: 4164  
Related CR Release Date: November 18, 2005  
Related CR Transmittal Number: 757  
Effective Date: October 1, 2005  
Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 757, CR 4164

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## 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.*

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 20, 2006, to reflect changes made to CR 4025, which has been revised. A new CR transmittal number and release date have also been revised. In addition, a note box has been added, which discusses a one-time adjustment payment that some providers may receive. Finally, Web addresses in the article were changed to conform to the new CMS website. All other information remains the same. This article was originally published in the First Quarter 2006 Medicare A Bulletin (page 78).

### 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**.

**Note:** Usually changes are made with prospective effective dates. However, since this change is retroactive to July 1, 2005, while the implementation date is March 31, 2006, CMS is instructing your intermediary to calculate and make a one-time lump sum adjustment payment to affected providers to account for the time that has passed between the July 1, 2005, effective date and the date this instruction is implemented.

### 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.



*Calculation of the Interim Payment of IME Full-Time Equivalent Resident Caps (continued)*

**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/MedlearnMattersArticles/downloads/MM4025.pdf>.

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/apps/contacts/>.

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

Medlearn Matters Number: MM4025 – Revised  
 Related Change Request (CR) Number: 4025  
 Related CR Release Date: January 19, 2006  
 Related CR Transmittal Number: R201OTN  
 Effective Date: July 1, 2005  
 Implementation Date: March 31, 2006

Source: CMS Pub. 100-20, Transmittal 201, CR 4025

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**Update to Repetitive Billing Instructions in Medicare Claims Processing Manual**

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on November 28, 2005, to reflect the revision to change request (CR) 4047. The CR release date and transmittal number have been changed. All other information in the article remains the same. This article was published in the First Quarter 2006 Medicare A Bulletin (pages 80-83).

**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. Soon after the release of CR 3633, CMS became aware of difficulties that may arise from instructions contained in CR 3633. Therefore, CMS reevaluated the policy of repetitive billing and provided clarifications in CR 4047.

CR 3633 may be found on the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R407CP.pdf>.

A Medlearn Matters article (MM3633) is also available on the CMS website at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3633.pdf>.

**General Billing Requirements**

**Frequency of Billing to Fiscal Intermediaries 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 CR 4047) 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:

<b>Type of Service</b>	<b>Revenue Code(s)</b>
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

## Update to Repetitive Billing Instructions in Medicare Claims Processing Manual (continued)

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.

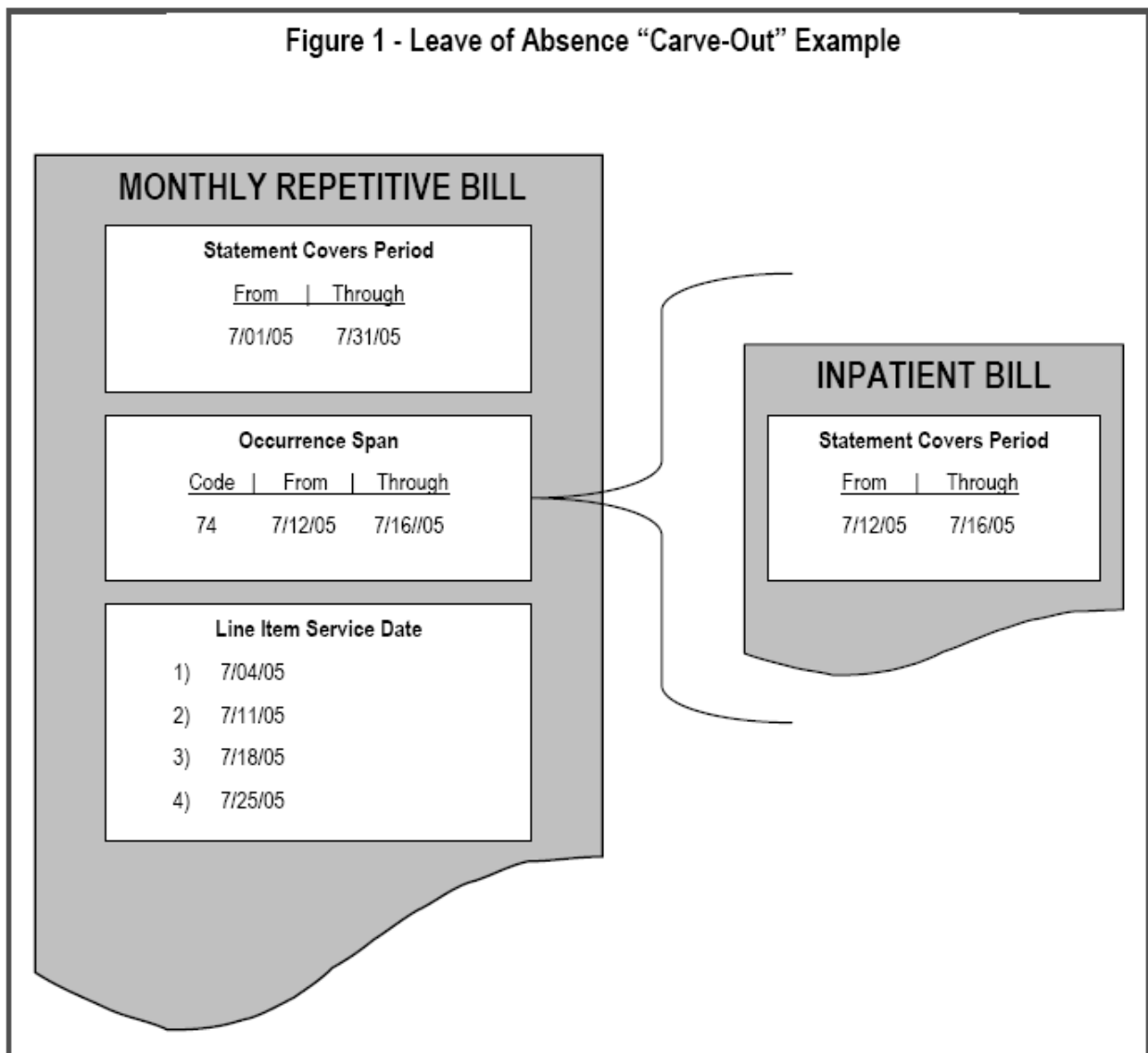
The provider will use an occurrence span code 74 (Leave of Absence) on the repetitive bill to encompass the:

- 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.



*Update to Repetitive Billing Instructions in Medicare Claims Processing Manual (continued)*

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 OPSS). If a nonrepetitive OPSS service is provided on the same date as a repetitive service, report on a separate OPSS claim:

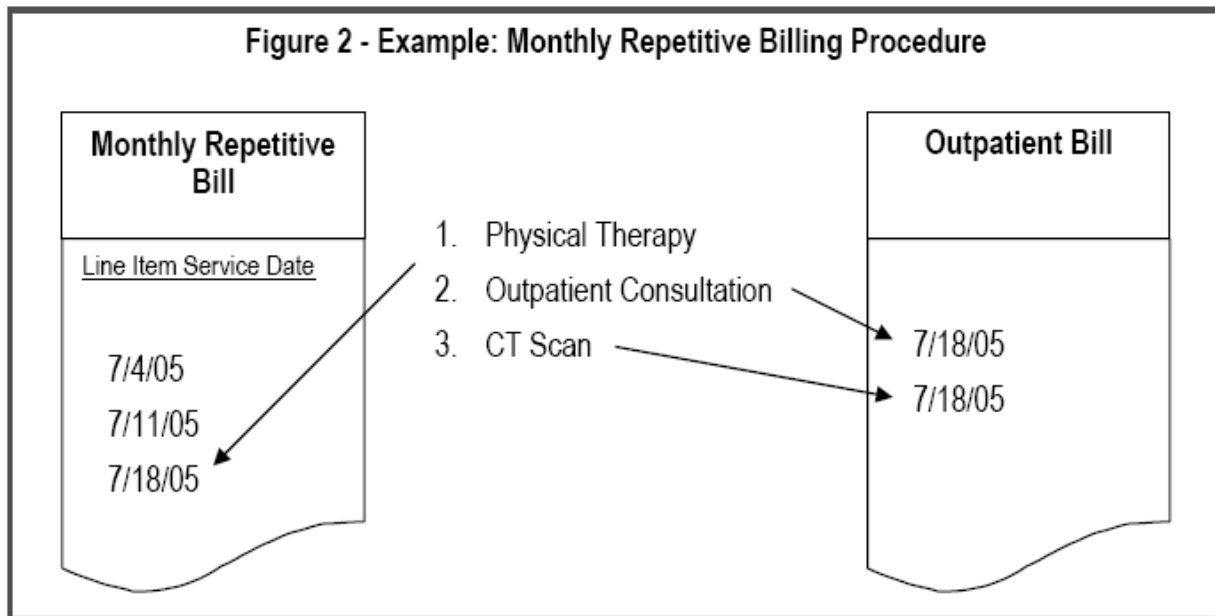
- The nonrepetitive OPSS services; and
- Any packaged and/or services related to the nonrepetitive OPSS service.

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.

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.

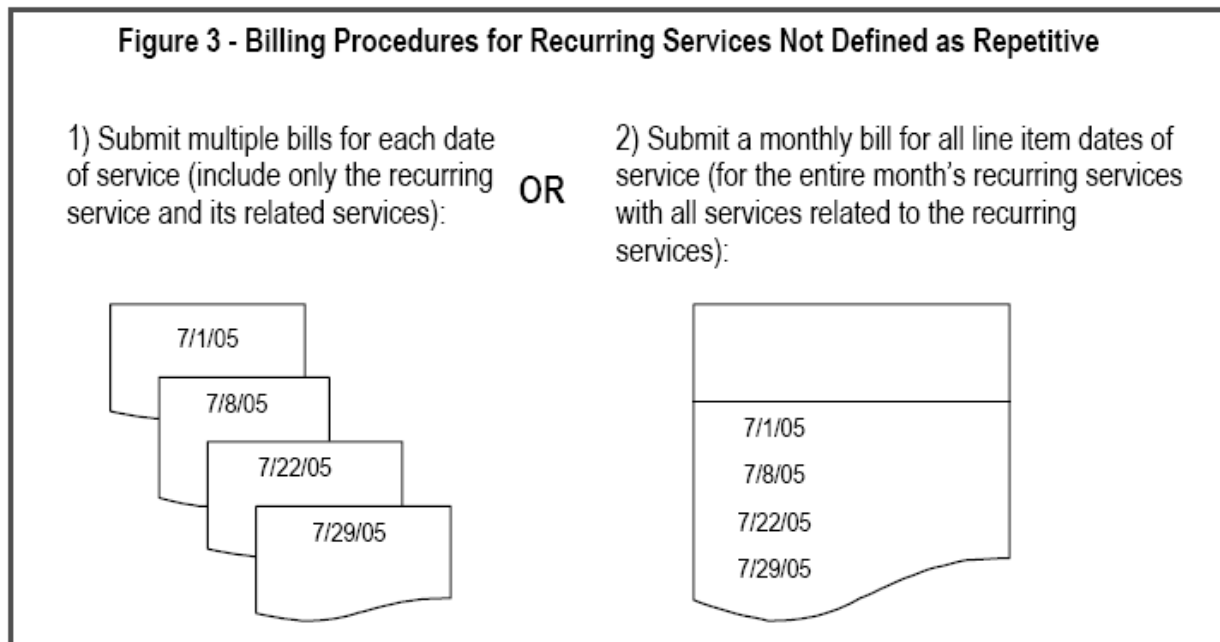
However, because it is common for these services to be furnished in multiple encounters that occur over several weeks or over the course of a month, hospitals have the option of reporting charges for those recurring services on a single bill, as though they were repetitive services.

If hospitals elect to report charges for recurring, nonrepetitive 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).

## Update to Repetitive Billing Instructions in Medicare Claims Processing Manual (continued)

This is shown in Figure 3 below:



### Part B Hospital (Including Inpatient Hospital Part B and OPSS) Hospital and Community Mental Health Center (CMHC) Reporting Requirements for Services Performed on the Same Day

When reporting a Healthcare Common Procedure Coding System (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.

That instruction may be viewed by going to the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R763CP.pdf>.

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/MedlearnMattersArticles/downloads/MM4047.pdf>.

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

Medlearn Matters Number MM: 4047 – Revised  
Related Change Request (CR) Number: 4047  
Related CR Release Date: November 25, 2005  
Related CR Transmittal Number: 763  
Effective Date: N/A  
Implementation Date: N/A

Source: CMS Pub. 100-4, Transmittal 763, CR 4047

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# CRITICAL ACCESS HOSPITAL SERVICES

## Drug and Biological Administration in a Method II Critical Access Hospital

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

### Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for services related to the administration of drugs and biologicals in method II critical access hospitals (CAHs)

### Provider Action Needed

#### STOP – Impact to You

This article is based on change request (CR) 4234, which provides updated instructions regarding the administration of drugs and biologicals in a Method II CAH.

#### CAUTION – What You Need to Know

CR 4234 provides new billing instructions with revised Healthcare Common Procedure Coding System (HCPCS) coding guidance for physician involvement (professional component) in the administration of drugs and biologicals in the outpatient department of a method II (optional method) CAH.

#### GO – What You Need to Do

See the *Background* section of this article for further details regarding these new billing instructions.

### Background

CR 4234 replaces CR 3911 (Transmittal 617, rescinded November 8, 2005) and provides updates to the billing requirements for physician involvement (professional component) in the administration of drugs and biologicals in the outpatient department of a Method II CAH. Both method I (standard method) and method II CAHs bill for technical services furnished in the outpatient department. However, only method II CAHs bill the fiscal intermediary (FI) for physician services furnished in the outpatient department:

- Method I is a reasonable (cost-based) facility services method with billing of a carrier for professional services (unless the CAH elects payment under method II); and
- Method II is the optional method with the billing of a fiscal intermediary (FI) for both facility and professional services. Under method II, Medicare makes payment for the facility services at the same level that would apply under the reasonable cost method (increasing to 101 percent for cost reporting periods beginning on or after January 1, 2004), but services of professionals to outpatients are paid at 115 percent of the amount that would have otherwise been paid under the Medicare physician fee schedule (MPFS).

**Note:** The *Code of Federal Regulation* (CFR 42 Section 413.70) provides regulations governing how physician involvement in the administration of drugs and biologicals (other than low osmolar contrast material (LOCM)) should be billed by a method II CAH. See the following GPO website to review 42 CFR 413.70: <http://www.gpoaccess.gov/cfr/retrieve.html>.

### Coding for the Professional Component in the Administration of LOCM

CR 4234 instructs the charges for outpatient physician involvement in the administration of LOCM to be submitted on type of bill (TOB) 85x (critical access hospitals), with:

- The appropriate outpatient hospital visit *Current Procedural Terminology (CPT)* code for evaluation and management (E & M) services, with
- Revenue code 096x, 097x or 098x (professional fees).

Payment is made based on the MPFS. Revenue codes 096x, 097x, and 098x are defined below in the *Additional Information* section of this article.

### Coding for the Technical Component in the Administration of LOCM

The technical component for LOCM may be billed by both method I and method II CAHs with revenue code 0636 (Pharmacy – Drugs Requiring Detailed Coding(s)) and one of the following HCPCS codes as appropriate:

#### HCPCS Code Long Description

Q9945	Low osmolar contrast material (up to 149 mg/ml iodine concentration, per ml)
Q9946	Low osmolar contrast material (150 - 199 mg/ml iodine concentration, per ml)
Q9947	Low osmolar contrast material (200 - 249 mg/ml iodine concentration, per ml)
Q9948	Low osmolar contrast material (250 - 299 mg/ml iodine concentration, per ml)
Q9949	Low osmolar contrast material (300 - 349 mg/ml iodine concentration, per ml)
Q9950	Low osmolar contrast material (350 - 399 mg/ml iodine concentration, per ml)
Q9951	Low osmolar contrast material (400 or greater mg/ml iodine concentration, per ml)

### Coding for the Administration of Other Drugs and Biologicals

CR 4234 further instructs your intermediary to accept the following from a method II CAH billing for physician involvement for hydration: chemotherapy or LOCM administration; therapeutic or diagnostic injections; and intravenous (IV) infusions (other than hydration), submitted on TOB 85x:

- CPT codes 99201 – 99205 (Office or Other Outpatient Visit New) or CPT codes 99211 – 99215 (Office or Other Outpatient Visit Established); with
- Revenue code 096X, 097X or 098X on TOB 85X.

See the *Additional Information* section of this article for definitions of CPT codes 99201-99205 and 99211-99215.

**Note:** The Medicare Claims Processing Manual (Pub. 100-04, Chapter 3, Section 30.1.3 (Costs of Emergency Room On-Call Providers)) has been revised to reflect



*Drug and Biological Administration in a Method II Critical Access Hospital (continued)*

that computing reasonable compensation and related costs for emergency room on-call coverage is based on the dates of service, and it is included with CR 4234. Previously, this section stated that the computation was based on cost reporting periods, and there are no policy changes related to the revisions in manual Section 30.1.3.

**Implementation**

The implementation date for the instruction is April 3, 2006.

**Additional Information**

To learn more about fee schedule payment for professional services, see Chapter 4, Section 250.2 (Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 percent fee schedule payment for professional services) of the *Medicare Claims Processing Manual* (Pub. 100-04) on the CMS website at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>.

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/Transmittals/downloads/R803CP.pdf>.

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/apps/contacts/>.

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

**Professional Fees (Revenue Codes 096x, 097x, and 098x) Defined**

Charges for medical professionals that hospitals or third party payers require to be separately identified on the billing form, and services that were not identified separately prior to uniform billing implementation should not be separately identified on the uniform bill.

**Revenue Code 096x – Professional Fees**

Subcategory Number (X)	Standard Abbreviations
0 – General Classification	PRO FEE
1 – Psychiatric	PRO FEE/PSYCH
2 – Ophthalmology	PRO FEE/EYE
3 – Anesthesiologist (MD)	PRO FEE/ANES MD
4 – Anesthetist (CRNA)	PRO FEE/ANES CRNA
9 – Other Professional Fees	OTHER PRO FEE

**Revenue Code 097x – Extension of 096x**

Subcategory X	Standard Abbreviations
1 – Laboratory	PRO FEE/LAB
2 – Radiology – Diagnostic	PRO FEE/RAD/DX
3 – Radiology – Therapeutic	PRO FEE/RAD/RX
4 – Radiology – Nuclear Medicine	PRO FEE/NUC MED
5 – Operating Room	PRO FEE/OR
6 – Respiratory Therapy	PRO FEE/RESPIR
7 – Physical Therapy	PRO FEE/PHYSI
8 – Occupational Therapy	PRO FEE/OCUPA
9 – Speech Pathology	PRO FEE/SPEECH

**Revenue Code 098x – Extension of 096x and 097x**

Subcategory Number (X)	Standard Abbreviations
1 – Emergency Room	PRO FEE/ER
2 – Outpatient Services	PRO FEE/OUTPT
3 – Clinic	PRO FEE/CLINIC
4 – Medical Social Services	PRO FEE/SOC SVC
5 – EKG	PRO FEE/EKG
6 – EEG	PRO FEE/EEG
7 – Hospital Visit	PRO FEE/HOS VIS
8 – Consultation	PRO FEE/CONSULT
9 – Private Duty Nurse	FEE/PVT NURSE

**CPT Codes for New Patients (99201-99205) and Established Patients (99211-99215)**

**Service Type – New patient**

- 99201 Office or other outpatient visit (problem focused)
- 99202 Office or other outpatient visit (expanded problem focused)
- 99203 Office or other outpatient visit (detailed)
- 99204 Office or other outpatient visit (comprehensive, moderate)
- 99205 Office or other outpatient visit (comprehensive, high)

**Service Type – Established patient**

- 99211 Office or other outpatient visit (minimal)
- 99212 Office or other outpatient visit (problem focused)
- 99213 Office or other outpatient visit (expanded)
- 99214 Office or other outpatient visit (detailed)
- 99215 Office or other outpatient visit (comprehensive, high)

Medlearn Matters Number: MM4234

Related Change Request (CR) Number: 4234

Related CR Release Date: January 3, 2006

Related CR Transmittal Number: R803CP

Effective Date: April 3, 2006

Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 803, CR 4234

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## Special Rules for Critical Access Hospital Outpatient Billing

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 18, 2006, to provide new Web addresses that reflect changes in the new CMS website. All other information remains the same. This article was originally published in the Second Quarter 2005 Medicare A Bulletin (page 38).

### Provider Types Affected

Critical access hospitals (CAHs).

### Provider Action Needed

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

### STOP – Impact to You

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

### CAUTION – What You Need to Know

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

### GO – What You Need to Do

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

### Background

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

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

### Additional Information

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

### Standard Payment Method

CAH outpatient services will be reimbursed at the lesser of:

- 80 percent of 101 percent** (up from 100 percent as of January 1, 2004) of reasonable cost for CAH services, **OR**
- 101 percent** of reasonable cost for CAH services, less the applicable Part B deductible and coinsurance amounts.

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

CAH outpatient services' reimbursement will be the **sum** of physician/professional services plus outpatient services (including ASC type services).

- Physician/Professional Services – 115 percent of what would be paid under the physician fee schedule (after applicable deductions) for physician outpatient services and 115 percent of 85 percent of the allowable amount for nonphysician practitioner professional services, **AND**
- Outpatient Services – 101 percent of the reasonable costs of the services. The lesser of: 80 percent of **101 percent** (up from 100 percent as of Jan. 1, 2004) of reasonable cost for CAH services; **OR**
- 101 percent** of reasonable cost for CAH services, less the applicable Part B deductible and coinsurance amounts.

For a more detailed comparison of the two payment methods, please refer to Chapter 4 of the Medicare Claims Processing Manual (Pub 100-04), sections 250.1 and 250.2. The table of contents for this manual may be found at: <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>.

The official instruction issued to your contractor regarding this change may be found at: <http://www.cms.hhs.gov/Transmittals/downloads/R63CP.pdf>.

Medlearn Matters Number: MM3051 – Revised  
 Related Change Request (CR) Number: 3051  
 Related CR Release Date: January 16, 2004  
 Related CR Transmittal Number: R63CP  
 Effective Date: January 1, 2004  
 Implementation Date: January 1, 2004

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

## **Changes to Rules for Receiving Optional Payment Method for Outpatient Services**

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 17, 2006, to provide new Web addresses that reflect changes in the new CMS website. All other information remains the same. This article was originally published in the Third Quarter 2004 Medicare A Bulletin (page 41).

### **Providers Affected**

Physicians/Practitioners and Critical Access Hospitals (CAH)

### **Provider Action Needed**

#### **STOP – Impact to You**

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 has modified the requirements for a CAH to receive payment for outpatient services under the optional payment method.

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

Understand the new requirements and their effective dates. The MMA changes the rules so the law does not require **all** physicians/practitioners to agree to reassign their billing rights to the CAH for outpatient services performed at the CAH in order for the CAH to select the optional payment method. This allows the CAH to receive payment for physician services at 115 percent of the Medicare fee schedule for such services. If a CAH elected the optional payment method before November 1, 2003, the effective date of this change is retroactive to July 1, 2001. If the election was made on or after November 1, 2003, then this rule is effective on July 1, 2004.

#### **GO – What You Need to Do**

CAHs need to understand the new rule and decide which payment method to select. (For more information on the optional payment method and the standard payment methods, please see the article MM3051, which may be retrieved at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3051.pdf>.)

Once the payment selection is made, the CAH must assure that physicians/practitioners are aware of the selection and act accordingly. In addition, CAHs must ensure that billing staffs are aware of any changes required as a result in any change of the selected payment methodology.

### **Background**

MMA changed the provision that required CAHs to have all of their physician/professional practitioners, who rendered outpatient services at their hospitals, reassign their billing rights to the CAH. Specifically, the MMA prohibits CMS from requiring that all physician/professional practitioners in a CAH reassign their billing rights to the CAH as a condition for electing the optional payment option (Method II).

This provision allows practitioners (**all licensed professionals who otherwise would be entitled to bill the carrier under Part B**) who render outpatient services in a

CAH’s outpatient department to choose whether they want to reassign their billing rights to the CAH, or file their own claims through their Medicare carrier.

If the CAH elected the optional method before November 1, 2003, the provision is effective beginning on or after July 1, 2001. If the CAH elected the optional method on or after November 1, 2003, the provision is effective July 1, 2004. Whichever method the CAH chose remains in effect for that entire cost reporting period.

Be aware that, with this change, CAHs will receive 115 percent of whatever Medicare would pay of the professional fee schedule for **only** those physicians/professional practitioners who reassign their billing rights to the CAH.

Also, CMS requires that the CAH fully document the fact that a practitioner elects to reassign their billing rights to the hospital. For those practitioners who elect to reassign their billing rights to the CAH, the hospital must have a copy of the 855I, which the individual practitioner must certify. The CAH must also have each practitioner sign an attestation that clearly states that they will not bill the carrier for any services rendered at the CAH once the reassignment has been given to the CAH.

### **Important Dates to Know**

**Effective Date:** July 1, 2004, for CAHs selecting the optional payment method on or after November 1, 2003; for those CAHs who selected the optional method prior to November 1, the effective date is retroactive to July 1, 2001.

### **Implementation Date**

The implementation date for this instruction is July 6, 2004

### **Related Instructions**

For more detailed information on the two payment methods available, please refer to CMS manual system, Publication 100-4, Claim Processing, Chapter 4, sections 250.1 and 250.2. This manual may be found at: <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>.

The official instruction issued to your carrier or fiscal intermediary regarding this change may be found at: <http://www.cms.hhs.gov/Transmittals/downloads/R103CP>.

Medlearn Matters Number: MM3114 – Revised  
 Related Change Request (CR) Number: 3114  
 Related CR Release Date: February 20, 2004  
 Related CR Transmittal number: R103CP  
 Effective Date: July 1, 2004  
 Implementation Date: July 6, 2004

Source: CMS Pub 100-4 Transmittal 103, CR 3114

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## Bonus Payments for Services in Health Professional Shortage Areas

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 18, 2006, to provide new Web addresses that reflect changes in the new CMS website. All other information remains the same. This article was originally published in the Fourth Quarter 2004 Medicare A Bulletin (page 66).

### Provider Types Affected

Critical access hospitals and psychiatrists

### Provider Action Needed

This instruction clarifies MM3108 by adding critical access hospital (CAHs) as eligible for the mental care health professional shortage area (HPSA) bonus payment. This bonus is designed for psychiatric services rendered in an eligible CAH.

To be eligible, the CAH must receive payment under the optional method (method II) payment rules and is located in a mental health area.

### Background

If a CAH, which has elected the optional method (method II), is located within a mental care HPSA, psychiatrists providing (outpatient) professional services in the CAH are eligible for the mental care HPSA bonus payments. When billing for this service, the CAH must bill using revenue code 961 plus the applicable HCPCS.

This mental care HPSA bonus will be paid to the CAH on a quarterly basis by their Medicare fiscal intermediary (FI). Also, the CAH should note that if their area is designated as both a mental care HPSA and a primary medical care HPSA, only one ten percent bonus payment will be paid for the service.

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### Additional Information

This change will be implemented by your FI on July 6, 2004 and will apply to services provided **on or after July 1, 2004**. To view the actual instruction issued to your FI, go to CMS website at <http://www.cms.hhs.gov/Transmittals/downloads/R203CP.pdf>.

Also, please see the related article, MM3108, on CMS website at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3108.pdf>.

Medlearn Matters Number: MM3336 – Revised  
 Related Change Request (CR) Number: 3336  
 Related CR Release Date: June 10, 2004  
 Related CR Transmittal Number: R203CP  
 Effective Date: July 1, 2004  
 Implementation Date: July 6, 2004

### FCSO Additional Information

For additional HPSA information and a link to a complete list of geographic HPSA designations is available through our provider education website <http://www.floridamedicare.com>.

On this site navigational menu, select "HPSA" under "Shared Topics" section. ❖

Source: CMS Pub 100-4 Transmittal 203, CR 3336



# LOCAL COVERAGE DETERMINATIONS

In accordance with publications specified by LCMS, Medicare contractors no longer distribute full-text local coverage determinations (LCDs) to providers in hardcopy format. Providers may obtain full-text LCDs from the provider education website [www.floridamedicare.com](http://www.floridamedicare.com). Final LCDs, draft LCDs available for comment, 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 LMRPs/LCDs 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 LCDs; the date the LCD is posted to the provider education website is considered the notice date.

## Electronic Notification

To receive quick, automatic notification when new and revised 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 LCD if you do not have Internet access, contact the Medical Policy department at:

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

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**This Bulletin Should Be Shared with All Health Care Practitioners and Managerial Members of the Provider Staff. Bulletins Are Available at no Cost from Our Provider Education Website at <http://www.floridamedicare.com>.**

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# ADDITIONS/REVISIONS TO LMRPs/LCDs

## A11000: Debridement Services—Addition to LCD

The local coverage determination (LCD) for debridement services was previously revised on January 1, 2006. Since that time, the following ICD-9-CM code ranges have been added to the ICD-9 Codes that Support Medical Necessity section of the LCD for CPT codes 97597 and 97598 only:

941.20-941.29	941.30-941.39	941.40-941.49
942.20-942.29	942.30-942.39	942.40-942.49
943.20-943.29	943.30-943.39	943.40-943.49
944.20-944.28	944.30-944.38	944.40-944.48
945.20-945.29	945.30-945.39	945.40-945.49
946.20-946.29	946.30-946.39	946.40-946.49

### No Action Required by Providers

Providers who have received denials for CPT codes 97597 and 97598 with one of these diagnoses for dates of service **on or after January 1, 2005** do not need to take any action. Adjustments will be performed on all the affected claims after February 2, 2006.

We apologize for any inconvenience this may have caused.

### Effective Date

This addition is effective for services provided **on or after January 1, 2005** for services processed **on or after February 2, 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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## A70450: Computed Tomography Scans—Revision to LCD

The local coverage determination (LCD) for computed tomography scans was last revised effective September 22, 2005. Since that time, this LCD has been revised and the title of the LCD has been changed to Computed Tomography Scans of the Head or Brain.

This revision includes changes to the “Indications and Limitations of Coverage” and “Documentation Requirements” sections of the LCD.

This revision also includes the following changes:

- CPT codes 70480-70492, 72125-72133, 73200-73202 and 73700-73702 were removed from the LCD.

- Since the ICD-9-CM codes associated with the many indications of the CT of the head or brain can be numerous and the ability to identify every appropriate diagnosis code for this service would result in an extensive diagnosis list, the ICD-9-CM codes were removed from the LCD.

### Effective Date

This revision is effective for services provided **on or after April 11, 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. ❖

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## A71250: Computed Tomography of the Thorax—Revision to LCD

The local coverage determination (LCD) for computed tomography of the thorax was last revised effective October 13, 2005. Since that time, this LCD has been revised to include changes to the “Indication and Limitations of Coverage” and “Documentation Requirements” sections of the LCD.

### Effective Date

This revision is effective for services provided **on or after April 11, 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. ❖

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**A76070: Bone Mineral Density Studies—Revision to LCD**

The local coverage determination (LCD) for bone mineral density studies was last updated effective November 21, 2005. Since that time, the following sections have been revised to include updating the NCD language, providing clarification for rendering this service for a woman who has been determined by the physician or a qualified nonphysician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings:

- Indications and Limitations of Coverage and/or Medical Necessity
- Type of Bill Codes

- ICD-9 Codes that Support Medical Necessity
- Documentation Requirements

In addition, the ICD-9-CM code 627.4 has been added to the “ICD-9 Codes that Support Medical Necessity” section of the LCD.

**Effective Date**

These revisions are effective for services provided **on or after April 11, 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. ❖

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**A90804: Individual Psychotherapy—Revision to LCD**

This local coverage determination (LCD) for individual psychotherapy was last updated on February 22, 2005. Since that time the LCD has been updated for clarification and revision of the following sections:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Do Not Support Medical Necessity
- Documentation Requirements
- Sources of Information and Basis for Decision
- ICD-9 Codes that Do Not Support Medical Necessity

Revisions include the removal of ICD-9-CM code 318.2 from the “ICD-9 Codes that Do Not Support Medical Necessity” section and adding it to the “ICD-9 Codes that Support Medical Necessity” section. Also, additional documentation requirements were added.

**Effective Date**

The revision of this LCD is effective for services provided **on or after April 11, 2006.**

The 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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**A90853: Group Psychotherapy—Revision to LCD**

This local coverage determination (LCD) for individual psychotherapy was last updated on February 22, 2005. Since that time the LCD has been updated for clarification and revision of the following sections:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Do Not Support Medical Necessity
- Documentation Requirements
- Sources of Information and Basis for Decision
- ICD-9 Codes that Do Not Support Medical Necessity

Revisions include the removal of ICD-9-CM code 318.2 from the “ICD-9 Codes that Do Not Support Medical Necessity” section and adding it to the “ICD-9 Codes that Support Medical Necessity” section. Also, additional documentation requirements were added.

**Effective Date**

The revision of this LCD is effective for services provided **on or after April 11, 2006.**

The 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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**A92081 Visual Field Examination—Revision to LCD**

The local coverage determination (LCD) for visual field examination was last updated effective October 1, 2005. This LCD has been revised to update references in the “Sources of Information and Basis for Decision” section and to remove the ICD-9-CM codes from the “ICD-9 Codes that Support Medical Necessity” section of the LCD

**Effective Date**

This revision is effective for services provided **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. ❖

**A92225: Ophthalmoscopy—Revision to LCD**

The local coverage determination (LCD) for ophthalmoscopy was last updated effective October 1, 2005. Since that time, this LCD has been updated and revised in the following sections:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Support Medical Necessity
- Documentation Requirements
- Sources of Information and Basis for Decision

Revisions include the addition of the following ICD-9-CM codes to the “ICD-9 Codes that Support Medical Necessity” section of the LCD:

361.89 362.03 362.05 362.06 998.82

**Effective Date**

This revision is effective for services provided **on or after April 11, 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. ❖

**A93922: Non-Invasive Physiologic Studies of Upper or Lower Extremity Arteries—Revision to LCD**

The local coverage determination (LCD) for non-invasive physiologic studies of upper or lower extremity arteries was last updated effective November 3, 2005. Since that time, the following sections of this LCD have been revised:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Support Medical Necessity
- Documentation Requirements
- Utilization Guidelines
- Coding Guidelines

Revisions include the provision of credentialing requirements and the addition of ICD-9-CM code 447.5 in the “ICD-9 Codes that Support Medical Necessity” section of the LCD.

**Effective Date**

This revision is effective for services provided **on or after April 11, 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. ❖

**A93925: Duplex Scan of Lower Extremity Arteries—Revision to LCD**

The local coverage determination (LCD) for duplex scan of lower extremity arteries was last updated effective November 3, 2005. Since that time, the following sections of this LCD have been revised:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Support Medical Necessity
- Documentation Requirements
- Utilization Guidelines
- Coding Guidelines

Revisions include the provision of credentialing requirements and the removal of ICD-9-CM codes 782.61, V67.00 and V67.09 and the addition of ICD-9-CM code V58.49 to the “ICD-9 Codes that Support Medical Necessity” section of the LCD.

**Effective Date**

This revision is effective for services provided **on or after April 11, 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. ❖

**A93965: Non-Invasive Evaluation of Extremity Veins—Revision to LCD**

The local coverage determination (LCD) for non-invasive evaluation of extremity veins was last updated effective November 3, 2005. Since that time, the following sections of this LCD have been revised:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Support Medical Necessity
- Documentation Requirements
- Utilization Guidelines
- Coding Guidelines

Revisions include the provision of credentialing requirements and the removal of ICD-9-CM code 454.9 and the addition of ICD-9-CM code V67.09 in the “ICD-9 Codes that Support Medical Necessity” section of the LCD.

**Effective Date**

This revision is effective for services provided **on or after April 11, 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. ❖

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**AC1300: Hyperbaric Oxygen Therapy (HBO Therapy)—Revision to LCD**

The local coverage determination (LCD) for hyperbaric oxygen therapy (HBO therapy) was last updated effective April 1, 2003. Since that time, the following sections of this LCD have been revised:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Support Medical Necessity
- Documentation Requirements
- Source of Information and Basis for Decision
- Coding Guidelines

Revisions include dual diagnosis requirements when billing HBO for the treatment of diabetic wounds of the lower extremities, clarification when billing evaluation and management (E/M) services and procedures on the same date of HBO therapy and coding information for calculating the total number of 30-minute intervals billable under HCPCS code C1300.

**Effective Date**

This revision is effective for services provided **on or after April 11, 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. ❖

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**ADYSPHRT: Dysphagia/Swallowing Diagnosis and Therapy—Revision to Policy**

The local medical review policy (LMRP) for dysphagia/swallowing diagnosis and therapy (ADYSPHRT) was previously revised on March 27, 2003. Since that time, the LMRP was revised to remove the following statement based on change request 3648:

“Modified barium swallow studies (CPT codes 70370, 70371, and 74230) are not covered when performed on a mobile basis.”

This revision is effective for services provided **on or after June 6, 2005**.

In addition, based on the Medicare Claims Processing Manual, Chapter 5, Section 40.3, revenue code 440 was changed to 44x.

This revision is effective for claims processed **on or after November 17, 2005**.

Furthermore, the LMRP has been converted to a local coverage determination (LCD) format.

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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**AEPO: Epoetin alfa—Revision to LCD**

The local coverage determination (LCD) for epoetin alfa was previously revised on October 1, 2005. Since that time, the “ICD-9 Codes that Support Medical Necessity” section of the LCD has been revised to add diagnosis 585.4 (Chronic kidney disease, Stage IV [severe]) for HCPCS code Q0136. This revision is effective for services provided **October 1, 2005 through December 31, 2005**. However, effective for services provided on or after January 1, 2006, HCPCS code Q0136 was discontinued and replaced with HCPCS code J0885.

In addition, the “ICD-9 Codes that Support Medical Necessity” section for HCPCS code J0885 was revised to

remove the benign neoplasm ICD-9-CM diagnosis codes 210.0-229.9. These ICD-9-CM diagnosis codes are not supported as medically necessary in the indication and limitation section of this LCD. Also, under EPO indication #6 – neoplastic disease was revised to read malignant neoplastic disease. The coding guideline for this LCD was revised accordingly. This revision is effective for services provided **on or after January 13, 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. ❖

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**AG0117: Screening Glaucoma Services—Retirement of Policy**

The local medical review policy (LMRP) for screening glaucoma services has been retired. This decision was based on information established with the issuance of change request 1914, dated November 2, 2001. The information for retiring this policy is based on national coverage.

**Effective Date**

The retirement of this LMRP is effective for services provided **on or after November 10, 2005**.

The full-text for this retired policy may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**AJ9000: Antineoplastic Drugs—Addition to LCD**

The local coverage determination (LCD) for antineoplastic drugs was last updated on October 20, 2005. A revision to this LCD was made to add the following additional off-label indication for oxaliplatin (J9263) under the “Indications and Limitations of Coverage and/or Medical Necessity” section:

- Oxaliplatin is allowed for colon cancer, stage II,

adjuvant treatment in combination with 5-fluorouracil/leucovorin

**Effective Date**

This addition is effective for services provided on or after **August 1, 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. ❖

**ANESP: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])—Revision to LCD**

The local coverage determination (LCD) for darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) was last updated on January 1, 2006. Since that time, the “ICD-9 Codes that Support Medical Necessity” section for HCPCS code J0881 was revised to remove the benign neoplasm ICD-9-CM diagnosis codes 210.0-229.9. These codes are not supported as medically necessary in the indication and limitation section of the

LCD. The coding guideline for this LCD was revised accordingly.

**Effective Date**

This revision is effective for services provided **on or after January 13, 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. ❖

**AVISCO: Viscosupplementation Therapy for Knee—Revision to LCD**

The local coverage determination (LCD) for viscosupplementation therapy for knee was last updated January 1, 2005. Since that time, a revision was made to the “Utilization Guideline” section of this LCD. The medication table was revised show the weekly dosage/injections per week for each medication and to show the total dosage for a course of treatment. The total dosage for Orthovisc® was revised to read 90-120mg. The duration of treatment for Hyalgan® was revised to read five weeks.

**Effective Date**

This revision is effective for services provided **on or after November 10, 2005**.

The full-text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**RETIREMENT OF EXISTING LMRPs**

**Multiple Policies Being Retired**

The following local medical review policies were retired. The decision to retire these policies was based on data analysis and standards of local practice.

<b>Policy Number</b>	<b>Policy Name</b>
A77280	Therapeutic Radiology Simulation-Aided Field Setting
A77300	Basic Radiation Dosimetry Calculation
A77305	Teletherapy Isodose Plan
A77326	Brachytherapy Isodose Calculation
A77331	Special Dosimetry
A77332	Treatment Devices, Design, and Construction
A77336	Radiation Physics Consultation
A77401	Radiation Treatment Delivery
A77750	Clinical Brachytherapy

**Effective Date**

The retirement of the above policies is effective for services provided **on or after January 1, 2006**.

The full-text for these retired policies are available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖



**A80100: Qualitative Drug Screen—Retirement of Policy**

The local medical review policy (LMRP) for qualitative drug screen – A80100 was last revised March 4, 2004. Since that time it has been determined that based on data analysis and local standards of medical practice, this policy is no longer necessary. Therefore, it has been retired.

**Effective Date**

The retirement of this policy is effective for services provided **on or after November 18, 2005**.

The full-text for this retired policy is available on the provider education website <http://www.floridamedicare.com> on or after this effective date. ❖

**ADDITIONAL MEDICAL INFORMATION**

**2006 HCPCS Local Coverage Determination Changes**

Florida Medicare has revised local coverage determinations (LCDs) impacted by the 2006 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and removed accordingly.

LCD Title	2006 Changes
A11000 – Debridement Services	<ul style="list-style-type: none"> <li>Deleted procedure codes 15350 and 15351</li> <li>Added procedure code range 15300-15336</li> <li>Updated “CMS National Coverage Policy” section of the policy <b>(Not related to 2006 HCPCS)</b></li> </ul>
A15822 Upper Eyelid and Brow Surgical Procedures	<ul style="list-style-type: none"> <li>Descriptor change for procedure codes 67901 and 67902</li> </ul>
A78459 Myocardial Imaging, Positron Emission Tomography (PET) Scan	<ul style="list-style-type: none"> <li>Deleted procedure code Q3000</li> <li>Added procedure code A9555</li> <li>Descriptor change for procedure code A9526</li> <li>Coding Guideline attachment retired as it is no longer applicable</li> </ul>
AALEFACEPT Alefacept	<ul style="list-style-type: none"> <li>Deleted procedure code C9212</li> <li>Added information related to new procedure code 90772 to the Coding Guideline attachment</li> </ul>
ABEXXAR Tositumomab and Iodine I 131 Tositumomab (Bexxar®) Therapy	<ul style="list-style-type: none"> <li>Deleted procedure codes C1080 and C1081</li> <li>Added procedure codes A9544 and A9545</li> <li>Updated “CMS National Coverage Policy” section of the policy <b>(Not related to 2006 HCPCS)</b></li> </ul>
ABOTULINUM TOXINS Botulinum Toxins <b>(Coding Guidelines only)</b>	<ul style="list-style-type: none"> <li>Added procedure codes 95865, 95873, and 95874 to the Coding Guideline attachment</li> </ul>
AEPO Epoetin alfa	<ul style="list-style-type: none"> <li>Deleted procedure codes Q0136 and Q4055</li> <li>Added procedure codes J0885 and J0886</li> </ul>
AJ1950 Leuprolide Acetate	<ul style="list-style-type: none"> <li>Deleted procedure code C9430</li> </ul>
AJ2430 Pamidronate (Aredia®, APD)	<ul style="list-style-type: none"> <li>Deleted procedure code C9411</li> </ul>
AJ3487 Zoledronic Acid (Zometa®) <b>(Coding Guidelines only)</b>	<ul style="list-style-type: none"> <li>Deleted procedure code G0347 and related billing instructions from the Coding Guideline attachment</li> </ul>
AJ7190 Hemophilia Clotting Factors	<ul style="list-style-type: none"> <li>Deleted procedure codes Q0187 and Q2022</li> <li>Added procedure codes J7188 and J7189</li> <li>Changed LCD Number from AJ7190 to AJ7188</li> </ul>
AJ9000 Antineoplastic Drugs	<ul style="list-style-type: none"> <li>Deleted procedure codes C9205, C9415, C9425, C9426, C9431, and C9432</li> </ul>
ANESP Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])	<ul style="list-style-type: none"> <li>Deleted procedure codes Q0137 and Q4054</li> <li>Added procedure codes J0881 and J0882</li> </ul>
AOOS Outpatient Observation Services	<ul style="list-style-type: none"> <li>Deleted procedure codes G0244, G0263, and G0264</li> <li>Added procedure codes G0378 and G0379</li> </ul>
APHPROG Psychiatric Partial Hospitalization Program	<ul style="list-style-type: none"> <li>Deleted procedure codes 96100, 96115, and 96117</li> <li>Added procedure codes 96101, 96116, and 96118</li> </ul>

LCD Title	2006 Changes
AQ9941 Intravenous Immune Globulin	<ul style="list-style-type: none"> <li>• Deleted procedure codes Q9941, Q9942, Q9943, and Q9944</li> <li>• Added procedure codes J1566 and J1567</li> <li>• Change LCD Number from AQ9941 to AJ1566</li> <li>• Coding Guideline attachment retired</li> </ul>
ASKINSUB Skin Substitutes	<ul style="list-style-type: none"> <li>• Deleted procedure codes C1305, C9200, C9201</li> <li>• Deleted procedure codes 15342 and 15343 and replaced them with generic skin substitute/skin replacement verbiage</li> <li>• Descriptor change for procedure codes J7340, J7342, J7343, and J7344</li> </ul>
ATHERSVCS Therapy and Rehabilitation Services	<ul style="list-style-type: none"> <li>• Deleted procedure codes 96115, 97020, 97504, 97520, and 97703</li> <li>• Added procedure codes 92626, 92627, 92630, 92633, 96116, 97760, 97761, and 97762</li> <li>• Descriptor change for procedure codes 92506, 92507, 97024, and 97542</li> <li>• Updated wheelchair management section with guidelines for assessment and fitting</li> </ul>
AVISCO Viscosupplementation Therapy for Knee	Deleted procedure code C9413
AZEVALIN Ibritumomab Tiuxetan (Zevalin™) Therapy	<ul style="list-style-type: none"> <li>• Deleted procedure codes C1082 and C1083</li> <li>• Added procedure codes A9542 and A9543</li> </ul>

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

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## **Prostate Specific Antigen Correct Coding: Use G0103 for Screening Exams**

Prostate cancer is the second leading cause of cancer death among men in the U.S. According to the American Cancer Society, more than 70 percent of all diagnosed prostate cancers are found in men ages 65 years or older. Medicare covers the two most common tests to detect prostate cancer. The *screening prostate specific antigen blood test (G0103) also known as the PSA test*, measures the amount of PSA enzyme in the blood, a marker for prostate cancer. The digital rectal examination (DRE; G0102) is the second test Medicare covers to detect prostate cancer.

Coding confusion may sometimes occur between PSA *screening* and *diagnostic* tests. *Screening prostate specific antigen test, total (G0103)* detects the marker for adenocarcinoma of the prostate in the absence of sign and/or symptoms.

Screening PSA tests are covered at a frequency of once every 12 months for men who have attained age 50, if at least 11 months have passed following the month in which the last Medicare-covered screening prostate specific antigen test was performed.

When a PSA is being performed for diagnostic purposes (e.g., as a marker following the progress of a cancer or as an aid in the management of a tumor once the diagnosis has been established, the applicable CPT code to bill is 84153 – *Prostate specific antigen, (PSA), total*. ❖

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## Requesting a Comparative Billing Report—Part A Providers

Comparative billing report (CBR) information is available to providers by request. The purpose of making CBRs available to providers is to show the type of comparative data that Medicare considers when determining on how the provider business practice differs from other providers in the same specialty payment area or locality, and potentially may require educational intervention. A provider-specific CBR may be a helpful tool for providers when conducting self-audits.

### Comparative Billing Reports by Type of Bill – Provider-Specific Report

Part A providers are compared to their peers by type of bill using average allowed dollars per beneficiary. This type of CBR contains billing information for a provider in six-month intervals. The reports are updated four times per year for the following dates of service:

January through June  
April through September  
July through December  
October through March

Since these reports are based on date of service and not processed dates, Medicare must allow two to three months to let claims for that period to be submitted before reports can be run. For example, the April through September timeframe is not available until December/January.

### How to Request a Comparative Billing Report

To request a CBR, providers **must** follow these steps:

- The CBR request must be done on an office or corporate letterhead and the provider/officer signature must be affixed. A request from a corporate entity must be requested by a corporate officer, or in the case of a hospital, the hospital administrator. If the requesting provider wants the information to be sent to another party, it must be noted in the letter.
- The mailing address must be stated clearly and legibly in the letter, since these reports will only be sent via the US mail, and will not be sent electronically.
- The CBR request must include the Medicare provider number and the type of bill.
- The request must be faxed to Statistical & Medical Data Analysis department at 904-791-8006 or mailed to:

Statistical & Medical Data Analysis  
532 Riverside Avenue, 19T  
Jacksonville, FL 32202.

**Note:** There is no fee for providing these reports.

Once a CBR request has been received, the provider-specific report will be mailed to the requesting provider (or other party as specified by the provider) within ten days, along with an explanation sheet to assist in interpreting the data. ❖

Source: CMS Pub-08, Medicare Program Integrity Manual, Chapter 1, Section 1.4.2.3

# ESRD SERVICES

## Processing End Stage Renal Disease Exceptions Under the Composite Rate Reimbursement System

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

### Provider Types Affected

Providers billing fiscal intermediaries (FIs) for pediatric end stage renal disease (ESRD) services

### Provider Action Needed

#### STOP – Impact to You

This article is based on change request (CR) 4188 which implements changes in Medicare's processes for handling requests by ESRD pediatric facilities for an exception from the composite payment rate.

#### CAUTION – What You Need to Know

Only those pediatric facilities that did not have an approved exception rate as of October 1, 2002, can now apply for an exception to its updated composite rate. Other changes to the exception process are also covered in this article.

#### GO – What You Need to Do

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

### Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 623) amended the Benefits Improvement and Protection Act (BIPA 2000) to allow only pediatric ESRD facilities that did not have an approved exception rate as of October 1, 2002, to file for an exception to its updated prospective payment (or composite) rate.

The pediatric facility would have to demonstrate that at least 50 percent of its patients are individuals less than 18 years of age. This statutory amendment to BIPA 2000 lifted the previous prohibition on exceptions and restored the exception process for pediatric facilities.

The Centers for Medicare & Medicaid Services (CMS) believes that pediatric facilities would not qualify for an exception under most of the five existing exception criteria because of the uniqueness of their pediatric patient population (at least 50 percent).

In the past, ESRD facilities with high percentages of pediatric patients only qualified for exceptions under the "atypical patient mix" criterion. Therefore, CMS is revising the exception criteria by:

- Eliminating the following three (of the five) exception criteria:
  - ♦ Isolated essential facilities
  - ♦ Extraordinary circumstances
  - ♦ Frequency of dialysis
- Retaining and revising the exception criterion for "pediatric patient mix;"

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- Retaining and renaming the exception criteria for self-dialysis and training costs.

In accordance with changes made by BIPA 2000 (Section 422) and the MMA (Section 623), CMS has revised instructions in the *Medicare Claims Processing Manual*. The major changes include the following:

- Only a pediatric ESRD facility that did not have an approved exception rate as of October 1, 2002 can now file for an exception to its updated composite payment rate
- A pediatric ESRD facility is defined as a renal facility with at least 50 percent of its patients under the age of 18
- The previous exception criteria have been eliminated (with the exception of self-dialysis training)
- Pediatric ESRD facilities can file for an exception to its composite payment rate at any time it is in operation for 12 consecutive months
- A pediatric ESRD facility that has been denied an exception rate may immediately file another exception request.

**Note:** The regulations pertaining to the servicing intermediary's responsibilities for reviewing ESRD exception requests have not changed.

### Implementation

The implementation date for the instruction is January 17, 2006.

### Additional Information

The revised portions of the *Medicare Claims Processing Manual* are attached to CR4188, which is 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/transmittals/downloads/R781CP.pdf>.

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/apps/contacts/>.

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

Medlearn Matters Number: MM4188  
 Related Change Request (CR) Number: 4188  
 Related CR Release Date: December 16, 2005  
 Related CR Transmittal Number: R781CP  
 Effective Date: January 1, 2006  
 Implementation Date: January 17, 2006

Source: CMS Pub. 100-4, Transmittal 781, CR 4188

## **National Monitoring Policy for EPO and Aranesp® for End-Stage Renal Disease Patients Treated in Renal Dialysis Facilities**

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

### **Provider Types Affected**

Providers billing Medicare fiscal intermediaries (FIs) for services related to erythropoietin (EPO) and darbepoetin (Aranesp) for end-stage renal disease (ESRD) patients

### **Provider Action Needed**

#### **STOP – Impact to You**

This article is based on Change Request (CR) 4135, in which the Centers for Medicare & Medicaid Services (CMS) institutes a new national monitoring policy for claims for erythropoietin and darbepoetin (EPO and Aranesp) administered to ESRD patients treated in renal dialysis facilities.

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

Under the new monitoring policy, CMS expects a 25 percent reduction in the dosage of these drugs for patients whose hematocrit exceeds 39.0 (hemoglobin of 13.0). If the dosage is not reduced, payment will be made for the medications as if the reduction had occurred. Also a new maximum limitation for each drug per month is created.

#### **GO – What You Need to Do**

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

### **Background**

CMS previously had an EPO monitoring policy, and its methodology limited monitoring of EPO to post-payment review based on a 90-day rolling average of claims. The CMS target for taking action was a hematocrit level of 37.5, although higher levels could be approved upon medical justification by the treating physician.

In the fall of 2003, CMS solicited scientific information from the ESRD community in order to develop a national claims monitoring policy on erythropoietin administered to ESRD patients in renal dialysis facilities. CMS found that there is considerable natural variability in individual patient hematocrit levels, making it difficult to consistently maintain a hematocrit within the narrow range of 33-36.

Therefore, effective April 1, 2006, Medicare is implementing a national monitoring policy to promote the efficient use of EPO and Aranesp in the Medicare ESRD in-facility dialysis population. To allow for unanticipated increases in hematocrit, CMS will not initiate monitoring until the hematocrit level reaches 39.0 (or a hemoglobin of 13.0).

**Note:** Hematocrit levels are reported in value code 49 (reflecting the most recent reading taken before the start of the billing period), while hemoglobin readings (taken before the start of the billing period) are reported in value code 48.

For claims on bill type 72x with hematocrit readings above the threshold of 39.0 (or hemoglobin of 13.0), the dosages of EPO and Aranesp should be reduced by 25 percent over the preceding month.

**Example:** If a beneficiary’s hematocrit level taken in May is 40.0, the facility should report this number in value code 49 on the June bill. The facility

should reduce the dosage of EPO furnished to the beneficiary in June by 25 percent over that provided in May; e.g., if the beneficiary was given 10,000 IU (international unit) in May, he/she should receive 7,500 IU in June.

If the dose has been reduced by 25 percent, modifier GS should be reported on the claim. When the GS modifier appears on the claim, payment will be made based on the reported dosage.

**Note:** Modifier GS is defined as “Dosage of EPO or darbepoetin alfa has been reduced 25 percent of preceding month’s dosage.”

For claims on bill type 72x, with hematocrit levels above 39.0 (hemoglobin of 13.0) without modifier GS, CMS will reduce the dosage payable by 25 percent for EPO and Aranesp. For example, if the June hematocrit level is 40.0, and there is no GS modifier and the dosage is 10,000 IU, CMS will pay the claim as if the dosage had been 7,500 IU.

**Note:** Renal facilities may not bill Medicare beneficiaries for the payment reduction unless they have issued an advanced beneficiary notice prior to administration of EPO or Aranesp. Medicare FIs will hold providers liable for the 25 percent reduction unless the occurrence code 32 is present on the claim or a modifier GA is present on the line item.

In addition to the dosage adjustments, effective April 1, 2006, Medicare will not make payment and will return to the provider those claims for dosage of EPO (HCPCS Q4055 (J0886 as of January 1, 2006)) in excess of 500,000 IUs per claim or Aranesp (HCPCS Q4054 (J0882 as of January 1, 2006)) in excess of 1500 mcg per claim.

### **Implementation**

The implementation date for the related 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/transmittals/downloads/R751CP.pdf>.

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/apps/contacts/>.

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

Medlearn Matters Number: MM4135  
 Related Change Request (CR) Number: 4135  
 Related CR Release Date: November 10, 2005  
 Related CR Transmittal Number: 751  
 Effective Date: April 1, 2006  
 Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 751, CR 4135



## Implementation of Changes in End Stage Renal Disease Payment for 2006

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

### Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for end stage renal disease (ESRD) services

### Provider Action Needed

#### STOP – Impact to You

This article is based on change request (CR) 4196, which implements changes in ESRD payment for calendar year (CY) 2006.

#### CAUTION – What You Need to Know

CR 4196 makes the following changes to payment to ESRD facilities: 1) revision to the geographic designation and wage index adjustment applied to the composite payment rate; 2) revision of the drug payment methodology, moving from acquisition cost pricing to average sales price (ASP) + six percent; and 3) revision of the drug add-on adjustment to the composite payment rate as required under MMA.

#### GO – What You Need to Do

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

### Background

The Social Security Act (Section 1881(b)), as amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 623), directed the Centers for Medicare & Medicaid Services (CMS) to make a number of revisions to the composite rate payment system, including payment for separately billable drugs furnished by ESRD facilities. For CY 2006, CMS is making several changes to payment to ESRD facilities and revising the following:

#### Geographic Designation and Wage Index Adjustment

There are changes to the geographic designation and wage index adjustment applied to the composite payment rate. CMS has revised the geographic classifications using core-based statistical area (CBSA) designations and wage indexes using the latest hospital data.

In addition, CMS is revising the labor component to which the revised wage index is applied. Beginning January 1, 2006, the labor portion of the composite rate will be 53.711 percent. These changes are being implemented over a four-year transition period. Therefore, for 2006, 75 percent of the wage adjusted composite rate will reflect the old geographic adjustments and 25 percent will reflect the revised adjustments.

#### Drug Payment Methodology

The drug payment methodology is moving to a single pricing system for all drugs furnished in ESRD facilities using ASP +6 percent pricing. This will allow consistent drug payments for both hospital-based and independent facilities beginning January 1, 2006.

#### Drug Add-On Adjustment

CMS is revising the drug add-on adjustment to the composite payment rate as required under the MMA. Changes were made to the add-on adjustment to accommo-

date the new payment methodology and expected growth in ESRD expenditures.

An add-on adjustment of 13.1 percent to the composite payment rate will account for the difference between previous payments for separately billed drugs and biologicals and the revised pricing effective January 1, 2006. CMS also updated that add-on adjustment to reflect changes in ESRD drug utilization of 1.4 percent. The combined drug add-on adjustment for CY 2006 is 14.7 percent.

#### Height and Weight Reporting Requirements for Double Amputee Dialysis Patients

CMS is revising the reporting requirements for the value codes A8 (weight) and A9 (height) applicable to double amputee dialysis patients. For dialysis treatments on or after January 1, 2006, CMS is revising the reporting requirements for value codes A8 (weight) and A9 (height) for double amputee dialysis patients:

- Weight should be calculated based on pre-amputation weight using the following formula: Pre-amputation weight = actual weight x 1.5.

**Example:** Current weight for double amputee patient = 75.5 kg; Pre-Amputation weight =  $75.5 \times 1.5 = 113.3$ kg; the resulting pre-amputation weight should be reported under value code A8. Height should be reported under value code A9 as pre-amputation height. Where feasible, this measurement may be obtained from Form 2728.

**Note:** CMS is instructing intermediaries to return to the provider any claims where the weight reported in value code A8 exceeds 500 kg and/or where the height in A9 exceeds 300 cm.

#### Implementation

The implementation date for the 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 on the CMS website at <http://new.cms.hhs.gov/transmittals/downloads/R774CP.pdf>.

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/apps/contacts/>.

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

Medlearn Matters Number: MM4196  
 Related Change Request (CR) Number: 4196  
 Related CR Release Date: December 2, 2005  
 Related CR Transmittal Number: 774  
 Effective Date: January 1, 2006  
 Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 774, CR 4196

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## **Restoring Composite Rate Exceptions for Pediatric Facilities Under the End Stage Renal Disease Composite Rate System**

*The following is a Medlearn Matters provider education article issued by the Centers for Medicare & Medicaid Services (CMS).*

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 17, 2006, to provide new Web addresses that reflect changes in the new CMS website. All other information remains the same. This article was originally published in the Third Quarter 2004 Medicare A Bulletin (page 43).

### **Provider Types Affected**

Pediatric end-stage renal disease (ESRD) facilities.

### **Provider Action Needed**

#### **STOP**

If you meet the definition of a pediatric ESRD facility and do not have an approved exception rate, you may be able to request an exception between April 1, 2004 and September 27, 2004.

#### **CAUTION**

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) has revised the definition of a pediatric ESRD facility to mean a renal facility in which at least 50 percent of its patients are under 18 years of age.

#### **GO**

If you meet these criteria and do not have an approved exception to the composite payment rate, you can apply for one to your intermediary between April 1, 2004, and September 27, 2004.

### **Background**

A hospital-based or independent pediatric renal dialysis facility may request the Centers for Medicare & Medicaid Services (CMS) to approve an exception to the composite payment rate and set a higher payment rate if:

- Your estimated allowable cost per treatment is higher than your composite rate; and
- If you meet the definition of a pediatric ESRD facility.

In accordance with MMA requirements, CMS has revised section 422(a)(2) of the Benefits Improvement and Protection Act of 2000 to:

- (a) Provide that pediatric exception rates in effect on October 1, 2002 will continue in effect so long as the exception rate exceeds the facility's updated composite payment rate; and
- (b) Restore the exceptions process for pediatric facilities only.

If you did not have an approved exception rate as of October 1, 2002, MMA Section 623(b)(1)(D) allows you to submit a request for a new exception to your intermediary between April 1, 2004 and September 27, 2004.

MMA also revises the definition of a pediatric ESRD facility. The statute defines the term "pediatric facility" to mean a renal facility in which at least 50 percent of your patients are individuals under 18 years of age.

If you meet these criteria and project, on the basis of prior years cost and utilization trends, that you will have an allowable cost per treatment higher than your prospective rate, you may request CMS to approve an exception to that rate and set a higher payment rate.

CMS will adjudicate these exception requests in accordance with the exception criteria contained in 42 CFR 413.180 and the Provider Reimbursement Manual, Part I, Chapter 27. However, be aware that your pediatric exception request will be denied if:

- You do not adequately justify the request in accordance with regulations or program instructions; and/or
- Your intermediary does not receive your request before close of business on September 27, 2004.

An exception request is deemed approved unless CMS disapproves it within 60 working days after it is filed with the intermediary. The first day of this 60-working-day deadline is the date that the exception request, containing all of the required documentation, is filed with the intermediary. Therefore, you must send your request to the intermediary through a method that documents the date of receipt. A postmark or other similar date will not serve as documentation of the date of receipt.

Send your request to:

First Coast Service Options, Inc.  
Attn: Murry L. McGowan  
532 Riverside Avenue, – 16T  
Jacksonville, FL 32202

Contact Telephone Number: 1-904-791-8683  
Fax Number: 1-904-791-8441

### **Additional Information**

Additional information is contained in the provider Reimbursement Manual Part I, sections 2720.0-2726.2; 42 CFR 413.180 and PRM, Part I, Chapter 27. To access this manual go to: <http://www.cms.hhs.gov/Manuals/PBM/list.asp#TopOfPage>.

Also, to view the actual instruction issued to your intermediary on this change, visit: <http://www.cms.hhs.gov/Transmittals/downloads/R101CP.pdf>.

Medlearn Matters Number – Revised  
Related Change Request (CR) Number: 3119  
Related CR Release Date: February 20, 2004  
Effective Date: March 1, 2004  
Implementation Date: April 1, 2004  
Related CR Transmittal Number: R101CP

Source: CMS Pub 100-4 Transmittal 101, CR 3119

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# SKILLED NURSING FACILITY SERVICES

## Swing Bed Rates for Calendar Year 2006

The Centers for Medicare & Medicaid Services (CMS) has added table 17 in section 2231 – Regional Medicare Swing-Bed Rates of the Provider Reimbursement Manual – Part 1 to update the Medicare payment rates for routine skilled nursing facility type services by swing-bed hospitals during calendar year 2006. These rates are used to carve out swing-bed costs on the hospital cost report.

**Medicare swing-bed rate payments for provider under CMS region 4 for services provided during the calendar year 2006 is \$163.85.**

Transmittal 429 may be viewed on the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R429PR1.pdf>. ❖

Source: CMS Provider Reimbursement – Part 1, Transmittal 429, December 2005

## Modifiers for Transportation of Portable X-Rays (R0075) When Billed by Skilled Nursing Facilities

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

### Provider Types Affected

Skilled nursing facilities (SNFs) billing Medicare fiscal intermediaries (FIs) for portable X-rays

### Provider Action Needed

#### STOP – Impact to You

This instruction requires SNFs to report modifiers UN, UP, UQ, UR, or US when billing FIs for the Healthcare Common Procedure Coding System (HCPCS) code R0075 on Part B type of bills (TOBs) 22x and 23x, effective April 1, 2006.

#### CAUTION – What You Need to Know

The five modifiers for HCPCS code R0075 will be used to report the number of patients served during a single trip that the portable X-ray supplier makes to a particular location.

#### GO – What You Need to Do

Be sure billing staff is aware of the requirements in this article to ensure prompt and accurate processing of your Medicare claims

### Background

On January 1, 2004, the Centers for Medicare & Medicaid Services (CMS) made effective five new portable X-ray Level II HCPCS modifiers (UN, UP, UQ, UR, US) that providers are required to report with HCPCS code R0075 when billing Medicare carriers for portable X-rays.

The five new modifiers are used to report the number of patients served during a single trip that the portable X-ray supplier makes to a particular location. (For further details, review CR2856 and CR3280. Instructions for accessing these CRs are available in the *Related Instructions* section of this article.)

Effective April 1, 2006, CMS is implementing the requirement that SNFs also report these modifiers when billing HCPCS code R0075 to the FI on Part B TOBs 22x and 23x.

The *Medicare Claims Processing Manual*, Chapter 13 (Radiology Services and Other Diagnostic Procedures), Section 90.5 (Transportation of Equipment Billed by an SNF to FI), requires that when an SNF bills for portable

X-ray equipment transported to a site by van or other vehicle, the SNF should bill for the transportation cost by using either the HCPCS code:

- **R0070** - the transportation of portable X-ray equipment and personnel to home or nursing home per trip to facility or location, one patient seen; or
- **R0075** - transportation of portable X-ray equipment and personnel to home or nursing home per trip to facility or location, more than one patient seen.

CR 4039 requires SNFs to report the five new portable X-ray level II HCPCS modifiers, relative to the number of patients served per trip to a facility or location, when the HCPCS code R0075 is billed to the *fiscal intermediary* on Part B TOBs 22x and 23x, effective for dates of service on or after April 1, 2006. The definitions of the five modifiers that must be reported are as follows:

- **UN** – Two patients served
- **UP** – Three patients served
- **UQ** – Four patients served
- **UR** – Five patients served
- **US** – Six or more patients served

**Note:** If only one patient is served, the HCPCS code R0070 must be reported without a modifier, since this codes applies to one patient seen per trip to a facility or location.

### Determining Payment for Multiple Patients Served

Medicare will make payment for the modifiers based on the definition of the modifier. The payment for serving a single patient (R0070) will be used as the base rate for R0075 (more than one patient seen), and will be prorated for the number of patients served. For example:

- If R0075 is reported with modifiers UN, UP, UQ, and UR, the total payment for a single patient served will be divided by the 2, 3, 4, and 5 respectively.
- If R0075 is reported with modifier US, the total payment for a single patient served will be divided by 6

**Modifiers for Transportation of Portable X-Rays (R0075) When Billed by Skilled Nursing Facilities (continued)**

regardless of the number of patients served. For example, if eight patients were served, R0075 would be reported with modifier US, and the total payment for a single patient for this service would be divided by 6.

The units field for R0075 will almost always be reported as "1." The number in the units field indicates the number of times the patient received the itemized services on the "line item date of service" specified on the same line.

The units field must reflect the number of services received by a specific beneficiary only, not the number of services received by other beneficiaries. The unit field must never be used to report the number of patients served during a single trip.

HCPCS code R0075 must be billed with the *Current Procedural Terminology (CPT)* radiology codes (70000 series) and only when the X-ray equipment used was actually transported to the location where the X-ray was taken. HCPCS code R0075 should **not** be billed for the use of X-ray equipment that is stored in the location where the X-ray is done (e.g., a nursing home) for use as needed.

Please be aware that Medicare will return to the provider claims containing R0075 when billed without one of the five modifiers.

**Related Instructions**

The *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 13 (Radiology Services and Other Diagnostic Procedures), Section 90.3 (Transportation Component (HCPCS Codes R0070 – R0076)), may be reviewed on the CMS website at <http://www.cms.hhs.gov/Manuals/PBM/list.asp#TopOfPage>.

CR 2856, Transmittal 14, October 24, 2003, may be found on the CMS website at [http://www.cms.hhs.gov/manuals/pm\\_trans/R14CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R14CP.pdf).

CR 3280, Transmittal 343, October 29, 2004, may be found on the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R343CP.pdf>.

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Also, see Medlearn Matters article MM3280, "Clarification: Modifiers for Transportation of Portable X-rays (R0075)." This article may be found on the CMS website at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3280.pdf>.

**Additional Information**

The *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 13 (Radiology Services and Other Diagnostic Procedures), Section 90.5 (Transportation of Equipment Billed by an SNF to a FI), is being revised to reflect that, effective April 1, 2006, SNFs are required to report the appropriate modifiers to identify the number of patients served when billing for R0075. The revised section is attached to CR 4039.

For complete details, please see the official instruction issued to your FI regarding this change. That instruction may be viewed by going on the CMS website to <http://www.cms.hhs.gov/transmittals/downloads/R716CP.pdf>.

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

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

Medlearn Matters Number: MM4039  
 Related Change Request (CR) Number: 4039  
 Related CR Release Date: October 21, 2005  
 Related CR Transmittal Number: 716  
 Effective Date: April 1, 2006  
 Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 716, CR 4039

**Message to Nursing Home Administrators on Prescription Drug Coverage**

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 11, 2006, to provide new Web addresses that reflect changes in the new CMS website. All other information remains the same. This article was originally published in the Fourth Quarter 2005 Medicare A Bulletin (pages 76-77).

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

**Provider Types Affected**

Skilled nursing facilities – This article contains important information for nursing home staff about the impact of the new prescription drug coverage on people who receive both Medicare and Medicaid.

**Information for Nursing Home Administrators**

The Centers for Medicare & Medicaid Services (CMS) released the following information via the minimum data set (MDS) submission system's Welcome Page on July 6, 2005:

- Starting January 1, 2006, Medicare prescription drug coverage will be available to everyone with Medicare. Also starting January 1, 2006, state Medicaid programs will no longer provide drug coverage for people also covered by Medicare (also known as full benefit dual eligibles or FBDEs); instead, Medicare will provide prescription drug coverage for people in this group. Since two thirds of residents in nursing homes fall into this category, this federal program will be critically important. State Medicaid coverage for **health care** coverage is not affected.



*Message to Nursing Home Administrators on Prescription Drug Coverage (continued)*

- All Medicaid beneficiaries who are eligible to receive benefits through both Medicare and Medicaid must enroll in a Medicare Prescription Drug Plan to get this coverage. They will receive information from Medicare and from the plans in their area this fall and they will need to choose and enroll in a plan that meets their needs. However, if they haven't joined a plan by December 31, 2005, Medicare will enroll them in a plan to make sure they don't miss a day of coverage. People in this group can switch to another plan at any time.
- The Centers for Medicare & Medicaid Services (CMS) will use the minimum data set (MDS) distribution system to keep nursing home administrators informed about Medicare prescription drug coverage as it applies to nursing home residents.
- All Medicare prescription drug plans will provide at least a standard level of coverage to all enrollees. Coverage will be available through both Medicare "Prescription Drug Plans" (PDPs), and as part of Medicare Advantage plans or other Medicare health plans (MA-PDs). All plans will be required to cover enrollees in all nursing homes in their regions. They will also be required to meet specific service and performance criteria to ensure safe prescription drug administration in the nursing home setting. While plans may offer different formularies (lists of covered drugs), CMS will require plans to cover a range of drugs in the most commonly prescribed classes to make sure that people with different medical conditions can get the treatment they need.

An "exceptions and appeals" process will be in place to ensure access to non-formulary drugs. The plans will arrange for medications to be packaged and made available to nursing homes through long-term care pharmacy providers. These will most likely include current pharmacy providers to nursing homes, as well as new organizations that are able to meet the CMS long-term care pharmacy standards. Nursing homes will be able to select from these pharmacy vendors to ensure that all of the residents have appropriate drug coverage.

- People who receive both Medicare and Medicaid and reside in a nursing home will receive continuous prescription drug coverage, with no premiums, no deductibles, and no co-payments.
- People with limited income and resources, who are **not** eligible for full Medicaid benefits, may qualify for extra help paying for Medicare prescription drug coverage. If they qualify, they will receive extra help to pay for premiums, deductibles, and co-payments. They **will** have to pay a copayment or coinsurance amount,

depending on their income and resources.

- More information concerning Medicare prescription drug coverage as it applies to the long-term care population, and operational steps that will be necessary to ensure a seamless transition in 2006, will be forthcoming through the MDS distribution system. Additional information and resources are also available on CMS website at: <http://www.cms.hhs.gov>.

**Additional Information**

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

Detailed drug coverage information for CMS partners and beneficiary advocates may be found on CMS website at <http://www.cms.hhs.gov/Partnerships/PDI/list.asp#TopOfPage>.

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

**Important Points to Remember**

- On January 1, 2006, new prescription drug coverage will be available to your Medicare residents. It will cover brand name and generic drugs.
- Starting January 1, 2006, state Medicaid programs will no longer provide drug coverage for people also covered by Medicare.
- All Medicaid beneficiaries who are eligible to receive benefits through both Medicare and Medicaid **must** enroll in a Medicare Prescription Drug Plan to get continuous coverage of their prescription drug costs.
- If Medicaid beneficiaries who are eligible to receive benefits through both Medicare and Medicaid do not enroll in a Medicare Prescription Drug Plan by December 31, 2005, Medicare will enroll them in a plan automatically to make sure they do not miss a day of coverage.
- Medicaid beneficiaries who live in a nursing home will pay nothing out of their pocket for Medicare prescription drug coverage.
- If your Medicare patients ask you questions about the new coverage, you can refer them for additional information and assistance to 1-800-MEDICARE and to <http://www.medicare.gov>.

Medlearn Matters Number: SE0544 – Revised  
 Related Change Request (CR) Number: N/A  
 Related CR Release Date: N/A

Source: CMS Special Edition Medlearn Article SE0544

**Skilled Nursing Facility Claims Returned to Providers Inappropriately**

The Centers for Medicare & Medicaid Services (CMS) has notified fiscal intermediaries that the January 2006 update to the outpatient prospective payment system outpatient code editor (OPPS-OCE) is applying edit 62, resulting in reason code W7062, inappropriately to types of bills 22x and 23x for services provided on or after October 1, 2005. CMS is correcting this situation in the April 2006 version of the OPPS-OCE.

**Action Required by Providers**

Skilled nursing facilities need to resubmit types of bill 22x and 23x for services provided on or after October 1, 2005, that have been returned to providers with a status location TB9997.

Once the affected claims have been reprocessed through the system, the claims will finalize accordingly. ❖

Source: CMS Joint Signature Memorandum 06224, January 30, 2006



# RURAL HEALTH CLINIC SERVICES

## Announcement of Medicare Rural Health Clinics and Federally Qualified Health Centers Payment Rate Increases

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

### Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for services to Medicare beneficiaries in **rural health clinics** (RHCs) and federally qualified health centers (HFQHCs)

### Provider Action Needed

This article is based on change request (CR) 4232, which informs your FI of the change in RHC and FQHC payment rates for calendar year (CY) 2006.

### Background

The Centers for Medicare & Medicaid Services (CMS) must annually update the rural health clinic (RHC) and federally qualified health center (FQHC) payment limits according to the rate of increase in the Medicare economic index (MEI), in accordance with the Social Security Act, Section 1833(f). Based on the rate of increase in the MEI, the 2006 payment rate for RHCs and FQHCs reflects a 2.8 percent increase over their 2005 payment limit.

Section 1833(f) of the Social Security Act may be found at [http://www.ssa.gov/OP\\_Home/ssact/title18/1833.htm](http://www.ssa.gov/OP_Home/ssact/title18/1833.htm).

### Changes in RHC and FQHC Payment Rates

Therefore, CR 4232 announces the following changes in RHC and FQHC payment rates:

#### Rural Health Clinics (RHCs)

Effective January 1, 2006 through December 31, 2006 (i.e., CY 2006), the upper Medicare payment limit per visit is:

- \$72.76 for RHCs (increased from \$70.78).

#### Federally Qualified Health Centers (FQHCs) – Urban and Rural

Effective January 1, 2006 through December 31, 2006 (i.e., CY 2006) the maximum Medicare payment limit per visit is:

- \$112.96 for urban FQHCs (increased from \$109.88)
- \$97.13 for rural FQHCs (increased from \$94.48).

The effective date of January 1, 2006, is necessary in order to update RHC and FQHC payment rates in accordance with the Social Security Act (Section 1833 (f)). To avoid unnecessary administrative burden, your intermediary will **not** retroactively adjust individual RHC/FQHC bills paid at previous upper payment limits. However, your intermediary retains the discretion to make adjustments to the interim payment rate (or a lump sum adjustment to total payments already made) to take into account any excess or deficiency in payments to date.

### 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/Transmittals/downloads/R796CP.pdf>.

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/apps/contacts/>.

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

Medlearn Matters Number: MM4232  
 Related Change Request (CR) Number: 4232  
 Related CR Release Date: December 30, 2005  
 Related CR Transmittal Number: R796CP  
 Effective Date: January 1, 2006  
 Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 796, CR 4232,

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# HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

## Changes to Coding and Payment for Hospital Observation Services

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

### Provider Types Affected

Providers billing fiscal intermediaries (FIs) for hospital observation services provided to Medicare beneficiaries and paid under the prospective payment system (OPPS)

### Provider Action Needed

This article is based on change request (CR) 4259 which includes changes included in the January 2006 OPPS OCE and the January 2006 OPPS PRICER.

### Background

CR 4259 describes changes to coding and payment for hospital observation care paid under the OPPS to be implemented in the January 2006 OPPS update (including OPPS OCE and OPPS PRICER changes). In addition, CR 4259 discusses changes to observation care under the OPPS.

### Observation Care

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, before a decision can be made regarding whether patients will require further treatment as hospital inpatients or whether they can be discharged from the hospital.

Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge.

Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

For complete details and the specific new instructions regarding observation care, see the revised portions of the *Medicare Claims Processing Manual* attached to CR 4259 on the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R787CP.pdf> and to the *Medicare Benefit Policy Manual* attached to CR 4259 at <http://www.cms.hhs.gov/transmittals/downloads/R42BP.pdf>.

### New G-Codes

Beginning January 1, 2006, the following two new G-codes should be reported by hospitals for observation services and direct admission for observation care:

### New G-Codes

- G0378 Hospital observation services, per hour
- G0379 Direct admission of patient for hospital observation care

The OPPS claims processing logic will determine the payment status of the observation and direct admission services, that is, whether they are packaged or separately payable. Thus, hospitals are able to provide consistent coding and billing under all circumstances in which they deliver observation care.

### CPT Codes

Beginning January 1, 2006, the following *Current Procedural Terminology (CPT)* codes should not be reported by hospitals for observation services:

### CPR Codes Not Paid Under OPPS

- 99217 *Observation care discharge*
- 99218 *Initial observation care, low severity*
- 99219 *Initial observation care, moderate severity*
- 99220 *Initial observation care, high severity*
- 99234 *Obs/Impt. care (incl. admit/discharge), low severity*
- 99235 *Obs/Impt. care (incl. admit/discharge), moderate severity*
- 99236 *Obs/Impt. care (incl. admit/discharge), high severity*

### G-Codes

Lastly, the following three G-Codes are discontinued as of January 1, 2006:

### Discontinued G-Codes

- G0244 Observation care by facility to patient
- G0263 Direct Admission with congestive heart failure, chest pain or asthma
- G0264 Assessment other than congestive heart failure, chest pain, or asthma

### CR 4047

CR 4047 (Transmittal 763, dated November 25, 2005) explains that some nonrepetitive OPPS services provided on the same day by a hospital may be billed on different claims, provided that all charges associated with each procedure or service being reported are billed on the same claim with the HCPCS code which describes that service.

The Medlearn Matters article that corresponds to CR4047 may be reviewed on the CMS website at: <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4047.pdf>.

Unless otherwise noted, the coding and payment policy addressed in CR 4259 are effective for services furnished on or after January 1, 2006.

## Changes to Coding and Payment for Hospital Observation Services (continued)

### Implementation

The implementation date for the 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 on the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R787CP.pdf>.

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/apps/contacts/>.

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## Coding and Payment for Drug Administration under the Outpatient Prospective Payment System

The Centers for Medicare & Medicaid Services (CMS) has updated the CMS Internet-only manual system, Pub 100-04, (Medicare Claims Processing Manual), Chapter 4 (Part B Hospital Including Inpatient Hospital Part B and OPSS), sections 230.2 through 230.2.3 that describes changes to coding and payment for drug administration for hospitals paid under the OPSS, implemented in the January 2006 OPSS update. The January 2006 OPSS OCE and OPSS PRICER reflect the changes identified in this manual section.

The instruction to install the January 2006 OPSS PRICER is provided in change request (CR) 4250, transmittal 786, dated December 16, 2005. The instruction to install the January 2006 OPSS OCE is provided in CR 4238, transmittal 784, dated December 16, 2005. **Unless otherwise noted, the coding and payment policy addressed in this manual revision are effective for services furnished on or after January 1, 2006.**

### 230.2 – Coding and Payment for Drug Administration

#### A. Overview

Certain drug administration services furnished under the hospital outpatient prospective payment system (OPSS) prior to January 1, 2005 were reported using HCPCS alphanumeric codes:

- |       |                                                                                                                                                                 |
|-------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Q0081 | Infusion therapy other than chemotherapy, per visit;                                                                                                            |
| Q0083 | Administration of chemotherapy by any route other than infusion, per visit                                                                                      |
| Q0084 | Administration of chemotherapy by infusion only, per visit) in combination with applicable CPT codes for administration of non-infused, non-chemotherapy drugs. |

**Note:** HCPCS code Q0085, administration of anti-neoplastic drugs by both infusion and a route other than infusion, per visit, was discontinued in 2004.

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

Medlearn Matters Number: MM4259

Related Change Request (CR) Number: 4259

Related CR Release Date: December 16, 2005

Related CR Transmittal Number: R787CP

Effective Date: January 1, 2006

Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 787, CR 4259,

These same drug administration services furnished by hospital outpatient departments to Medicare beneficiaries during calendar year (CY) 2005 were reported using CPT codes 90780, 90781, and 96400-96459. Payments for these drug administration services in 2005 continued to be made on a per visit basis (rather than a per service basis) due to the per-day 2003 cost data available to set CY 2005 payment rates.

Effective January 1, 2006, some of the CPT codes that were used for drug administration services under the OPSS throughout CY 2005 are replaced with more detailed CPT codes incorporating specific procedural concepts, as defined and described by the CPT manual, such as "initial," "concurrent," and "sequential."

In order to facilitate the transition to more specific CPT codes within the hospital environment and to assist hospitals in ensuring continued correct coding concepts, drug administration services provided in CY 2006 under the OPSS will be billed using a combination of CPT codes and C-codes that were created to be consistent with some aspects of the CY 2005 CPT coding structure.

Hospitals are reminded to bill a separate evaluation and management (E/M) code (with modifier 25) only if a significant, separately identifiable E/M service is performed in the same encounter with OPSS drug administration services.

#### B. Billing for Infusions and Injections

**First Hour of Infusion** – Hospitals are to report first hour infusion codes (e.g., C8950, C8954, 96422) after 15 minutes of infusion. Infusions lasting 15 minutes or less should be billed as intravenous (or intra-arterial) pushes and must be coded accordingly. If hospitals provide different types of infusions (1) that could be reported with separate first hour infusion codes (e.g. chemotherapy and non-chemotherapy intravenous infusions, or intra-arterial and intravenous chemotherapy infusions) in the same encounter and (2) that

**Coding and Payment for Drug Administration under the OPPTS (continued)**

also meet the time requirements for billing an hour of each type of infusion, then hospitals may report a first hour for each different type of infusion provided.

**Subsequent Infusion Hours** – Hospitals are to report additional hours of infusion (e.g., C8951, C8955, 96423), either a continuing infusion of the same substance or drug or a sequential infusion of a different substance or drug, beyond the first hour, in accordance with sections 230.2.2 and 230.2.3, and only after more than 30 minutes have passed from the end of the previously billed hour. Therefore, to bill an additional hour of infusion after the first hour, more than 90 minutes of infusion services must be provided. One unit of the appropriate code is to be reported for each additional hour of infusion.

**Concurrent Infusions** – Concurrent infusions through the same vascular access site of the same type are not separately reportable under the OPPTS. Hospitals are to include the charges associated with concurrent infusions in their charges for the infusion service billed.

**Infusion Time** – Hospitals are to report HCPCS codes that describe the actual time over which the infusion is administered to the beneficiary for time-specific drug administration codes (e.g., C8950, C8951, C8954, C8955, 96422, 96423). Hospitals should not include in their reporting the time that may elapse between establishment of vascular access and initiation of the infusion.

**Intravenous or Intra-Arterial Push** – Hospitals are to bill push codes (e.g. C8952, C8953, 96420) for services that meet either of the following criteria:

- A healthcare professional administering an injection is continuously present to administer and observe the patient; or
- An infusion lasting 15 minutes or less.

Hospitals are to bill for additional IV pushes of different substances or drugs using multiple units of the appropriate push code.

**Included Services** – Hospitals are instructed that the following services, when performed to facilitate an infusion or injection, are not separately billable:

- Use of local anesthesia
- IV start
- Access to indwelling IV, subcutaneous catheter or port
- Flush at conclusion of infusion
- Standard tubing, syringes and supplies
- Preparation of chemotherapy agent(s)

Fluid used to administer drug(s) is considered incidental hydration and a separate nonchemotherapy infusion service should not be reported.

**EXAMPLE 1**

A non-chemotherapy infusion lasts 3 hours and 7 minutes. The hospital bills one unit of C8950 (for the first hour) and two units of C8951 (for the second and third hour). Hospitals cannot bill push codes for carryover infusion services not otherwise eligible for billing of a

subsequent infusion hour. Payment will be one unit of APC 0120. (NOTE: See §230.1 for drug billing instructions.)

**C. Use of Modifier 59**

With respect to chemotherapy administration and non-chemotherapy drug infusion, the use of modifier 59 indicates a distinct encounter on the same date of service. In the case of chemotherapy administration or non-chemotherapy infusion, modifier 59 is appended to drug administration HCPCS codes that meet the following criteria:

1. The drug administration occurs during a distinct encounter on the same date of service of previous drug administration services; and
2. The same HCPCS code has already been billed for services provided during a separate and distinct encounter earlier on that same day.

The CPT modifier 59 is NOT to be used when a beneficiary receives infusion therapy at more than one vascular access site of the same type (intravenous or intra-arterial) in the same encounter or when an infusion is stopped and then started again in the same encounter. In the instance where infusions of the same type (e.g. chemotherapy, nonchemotherapy, intra-arterial) are provided through two vascular access sites of the same type in one encounter, hospitals may report two units of the appropriate first hour infusion code for the initial infusion hours without modifier 59.

The outpatient code editor (OCE) will pay one unit of the corresponding APC for each separate encounter, up to the daily maximum listed in Table 1. Units of service exceeding daily maximum allowances will be packaged and no additional payment will be made.

**EXAMPLE 1**

A beneficiary receives infused non anti-neoplastic drugs for two hours. The hospital reports one unit of HCPCS code C8950 and one unit of HCPCS code C8951 for the services in the encounter. The beneficiary leaves the hospital and returns for a second encounter in which the beneficiary again receives infused non anti-neoplastic drugs for two hours. For the second encounter on the same date of service, the hospital reports one unit of HCPCS code C8950 with modifier 59 and one unit of HCPCS code C8951 with modifier 59. The OCE will pay two units of APC 0120 (i.e., one unit for each encounter). (Note: See section 230.1 for drug billing instructions.)

**EXAMPLE 2**

A beneficiary receives one injection of non-hormonal anti-neoplastic drugs and two hours of an infusion of anti-neoplastic drugs in the first encounter. The hospital reports one unit of 96401 and one unit each of C8954 and C8955. The OCE will pay one unit of APC 0116 (for one unit of 96401) and one unit of APC 0117 (for the one unit each of C8954 and C8955). Later on the same date of service, the beneficiary returns to the hospital and receives two injections of non-hormonal anti-neoplastic drugs. For the second encounter, the hospital reports one unit of 96401 with modifier 59, and one unit of 96401 without modifier 59. The hospital



## Coding and Payment for Drug Administration under the OPPTS (continued)

will be paid one unit of APC 0116 for two units of 96401 (as the second unit of 96401 provided during the second encounter is bundled with the first unit of 96401 provided during the second encounter). (Note: See section 230.1 for drug billing instructions.)

### EXAMPLE 3

A beneficiary receives three injections of non-hormonal anti-neoplastic drugs and two hours of infusion of anti-neoplastic drugs in one encounter. The beneficiary returns to the hospital in a separate encounter on the same date for administration of hydrating solution provided via infusion over two hours to treat dehydration and vomiting. For services in the first encounter, the hospital reports CPT codes as three units of 96401, one unit of C8954, and one unit of C8955 (all without modifier 59). For services in the second encounter, the hospital reports one unit of HCPCS code C8950 and one unit of HCPCS code C8951. The OCE pays one unit of APC 0116 (for the three units of 96401), one unit of APC 0117 (for the one unit of C8954 and C8955) and one unit of APC 0120 (for the one unit of C8950 and the one unit of C8951). No modifiers are needed when billing for services in the second encounter as these services were not provided during the first encounter on that day. (Note: See section 230.1 for drug billing instructions.)

### EXAMPLE 4

A beneficiary receives three injections of anti-neoplastic drugs and two hours of infusion of anti-neoplastic drugs in one encounter. The beneficiary has a second encounter on the same date of service in which the beneficiary receives three injections of non-hormonal anti-neoplastic drugs and one hour of infusion of drugs other than anti-neoplastic drugs (includes hydrating solution). For the first encounter the hospital reports the following:

Three units of 96401, one unit of C8954, and one unit of C8955 (without modifier 59).

For the second encounter, the hospital bills three units of CPT code 96401 (one unit with modifier 59, two units without modifier 59), and one unit of CPT code C8950 (without modifier 59). The OCE pays two units of APC 0116 (one for each encounter – three units of 96401 during the first encounter and three units during the second), one unit of APC 0117 (for the one unit each of C8954 and C8955 during the first encounter) and one unit of APC 0120 (for the one unit of C8950 during the

second encounter). (Note: See section 230.1 for drug billing instructions.)

## D. Payments For Drug Administration Services

Payment for drug administration services in CY 2006 will again be based on a per-visit basis due to the per-visit claims data available with which to set CY 2006 payment rates.

The OCE includes claims processing logic that assesses each OPPTS claim and assigns APC payments to HCPCS codes as appropriate. OCE logic allows for drug administration APC payments as noted below.

**Table 1: OCE Parameters for Drug Administration APC Payments**

APC	Maximum # of Units Without Modifier 59	Maximum # of Units With Modifier 59
0116	1	2
0117	1	2
0120	1	4

The OCE groups each HCPCS code appearing on a claim into one of these three APCs based on their APC assignment in Addendum B of the OPPTS final rule with comment period. If none of the reported drug administration HCPCS codes contain modifier 59, the OCE will provide a single per-encounter APC payment for each APC that has a corresponding HCPCS code billed on the claim. If modifier 59 does appear on the claim, the OCE can assign one additional payment per incidence of the modifier, with an upper limit of APC payments listed above in Table 1.

For CY 2006 APC payment rates, refer to Addendum B on the CMS website at

<http://www.cms.hhs.gov/center/hospital.asp>.

## E. Infusions Started Outside the Hospital

Hospitals may receive Medicare beneficiaries for outpatient services who are in the process of receiving an infusion at their time of arrival at the hospital (e.g. a patient who arrives via ambulance with an ongoing intravenous infusion initiated by paramedics during transport). Hospitals are reminded to bill for all services provided using the HCPCS code(s) that most accurately describe the service(s) they provided. This includes hospitals billing C8950 or C8954 for the first hour of intravenous infusion that the patient receives while at the hospital, even if the hospital did not initiate the infusion, and HCPCS codes for additional hours of infusion if needed.

## Administration of Drugs Via Implantable or Portable Pumps

**Table 2: CY 2006 OPPTS Drug Administration Codes for Implantable or Portable Pumps**

2005 CPT		Final CY 2006 OPPTS			
2005 CPT	2005 Description	Code	Description	SI	APC
n/a	n/a	C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump	S	0120



*Coding and Payment for Drug Administration under the OPPS (continued)*

2005 CPT		Final CY 2006 OPPS			
2005 CPT	2005 Description	Code	Description	SI	APC
96414	<i>Chemotherapy administration, intravenous; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump</i>	96416	<i>Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of portable or implantable pump</i>	S	0117
96425	<i>Chemotherapy administration, infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump)</i>	96425	<i>Chemotherapy administration, intraarterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump</i>	S	0117
96520	<i>Refilling and maintenance of portable pump</i>	96521	<i>Refilling and maintenance of portable pump</i>	T	0125
96530	<i>Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic [e.g. Intravenous, intra-arterial]</i>	96522	<i>Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)</i>	T	0125
n/a	n/a	96523	<i>Irrigation of implanted venous access device for drug delivery systems</i>	N	

Hospitals are to report HCPCS code C8957 and CPT codes 96416 and 96425 to indicate the initiation of a prolonged infusion that requires the use of an implantable or portable pump. CPT codes 96521, 96522, and 96523 should be used by hospitals to indicate refilling and maintenance of drug delivery systems or irrigation of implanted venous access devices for such systems, and may be reported for the servicing of devices used for therapeutic drugs other than chemotherapy.

**230.2.2 Chemotherapy Drug Administration**

**A. Overview**

AMA chemotherapy administration instructions for CPT codes 96401-96549 additionally apply to HCPCS codes C8954, C8955 and C8953. Therefore, hospitals are to report chemotherapy drug administration HCPCS codes when providing non-radionuclide antineoplastic drugs to treat cancer and when administering non-radionuclide antineoplastic drugs, anti-neoplastic agents, monoclonal antibody agents, and biologic response modifiers for treatment of noncancer diagnoses.

Medicare’s general policy regarding physician supervision within hospital outpatient departments meets the physician supervision requirements for use of CPT codes 96401-96549. (Reference: Medicare Benefit Policy Manual, Pub.100-02, Chapter 6, section 20.4.1.)

**B. Administration of Chemotherapy Drugs by Intravenous Infusion**

Effective for services furnished on or after January 1, 2006, hospitals paid under the OPPS (12x and 13x bill types) are to report an appropriate HCPCS code for chemotherapy drug administration by intravenous infusion as listed in Table 3.

**Table 3: CY 2006 OPPS Chemotherapy Drug Administration – Intravenous Infusion Technique**

2005 CPT		Final CY 2006 OPPS			
2005 CPT	2005 Description	Code	Description	SI	APC
96410	<i>Chemotherapy administration, intravenous; infusion technique, up to one hour</i>	C8954	<i>Chemotherapy administration, intravenous; infusion technique, up to one hour</i>	S	0117
96412	<i>Chemotherapy administration, intravenous; infusion technique, one to 8 hours, each additional hour (List separately in addition to code for primary procedure)</i>	C8955	<i>Chemotherapy administration, intravenous; infusion technique, each additional hour (List separately in addition to C8954)</i>	N	
96414	<i>Chemotherapy administration, intravenous; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump</i>	96416	<i>Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of portable or implantable pump</i>	S	0117

## Coding and Payment for Drug Administration under the OPPS (continued)

For services furnished in hospital outpatient departments prior to January 1, 2005, chemotherapy drug infusions were reported using HCPCS alphanumeric code Q0084, Administration of Chemotherapy by Infusion only, per visit. Chemotherapy infusion services furnished in hospital outpatient departments during CY 2005 were reported using CPT codes 96410, 96412 and 96414.

Table 3 maps CY 2005 chemotherapy administration via intravenous infusion CPT codes to OPPS drug administration codes effective January 1, 2006.

HCPCS code C8955 is an add-on code. HCPCS code C8955 should be used by hospitals to report the total number of additional infusion hours after the first hour of chemotherapy infusion. Additional hours of chemotherapy infusion beyond nine hours will no longer need to be reported on separate lines, as there is no hour limit associated with this code.

The OCE logic assumes that all services for chemotherapy infusions billed on the same date of service were provided during the same encounter. In those unusual cases where the beneficiary makes two separate visits to the hospital for chemotherapy infusions in the same day, the hospital reports modifier 59 for chemotherapy infusion codes during the second encounter that were also furnished in the first encounter. The OCE identifies modifier 59 and pays up to a maximum number of units per day, as listed in Table 1.

### EXAMPLE 1

A beneficiary receives one injection of non-hormonal anti-neoplastic drugs and an infusion for two hours of anti-neoplastic drugs in one encounter. The patient leaves the hospital and later that same day returns to the hospital for two injections of nonhormonal anti-neoplastic drugs. To bill for the first encounter, the hospital reports one unit of 96401 (without modifier 59), one unit of C8954, and one unit of C8955 (without modifier 59). To bill for the second encounter, the hospital reports one unit of 96401 (with modifier 59) and one unit of 96401 (without modifier 59). The hospital will be paid two units of APC 0116 (once for each encounter with 96401 – one unit in the first, two units in the second) and one unit of APC 0117 (for the one unit of C8954 and the one unit of C8955). (**Note:** See section 230.1 for drug billing instructions.)

### EXAMPLE 2

A beneficiary receives an infusion of anti-neoplastic drugs for two hours using a hydrating solution to which the anti-neoplastic drug has been added, without a specific medically necessary order for hydration. The hospital reports one unit of C8954 and one unit of C8955. The OCE will pay one unit of APC 0117 (for the one unit each of C8954 and C8955). (**Note:** See section 230.1 for drug billing instructions.)

## C. Administration of Chemotherapy Drugs by a Route Other Than Intravenous Infusion

Effective for services furnished on or after January 1, 2006, hospitals paid under the OPPS (12x and 13x bill types) are to report an appropriate HCPCS code for chemotherapy drug administration by route other than infusion as listed in Table 4.

**Table 4: CY 2006 OPPS Chemotherapy Drug Administration – Route Other Than Intravenous Infusion**

2005 CPT		Final CY 2006 OPPS			
2005 CPT	2005 Description	Code	Description	SI	APC
96408	Chemotherapy administration, intravenous; push technique	C8953	Chemotherapy administration, intravenous; push technique	S	0116
96400	Chemotherapy administration, subcutaneous or intramuscular, with or without local anesthesia	96401	Chemotherapy administration, subcutaneous or intramuscular; nonhormonal anti-neoplastic	S	0116
96400	Chemotherapy administration, subcutaneous or intramuscular, with or without local anesthesia	96402	Chemotherapy administration, subcutaneous or intramuscular; hormonal anti neoplastic	S	0116
96405	Chemotherapy administration, intralesional; up to and including 7 lesions	96405	Chemotherapy administration; intralesional, up to and including 7 lesions	S	0116
96406	Chemotherapy administration, intralesional; more than 7 lesions	96406	Chemotherapy administration; intralesional, more than 7 lesions	S	0116
96420	Chemotherapy administration, intra-arterial; push technique	96420	Chemotherapy administration, intraarterial; push technique	S	0116
96422	Chemotherapy administration, infusion technique up to one hour	96422	Chemotherapy administration, intraarterial; infusion technique, up to one hour	S	0117
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	S	0116
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	S	0116

*Coding and Payment for Drug Administration under the OPSS (continued)*

2005 CPT		Final CY 2006 OPSS			
2005 CPT	2005 Description	Code	Description	SI	APC
96450	Chemotherapy administration, into CNS (e.g. Intrathecal) requiring and including spinal puncture	96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture	S	0116
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	S	0116
96549	Unlisted chemotherapy procedure	96549	Unlisted chemotherapy procedure	S	0116
96423	Chemotherapy administration, infusion technique, one to 8 hours, each additional hour (List separately in addition to code for primary procedure)	96423	Chemotherapy administration, intraarterial; infusion technique, each additional hour up to 8 hours (List separately in addition to code for primary procedure)	N	

Chemotherapy drug administration services other than intravenous infusion that were furnished in hospital outpatient departments during CY 2005 were reported using CPT codes 96420-96549.

Table 4 maps CY 2005 chemotherapy administration via routes other than intravenous infusion CPT codes to OPSS drug administration HCPCS codes effective January 1, 2006.

CPT code 96423 is an add-on code to indicate the total number of hours of intra-arterial infusion that are provided in addition to the first hour of administration. CPT code 96423 should be used by hospitals to report the total number of additional infusion hours. Additional hours of infusion beyond 8 should be reported on another separate line with CPT code 96423 and the appropriate number of hours.

OCE logic assumes that all services for chemotherapy drug administration by a route other than infusion that are billed on the same date of service were provided during the same encounter. In those unusual cases where the beneficiary makes two separate visits to the hospital for chemotherapy treatment in the same day, hospitals are instructed to report modifier 59 for chemotherapy drug administration (by a route other than infusion) codes during the second encounter that were also furnished in the first encounter. The OCE identifies modifier 59 and pays up to a maximum number of units per day, as listed in Table 1.

**230.2.3 – Non-Chemotherapy Drug Administration**

**A. Administration of Non-Chemotherapy Drugs by Intravenous Infusion**

**Table 5: CY 2006 OPSS Non-Chemotherapy Drug Administration – Intravenous Infusion Technique**

2005 CPT		Final CY 2006 OPSS			
2005 CPT	2005 Description	Code	Description	SI	APC
90780	Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour	C8950	Intravenous infusion for therapy/diagnosis; up to 1 hour	S	0120
90781	Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)	C8951	Intravenous infusion for therapy/diagnosis; each additional hour (List separately in addition to C8950)	N	
n/a	n/a	C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump	S	0120

Hospitals are to report HCPCS code C8950 to indicate an infusion of drugs other than anti-neoplastic drugs furnished on or after January 1, 2006 (except as noted at 230.2.2(A) above). HCPCS code C8951 should be used to report all additional infusion hours, with no limit on the number of hours billed per line. Medically necessary separate therapeutic or diagnostic hydration services should be reported with C8950 and C8951, as these are considered intravenous infusions for therapy/diagnosis.

HCPCS codes C8950 and C8951 should not be reported when the infusion is a necessary and integral part of a separately payable OPSS procedure.

## *Coding and Payment for Drug Administration under the OPPTS (continued)*

When more than one nonchemotherapy drug is infused, hospitals are to code HCPCS codes C8950 and C8951 (if necessary) to report the total duration of an infusion, regardless of the number of substances or drugs infused. Hospitals are reminded to bill separately for each drug infused, in addition to the drug administration services.

The OCE pays one APC for each encounter reported by HCPCS code C8950, and only pays one APC for C8950 per day (unless Modifier 59 is used). Payment for additional hours of infusion reported by HCPCS code C8951 is packaged into the payment for the initial infusion. While no separate payment will be made for units of HCPCS code C8951, hospitals are instructed to report all codes that appropriately describe the services provided and the corresponding charges so that CMS may capture specific historical hospital cost data for future payment rate setting activities.

OCE logic assumes that all services for non-chemotherapy infusions billed on the same date of service were provided during the same encounter. Where a beneficiary makes two separate visits to the hospital for non-chemotherapy infusions in the same day, hospitals are to report modifier 59 for non-chemotherapy infusion codes during the second encounter that were also furnished in the first encounter. The OCE identifies modifier 59 and pays up to a maximum number of units per day, as listed in Table 1.

### **EXAMPLE 1**

A beneficiary receives infused drugs that are not anti-neoplastic drugs (including hydrating solutions) for two hours. The hospital reports one unit of HCPCS code C8950 and one unit of HCPCS code C8951. The OCE will pay one unit of APC 0120. Payment for the unit of HCPCS code C8951 is packaged into the payment for one unit of APC 0120. (**Note:** See section 230.1 for drug billing instructions.)

### **EXAMPLE 2**

A beneficiary receives infused drugs that are not anti-neoplastic drugs (including hydrating solutions) for 12 hours. The hospital reports one unit of HCPCS code C8950 and eleven units of HCPCS code C8951. The OCE will pay one unit of APC 0120.

Payment for the 11 units of HCPCS code C8951 is packaged into the payment for one unit of APC 0120. (**Note:** See section 230.1 for drug billing instructions.)

### **EXAMPLE 3**

A beneficiary experiences multiple attempts to initiate an intravenous infusion before a successful infusion is started 20 minutes after the first attempt. Once started, the infusion lasts one hour. The hospital reports one unit of HCPCS code C8950 to identify the 1-hour of infusion time. The 20 minutes spent prior to the infusion attempting to establish an IV line are not separately billable in the OPPTS. The OCE pays one unit of APC 0120. (**Note:** See section 230.1 for drug billing instructions.)

## **B. Administration of Non-Chemotherapy Drugs by a Route Other Than Intravenous Infusion**

**Table 6: CY 2006 OPPTS Non-Chemotherapy Drug Administration – Route Other Than Intravenous Infusion**

2005 CPT		Final CY 2006 OPPTS			
2005 CPT	2005 Description	Code	Description	SI	APC
90784	Therapeutic, prophylactic or diagnostic injection (specify material injected); intravenous	C8952	Therapeutic, prophylactic or diagnostic injection; intravenous push	X	0359
90782	Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular	90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	X	0353
90783	Therapeutic, prophylactic or diagnostic injection (specify material injected); intra-arterial	90773	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial	X	0359
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intraarterial, injection or infusion	90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intraarterial injection or infusion	X	0352

Source: CMS Pub. 100-4, Transmittal 785, CR 4258

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## January 2006 Outpatient Prospective Payment System Code Editor Specifications Version 7.0

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

### Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) and regional home health intermediaries (RHHIs) for services paid under the OPSS

- In a Comprehensive outpatient rehabilitation facility (CORF) or home health agency (HHS) not under the home health prospective payment system; or
- To a hospice patient for the treatment of a non-terminal illness.

### Provider Action Needed

This article is based on Change Request (CR) 4238 which informs your FI that the January 2006 outpatient prospective payment system outpatient code editor (OPSS OCE) specifications have been updated with new additions, deletions, and changes.

The modifications of the OPSS OCE for the January 2006 release (V7.0) are summarized in the table below. Readers should also examine the specifications attached to CR3583 and note the highlighted sections, which also indicate changes from the prior release of the OPSS OCE software.

### Background

Change request (CR) 4238 reflects specifications that were issued for the October revision of the OPSS OCE (version 6.3). All shaded material in Attachment A of CR4238 reflects changes that were incorporated into the January version of the revised OPSS OCE (version 7.0).

Instructions for accessing the complete specifications are provided in the *Additional Information* section of this article. Note also that some of these modifications have an effective date earlier than January 1, 2006, and such dates are reflected in the “Effective Date” column.

CR 4238 provides the revised OPSS OCE instructions and specifications that will be utilized under the OPSS for hospital outpatient departments, community mental health centers (CMHCs), and for limited services when provided:

Some OCE/APC modifications in the release may also be retroactively added to prior releases. If so, the retroactive date will appear in the “Effective Date” column. The modifications of the OCE/APC for the January 2006 release (V7.0) are summarized in the following table:

### Summary of OPSS/OCE Modifications

#	Modification Type	Effective Date	Edit	Description
1.	Logic	1/1/06	19/20, 39/40	Modify appendix F to apply CCI edits to bill types 22x, 23x, 34x, 74x and 75x (in addition to bill types 12x, 13x and 14x)
2.	Logic	1/1/06		Add new Status Indicator “Q – Packaged services subject to separate payment based on criteria”; Payment Indicator = 3
3.	Logic	1/1/06	53, 57	Modify observation logic to package observation code (instead of claim RTP) when criteria for separate payment are not met; see Appendix H
4.	Logic	1/1/06	52, 56	Deactivate observation edits 52 and 56
5.	Logic	1/1/06	57	Modify edit 57 to trigger only when the DOS for the observation code is January 1
6.	Logic	1/1/06	58	Modify logic for direct admission from physician’s office to pay a medical visit APC if observation is not payable; see Appendix H
7.	Logic	1/1/06		Change SI from “T” to “S” for APC 375 (Inpatient-only procedure when patient expires before adm)
8.	Logic	1/1/06	13,14	Deactivate edits 13 and 14 (SI/edit reassignment for code contents)
9.	Logic	1/1/06		Modify partial hospitalization and mental health logic to remove editing for ECT or type “T” procedure on same day as partial hospital (level of care; see Appendix C of Attachment A
10.	Logic	1/1/06	31,36	Deactivate edits 31 and 36
11.	Logic	8/21/05	22	Implement a retroactive mid-quarter activation date for modifier CR – Catastrophe/Disaster Related
12.	Logic	8/1/00	27	Change disposition for edit 27 to claim rejection, retroactive to 8/1/2000
13.	Logic	1/1/06		Implement 50% discounting for non-type “T” procedures with modifier 52; see Appendix D of Attachment A of CR4238
14.	Logic	1/1/06		Reassign SI to A (APC 0) for specified wound care codes when submitted with therapy revenue code (420, 430, 440) or therapy modifier (GN, GO, GP)
15.	Content			Make HCPCS/APC/SI changes, as specified by CMS
16.	Content		19,20, 39,40	Implement version 11.3 of the NCCI file, removing all code pairs which include Anesthesia (00100-01999), E&M (92002-92014, 99201-99499), MH (90804-90911), or Drug Admin (96400-96450; 96542-96549; 90780,90781)



# OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

January 2006 Outpatient Prospective Payment System Code Editor Specifications Version 7.0 (continued)

#	Modification Type	Effective Date	Edit	Description
17.	Content		17	Update bilateral procedure indicators in the OCE consistent with the Medicare Physician Fee Schedule (MPFS)
18.	Content	4/1/05	71	Update procedure/device edit requirements
19.	Content			Add/Delete modifiers as indicated by CMS
20.	Doc	1/1/06	53	Change edit description to: "Codes G0378 and G0379 only allowed with bill type 13x"
21.	Doc	1/1/06	57	Change edit description to: "E/M condition not met for separately payable observation and line item date for code G0378 is 1/1"
22.	Doc	1/1/06	58	Change edit description to: "G0379 only allowed with G0378"
23.	Doc	1/1/06	32	Change edit description to: "Partial hospitalization claim spans 3 or less days with insufficient services on at least one of the days"
24.	Content	1/1/06		Codes G0008 and G0009, Flu and PPV administration, added to "vaccines" (see Appendix F footnote of Attachment A)
25.	Doc			Change description for SI H to: "Pass-through device categories, brachytherapy sources, and radiopharmaceutical agents"
26.	Doc			Change description of SI K to: "Non-pass-through drugs and biologicals"

## Implementation

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

## Additional Information

For complete details, please see the official instruction issued to your FI/RHHI regarding this change. That instruction may be viewed on the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R784CP.pdf>.

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

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

Medlearn Matters Number: MM4238

Related Change Request (CR) Number: 4238

Related CR Release Date: December 16, 2005

Related CR Transmittal Number: R784CP

Effective Date: January 1, 2006

Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 784, CR 4238

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## January 2006 Update of the Hospital Outpatient Prospective Payment System

### Summary of Payment Policy Changes and OPSS PRICER Logic Changes

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

### Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) and/or regional home health intermediaries (RHHIs) for services subject to the OPSS

### Provider Action Needed

#### STOP – Impact to You

This article is based on change request (CR) 4250, which describes changes to, and billing instructions for, various payment policies implemented in the January 2006 OPSS update, and changes to the OPSS PRICER logic.

#### CAUTION – What You Need to Know

Unless otherwise noted, all changes addressed in CR 4250 are effective for services furnished on or after January 1, 2006.

#### GO – What You Need to Do

See the *Background* section of this article for further details regarding the January 2006 update to the hospital OPSS.

*January 2006 Update of the Hospital Outpatient Prospective Payment System (continued)*

**Background**

CR 4250 describes changes to, and billing instructions for, various payment policies implemented in the January 2006 OPSS update. The January 2006 OPSS outpatient code editor (OCE) and OPSS PRICER reflects additions, changes, and deletions to:

- Healthcare Common Procedure Coding System (HCPCS) codes
- Ambulatory payment classification (APC)
- HCPCS modifier
- Revenue codes

CR 4250 further describes changes to the OPSS PRICER logic. January 2006 revisions to OPSS OCE data files, instructions and specifications are provided in CR 4238, “January 2006 Outpatient Prospective Payment System Code Editor (OPSS OCE) Specifications Version 7.0,” issued December, 2005. This CR may be found at on the CMS web site <http://www.cms.hhs.gov/Transmittals/downloads/R784CP.pdf>.

The corresponding Medlearn Matters article is available on the CMS web site at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4238.pdf>.

Instructions for drug administration, observation, and intravenous immune globulin (IVIG) will be issued separately.

**Changes to the OPSS PRICER Logic**

CR 4250 makes the following changes to the OPSS PRICER Logic:

- Hospitals reclassified for the inpatient prospective payment system (IPPS) effective October 1, 2005, will be reclassified for OPSS effective January 1, 2006.
- Section 401 designations and floor metropolitan statistical area (MSA) designations effective October 1, 2005, will be effective for OPSS January 1, 2006.

- Rural sole community hospitals will receive a 7.1 percent payment increase in 2006.
- New OPSS payment rates and coinsurance amounts will be effective January 1, 2006. All coinsurance rates will be limited to 40 percent of the APC payment rate. Coinsurance rates cannot exceed the inpatient deductible of \$952.
- For hospital outlier payments under OPSS, there will be no change in the multiple threshold of 1.75. This threshold of 1.75 is multiplied by the total line item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount.

The payment formula is  $(\text{cost} - (\text{APC payment} \times 1.75))/2$ .

However, there will be a change in the fixed threshold. The estimated cost of service must be greater than the APC payment amount plus \$1,250 in order to qualify for outlier payments. The previous fixed dollar threshold was \$1,175.

- For outliers for community mental health centers (CMHCs; type of bill 76x), there will be a new multiple threshold of 3.4. The previous threshold was 3.5. The new threshold of 3.4 is multiplied by the total line item APC payment to determine eligibility for outlier payments. This factor is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is  $(\text{cost} - (\text{APC payment} \times 3.4))/2$ . *CMHC outlier payments are not subject to a fixed dollar threshold.*

**New Service**

The following new service is assigned for payment under the OPSS:

**Table 1: New Coding Information for Placement and Removal (If Performed) of Applicator into Breast for Radiation Therapy**

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment	Minimum Unadjusted Copayment
C9726	01/01/06	S	1508	Rxt breast appl place/remov	Placement and removal (if performed) of applicator into breast for radiation therapy	\$650.00	\$130.00

The code is to be used as its descriptor states, for placement or removal (if performed) of an applicator into the breast for radiation therapy. C9726 should be billed when such a service is performed and a more specific CPT or HCPCS code that better describes the service is not available. C9726 does not describe the delivery of radiation therapy or the application or placement of radioactive sources.

**New Device Pass-Through Category**

The Social Security Act (Section 1833(t)(6)(B), [http://www.ssa.gov/OP\\_Home/ssact/title18/1833.htm](http://www.ssa.gov/OP_Home/ssact/title18/1833.htm)) requires that (under the OPSS) categories of devices be eligible for transitional pass-through payments for at least two years, but not more than three years. And, section 1833(t)(6)(B)(ii)(IV) requires that CMS create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

Therefore, CMS is establishing one new device pass-through category as of January 1, 2006. The following table provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment.

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**Table 2: New Device Category Pass-Through Coding Information**

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Device Offset from Payment
C1820	01/01/06	H	1820	Generator neuro rechgbat sys	Generator, neurostimulator (implantable), with rechargeable battery and charging system	\$8,647.81 (applied to APC 222)

### Device Offset from Payment

The Social Security Act (Section 1833(t)(6)(D)(ii)) requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount that CMS determines is associated with the cost of the device (70 FR 68627-8).

CMS has determined that it is able to identify the portion of the APC payment amount associated with the cost of the historically utilized device, that is, the nonrechargeable neurostimulator generator implanted through procedures assigned to APC 222, Implantation of Neurological Device, that C1820 would replace.

The device offset from the pass-through payment for C1820 represents the deduction from the pass-through payment for category C1820 that will be made when C1820 is billed with a service assigned to APC 222. Please note that the offset amount from the APC payment is wage adjusted before it is subtracted from the device cost.

Section 1833(t)(6)(D)(ii) of the Social Security Act may be found on the web at [http://www.ssa.gov/OP\\_Home/ssact/title18/1833.htm](http://www.ssa.gov/OP_Home/ssact/title18/1833.htm) and 70 FR 68627-8 may be found at <http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/05-22136.htm>.

### Revision of Device Category Descriptor for C1767

Section 1833(t)(6)(B)(ii)(IV) of the Social Security Act and 42 CFR 419.66(c)(1) require that CMS establish a new category for a medical device when no existing or previously existing device category is appropriate for the device (67 FR 66781).

In the November 10, 2005 OPSS final rule with comment period for CY 2006 ([http://www.access.gpo.gov/su\\_docs/fedreg/a051110c.html](http://www.access.gpo.gov/su_docs/fedreg/a051110c.html)), CMS announced that effective January 1, 2006, an additional category will be created for devices that meet all of the criteria required to establish a new category for pass-through payment in instances where CMS believes that an existing or previously existing category descriptor does not appropriately describe the new type of device.

CMS also announced that this may entail the need to clarify or refine the short or long descriptors of the previous category. CMS indicated that each situation will be evaluated on a case-by-case basis using two tests described in the November 10, 2005 final rule with comment period. Any such clarification to a category descriptor will be made prospectively from the date the new category would be made effective (70 FR 68631).

With the creation of C1820 (Generator, neurostimulator (implantable)) with rechargeable battery and charging system, as described above, CMS determined that it is necessary to modify the current short and long descriptors of C1767 (Generator, neurostimulator (implantable)).

Effective January 1, 2006, the revised descriptors for C1767 are the following:

- **Revised long descriptor:** Generator, neurostimulator (implantable), nonrechargeable
- **Revised short descriptor:** Generator, neuro non-recharge

These revisions to category C1767's descriptors are effective on and after January 1, 2006, and do not apply to claims for services provided prior to January 1, 2006.

**Note:** The January 2006 OPSS OCE does not contain the revised short descriptor for C1767. However, the correct short descriptor is listed in the January 2006 update of OPSS Addendum B on the CMS website. The revised short descriptor will be included in the April 2006 OCE update.

### Modifier FB – Item Provided Without Cost to Provider, Supplier or Practitioner (Examples, but not Limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples)

Effective for services furnished on or after January 1, 2006, hospitals must report HCPCS modifier FB with the HCPCS code for a device that was furnished to the hospital without cost to the provider.

For example, when a manufacturer furnishes a replacement device that has been recalled or has failed and that was furnished to the provider without cost to the provider, the hospital must report the modifier FB with the device code to indicate that the hospital did not incur a cost for the item.

This requirement applies to all HCPCS alphanumeric device codes with initial letter of "C" or "L." Hospitals should submit a token charge (e.g., \$1.00) on the line with the device code for the claim to be accepted and processed. If the hospital uses a device that was furnished to it for no cost, but for which the usual cost to the hospital is greater than \$50.00 and for which there is no suitable HCPCS alphanumeric code beginning with initial letter of "C" or "L," the hospital must use the modifier FB with the procedure code for the service in which the device is used.

### Modifier 52

Effective for services provided January 1, 2006, a 50 percent reduction will be made for those services to which a modifier 52 is appended. The modifier 52 is used to indicate that a service that did not require anesthesia was partially reduced or discontinued at the physician's discretion.

The physician may discontinue or cancel a procedure that is not completed in its entirety due to a number of circumstances, such as adverse patient reaction or medical judgment that completion of the full study is unnecessary. The modifier is reported most often to identify interrupted or reduced radiological and imaging procedures, and prior to January 1, 2006, policy has been to make full payment for procedures with a modifier 52.

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Hospitals should continue to use modifier 52, as appropriate, to report interrupted procedures that do not require anesthesia.

**Billing for Drugs, Biologicals, and Radiopharmaceuticals  
New HCPCS Codes and Dosage Descriptors for Certain  
Drugs, Biologicals, and Radiopharmaceuticals**

Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. Also important is that hospitals billing for these products ensure that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was actually administered to the patient.

For CY 2006, many HCPCS codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS code descriptors.

In addition, many temporary C-codes and Q-codes have also been discontinued effective December 31, 2005, and replaced with permanent HCPCS codes in CY 2006.

Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the new long descriptors of the active CY 2006 HCPCS codes. The affected HCPCS codes are listed in Table 4 of CR 4250 (“New HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals”).

CR 4250, which may be found on the CMS website at <http://new.cms.hhs.gov/transmittals/downloads/R804CP.pdf>.

**Additional Coding Changes for LOCM, MRI Contrast Agents, and HOCM effective January 1, 2006**

The following HCPCS codes that are used to describe low osmolar contrast material (LOCM) will be discontinued effective December 31, 2005:

- A4644 Supply of low osmolar contrast material (100-199 mgs of iodine)
- A4645 Supply of low osmolar contrast material (200-299 mgs of iodine)
- A4646 Supply of low osmolar contrast material (300-399 mgs of iodine)

They are replaced with HCPCS codes Q9945-Q9951 for reporting in the CY 2006 OPSS. The descriptors for the replacement Q-codes for LOCM are listed below:

**Coding Changes for LOCM**

**CY 2006 Code HCPCS Description**

- Q9945 Low osmolar contrast material, up to 149 mg/ml iodine concentration, per ml
- Q9946 Low osmolar contrast material, 150-199 mg/ml iodine concentration, per ml
- Q9947 Low osmolar contrast material, 200-249 mg/ml iodine concentration, per ml
- Q9948 Low osmolar contrast material, 250-299 mg/ml iodine concentration, per ml
- Q9949 Low osmolar contrast material, 300-349 mg/ml iodine concentration, per ml
- Q9950 Low osmolar contrast material, 350-399 mg/ml iodine concentration, per ml
- Q9951 Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml

HCPCS codes A4643 (Supply of additional high dose contrast material(s) during magnetic resonance imaging, e.g., gadoteridol injection) and A4647 (Supply of paramagnetic contrast material, e.g., gadolinium) that are used to describe MRI contrast agents will be discontinued effective December 31, 2005 and replaced with HCPCS codes Q9952-Q9954 for reporting in the CY 2006 OPSS. The descriptors for the replacement Q-codes for MRI contrast agents are listed below.

**Coding Changes for MRI Contrast Agents**

**CY 2006 Code HCPCS Description**

- Q9952 Injection, gadolinium-based magnetic resonance contrast agent, per ml
- Q9953 Injection, iron-based magnetic resonance contrast agent, per ml
- Q9954 Oral magnetic resonance contrast agent, per 100 ml

Beginning on January 1, 2006, hospitals can use the HCPCS codes Q9958-Q9964 to bill for high osmolar contrast material (HOCM) under the OPSS. The descriptors for the new Q-codes for HOCM are listed below.

**Coding Changes for HOCM CY 2006**

**Code HCPCS Description**

- Q9958 High osmolar contrast material, up to 149 mg/ml iodine concentration, per ml
- Q9959 High osmolar contrast material, 150-199 mg/ml iodine concentration, per ml
- Q9960 High osmolar contrast material, 200-249 mg/ml iodine concentration, per ml
- Q9961 High osmolar contrast material, 250-299 mg/ml iodine concentration, per ml
- Q9962 High osmolar contrast material, 300-349 mg/ml iodine concentration, per ml
- Q9963 High osmolar contrast material, 350-399 mg/ml iodine concentration, per ml
- Q9964 High osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml

**Coding for Sodium Hyaluronan Products**

In CY 2006, hospitals **must** use the following HCPCS codes to bill for sodium hyaluronan products under the OPSS:

- C9220** Sodium hyaluronate per 30 mg dose, for intra-articular injection
- J7317** Sodium hyaluronate per 20 to 25 mg dose for intra-articular injection
- J7320** Hylan G-F 20, 16 mg, for intra-articular injection

**Billing for Preadministration-Related Services Associated With Intravenous Immune Globulin Administration**

In the CY 2006 hospital OPSS final rule published in the *Federal Register* on November 10, 2005, ([http://www.access.gpo.gov/su\\_docs/fedreg/a051110c.html](http://www.access.gpo.gov/su_docs/fedreg/a051110c.html)), CMS announced that they would establish a temporary add-on payment for hospital outpatient departments that administer intravenous immune globulin (IVIG) to Medicare beneficiaries for 2006.

This additional payment is for the additional preadministration-related services required to locate and



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acquire adequate IVIG product and prepare for an infusion of IVIG during this current period where there may be potential market issues.

For dates of service on or after January 1, 2006, and on or before December 31, 2006, Medicare will make a separate payment to hospital outpatient departments for preadministration-related services associated with the administration of IVIG. HCPCS code G0332 has been established to allow providers to bill for this service in CY 2006.

This IVIG preadministration service may be billed by the outpatient hospital providing the IVIG infusion only once per patient per day of IVIG administration.

The service must be billed on the same claim form as the IVIG product (J1566 and/or J1567) and have the same date of service as the IVIG product and a drug administration service.

This IVIG pre-administration service payment is in addition to Medicare's payments to the hospital for the IVIG product itself and for administration of the IVIG product via intravenous infusion. The coding and payment information for this new service is shown in the table below.

### New Coding Information for Preadministration-Related Services Associated with Intravenous Immune Globulin Administration

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment	Minimum Unadjusted Copayment
G0332	01/01/06	S	1502	Preadmin IV immunoglobulin	Preadministration-related services for intravenous infusion of immunoglobulin, per infusion encounter (This service is to be billed in conjunction with administration of immunoglobulin)	\$75.00	\$15.00

### Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2006

The CY 2006 OPSS final rule (70 FR 68643, [http://www.access.gpo.gov/su\\_docs/fedreg/a051110c.html](http://www.access.gpo.gov/su_docs/fedreg/a051110c.html)) stated that payments for drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available.

Effective January 1, 2006, payment rates for many drugs and biologicals have changed from the values published in the CY 2006 OPSS final rule as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2005.

In cases where adjustments to payment rates are necessary, CMS will incorporate changes to the payment rates in the January 2006 release of the OPSS PRICER. CMS is not publishing the updated payment rates in this article instruction implementing the January 2006 update of the OPSS.

However, the updated payment rates effective January 1, 2006 may be found in the January 2006 update of the OPSS Addendum A and Addendum B on the CMS website at [http://new.cms.hhs.gov/HospitalOutpatientPPS/02\\_Addendums.asp#TopOfPage](http://new.cms.hhs.gov/HospitalOutpatientPPS/02_Addendums.asp#TopOfPage).

### Coding and Payment Changes for Administration of Hepatitis B Vaccine

Effective for services furnished on or after January 1, 2006, providers paid under the OPSS—hospitals (type of bills 12x and 13x) and home health agencies (type of bill 34x)—should use the following CPT codes to report administration of hepatitis B vaccine:

**90471** *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)*

or

**90472** *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (as appropriate)*

In CY 2006, CPT codes 90471 and 90472 map to APC 0353 (Injection, level II) for payment under the OPSS. (Beginning in CY 2006, payment for hepatitis B vaccine is made on a reasonable cost basis to providers paid under the OPSS.)

Providers paid under the OPSS should discontinue use of HCPCS code G0010, *Administration of hepatitis B vaccine*, effective for services furnished on or after January 1, 2006.

### Billing for Intensity Modulated Radiation Therapy

Intensity modulated radiation therapy (IMRT), also known as conformal radiation, delivers radiation with adjusted intensity to preserve adjoining normal tissue.

IMRT has the ability to deliver a higher dose of radiation within the tumor while delivering a lower dose of radiation to surrounding healthy tissue. IMRT is provided in two treatment phases, planning and delivery. Two methods by which IMRT can be delivered to patients include *multi-leaf collimator-based IMRT* and *compensator-based IMRT*.

Effective January 1, 2006, when IMRT is furnished to beneficiaries in a hospital outpatient department that is paid under the hospital outpatient prospective payment system (OPSS), hospitals are to bill according to the following guidelines:

- When billing for the planning of IMRT treatment services, CPT codes 77280 through 77295, 77305 through 77321, 77336, and 77370 are not to be billed in addition to 77301; however, charges for those services should be included in the charge associated with CPT code 77301.



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- Hospitals are not prohibited from using existing CPT code 77301 to bill for compensator-based IMRT planning in the hospital outpatient setting.
- As instructed in the 2006 CPT manual, hospitals should bill CPT code 77418 for multi-leaf collimator-based IMRT delivery and Category III CPT code 0073T for compensator-based IMRT delivery in the hospital outpatient setting.
- Payment for IMRT planning does not include payment for CPT codes 77332 - 77334 when furnished on the same day. When provided, these services are to be billed in addition to the IMRT planning code 77301.
- Providers billing for both CPT codes 77301 (IMRT treatment planning) and 77334 (design and construction of complex treatment devices) on the same day should append a modifier 59.

- 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

### Billing for Positron Emission Tomography (PET) Scans

As a result of a recent Medicare national coverage decision (Publication 100-3, *Medicare National Coverage Determinations*, Section 220.6, effective January 28, 2005), CMS discontinued the HCPCS alphanumeric codes with initial letter "G" that had been used to report PET scans (see table below), and activated the CPT codes listed below for myocardial and nonmyocardial PET scans and concurrent PET/CT scans for anatomical localization.

These lists of codes, along with claims processing instructions, are provided in CR 3756 (Transmittal 514, Publication 100-04, found on the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R514CP.pdf>).

The corresponding Medlearn Matters article may be found on the CMS web site at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3756.pdf>.

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

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

### CPT Codes for Covered PET Scan Indications Effective for Dates of Service on or after January 28, 2005

CPT Code	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
78811	Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck)

Effective January 28, 2005, hospitals should report the CPT codes listed above for myocardial and nonmyocardial PET scans and concurrent PET/CT scans for anatomical localization delivered in the hospital outpatient setting.

In addition, in the CY 2006 OPPS final rule (70 FR 68581, [http://www.access.gpo.gov/su\\_docs/fedreg/a051110c.html](http://www.access.gpo.gov/su_docs/fedreg/a051110c.html)) CMS changed the status indicator for CPT code 78609 (Brain imaging, PET; perfusion evaluation) from "S" (separately paid under the OPPS) to "E" (not paid under the OPPS) retroactive to January 28, 2005, as historically there has been and currently there remains no coverage for this service under the Medicare program.

### Billing for Stereotactic Radiosurgery

Stereotactic radiosurgery (SRS) is a form of radiation therapy for treating abnormalities, functional disorders, and tumors of the brain, neck, and most recently has expanded to treating tumors of the spine, lung, pancreas, prostate, bone, and liver.

There are two basic methods in which SRS can be delivered to patients: *linear accelerator-based* treatment, and *multi-source photon-based* treatment (often referred to as Cobalt 60). Advances in technology have further distinguished linear accelerator-based SRS therapy into two types: *gantry-based systems* and *image-guided robotic SRS systems*. These two types of linear accelerator-based SRS therapies may be delivered in a complete session or in a fractionated course of therapy up to a maximum of five sessions.

Effective January 1, 2006, CMS is discontinuing HCPCS codes G0242 and G0338 for the reporting of charges for stereotactic radiosurgery (SRS) planning under the OPPS. Hospitals should bill charges for SRS planning, regardless of the mode of treatment delivery, using all of the available CPT codes that most accurately reflect the services provided.

### Billing for Wound Care Services

Pursuant to a congressional mandate to pay for all therapy services under one prospective payment system, CMS created a therapy code list to identify and track outpatient therapy services paid under the Medicare Physician Fee Schedule (MFPS). (Balanced Budget Act of 1997, Pub. L. 105-33, Section 1834(k)(5)) CMS provides this list of therapy codes along with their respective designations in

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the Medicare Claims Processing Manual (Pub. 100-04, Chapter 5, Section 20, on the CMS website at <http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf>).

### “Always” versus “Sometimes” Therapy

CMS defines an “always therapy” service as a service that must be performed by a qualified therapist under a certified therapy plan of care, and a “sometimes therapy” service as a service that may be performed by a non-therapist outside of a certified therapy plan of care.

Effective January 1, 2006, CMS is reclassifying CPT codes 97602, 97605, and 97606 as “sometimes therapy” services that may be appropriately provided either as therapy or non-therapy services, as well as maintaining our designation of CPT codes 97597 and 97598 as “sometimes therapy” services.

In order to pay hospitals accurately when delivering these “sometimes therapy” services independent of a therapy plan of care, CMS is establishing payment rates for CPT codes 97597, 97598, 97602, 97605, and 97606 under the OPSS when performed as non-therapy services in the hospital outpatient setting.

The list below the APC assignments and status indicators for these codes when delivered independent of a therapy plan of care in a hospital outpatient setting.

### CPT Codes for Wound Care Services Paid under the OPSS Effective for Dates of Service on or after January 1, 2006

CPT Code	Descriptor	CY 2005		CY 2006		
		Therapy Designation	Status Indicator	Therapy Designation	APC	Status Indicator
97597	Selective debridement (less than or equal to 20 sq. cm.)	“Sometimes” therapy	A	“Sometimes” therapy	0012	T
97598	Selective debridement (greater than 20 sq. cm.)	“Sometimes” therapy	A	“Sometimes” therapy	0013	T
97602	Non-selective debridement	“Always” therapy	A	“Sometimes” therapy	0340	X
97605	Negative pressure wound therapy (less than or equal to 50 sq. cm.)	“Always” therapy	A	“Sometimes” therapy	0012	T
97606	Negative pressure wound therapy (greater than 50 sq. cm.)	“Always” therapy	A	“Sometimes” therapy	0013	T

To further clarify, hospitals will receive separate payment under the OPSS when they bill for wound care services described by CPT codes 97597, 97598, 97602, 97605, and 97606 that are furnished to hospital outpatients by non-therapists independent of a therapy plan of care.

In contrast, when such services are performed by a qualified therapist under an approved therapy plan of care, providers should attach an appropriate therapy modifier (that is, GP for physical therapy, GO for occupational therapy, and GN for speech-language pathology) and/or report their charges under a therapy revenue code (that is, 420, 430, or 440) to receive payment under the MPFS.

The OCE logic will either assign these services to the appropriate APC for payment under the OPSS if the services are non-therapy, or will direct Medicare FIs to the MPFS established payment rates if the services are identified on hospital claims with a therapy modifier or therapy revenue code as therapy.

### Billing for Therapeutic Apheresis

Services treating a variety of disorders by modifying or selectively removing agents from the blood and returning that blood to the patient include those described by the following CPT codes:

- 36515** Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion
- 36516** (Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion)
- 36522** Photopheresis, extracorporeal

In every case, hospitals should report the codes that most accurately describe the service that is furnished. When billing CPT code 36515 to report extracorporeal immunoadsorption treatment and plasma reinfusion with a protein A column for indications such as rheumatoid arthritis and idiopathic thrombocytopenic purpura, hospitals may:

- Include the charge for the protein A column in the procedure charge for CPT code 36515; or
- May report the charge separately on a line with an appropriate supply revenue code.

Similarly, when billing CPT code 36516 to report extracorporeal selective adsorption or selective filtration and plasma reinfusion for indications such as familial hypercholesterolemia, supply charges may be included either in the procedure charge for CPT code 36516 or reported separately on a line with an appropriate supply revenue code.

Lastly, when billing CPT code 36522 to report extracorporeal photopheresis for indications such as cutaneous T cell lymphoma, hospital supply charges may be included in the charge for CPT code 36522 or billed separately on a line with an appropriate supply revenue code. In all cases, payments for the supplies are packaged into the OPSS payments for the apheresis service.

### Billing for Allergy Testing

Providers have expressed confusion related to the reporting of units for allergy testing services described by CPT codes 95004 through 95078. Nine of these CPT codes

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instruct providers to specify the number of tests or use the singular word “test” in their descriptors, while five of these CPT codes do not contain such an instruction or do not contain “tests” or “testing” in their descriptors.

The lack of clarity related to the reporting of units has resulted in erroneous reporting of charges for multiple allergy tests under one unit (that is, “per visit”) for the CPT codes that instruct providers to specify the number of tests.

Effective January 1, 2006, CMS is differentiating single allergy tests (“per test”) from multiple allergy tests (“per visit”) by assigning these services to two different APCs. CMS is assigning single allergy tests to newly established APC 0381 and maintaining multiple allergy tests in APC 0370.

Hospitals should report charges for the CPT codes that describe single allergy tests (or where CPT instructions direct providers to specify the number of tests) to reflect charges per test rather than per visit and bill the appropriate number of units of these CPT codes to describe all of the tests provided. The CPT codes assigned to APCs 0370 and 0381 for CY 2006 are:

**Assignment of CPT Codes to APC 0370 and APC 0381 for CY 2006**

**APC 0370 (Report per encounter)**

- 95056 Photosensitivity tests
- 95060 Eye allergy tests
- 95078 Provocative testing
- 95180 Rapid desensitization
- 95199U Unlisted allergy/clinical immunologic service or procedure

**APC 0381 (Report per test)**

- 95004 Percutaneous allergy skin tests
- 95010 Percutaneous allergy titrate test
- 95015 Intradermal allergy titrate-drug/bug
- 95024 Intradermal allergy test, drug/bug
- 95027 Intradermal allergy titrate-airborne
- 95028 Intradermal allergy test-delayed type
- 95044 Allergy patch tests
- 95052 Photo patch test
- 95065 Nose allergy test

**Corrections for the April 2006 Update**

The following changes were not made in the January 2006 OPSS OCE and Addendum B but will be implemented in the April 2006 update:

**HCPCS Deletions, Additions, and Reactivations**

HCPCS	Action	Effective Date	Short Descriptor	SI	Edit
G8054	Added	01/01/06	Falls assess not docum 12 mo	M	72
E0590	Discontinued	1/1/06			
G0252	Reactivated	4/1/05		E	28
E1239	Reactivated	1/1/06		Y	61

**Short Descriptor Changes**

HCPCS	Old Short Descriptor	New Short Descriptor
J7640	Formoterol injection	Formoterol injection
G8019	Diabetic pt w/LDL> 100mg/dl	Diabetic pt w/LDL>= 100mg/dl
G8020	Diab pt w/LDL<or=100mg/dl	Diab pt w/LDL< 100mg/dl
G8023	DM pt w BP>140/80	DM pt w BP>=140/80

**Coverage Determinations**

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

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

**Note:** For those home health agencies that may have some claims being held by their RHHI/FI due to the fact that there was no CBSA or “special wage index” in the RHHI/FI files, please be aware that CMS has instructed the RHHI/FI to update their files and process those claims.

**Implementation**

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

**Additional Information**

For complete details, please see the official instruction issued to your FI/RHHI regarding this change. That instruction may be viewed on the CMS website at <http://www.cms.hhs.gov/transmittals/downloads/R804CP.pdf>.

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

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: January 3, 2006  
 Related CR Transmittal Number: 804  
 Effective Date: January 1, 2006  
 Implementation Date: January 3, 2006

Source: CMS Pub. 100-4, Transmittal 804, CR 4250



## Billing for Devices Under the Hospital Outpatient Prospective Payment System

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 12, 2006, to provide new Web addresses that reflect changes in the new CMS website. All other information remains the same. This article was originally published in the First Quarter 2006 Medicare A Bulletin (pages 106-107).

### 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

See the CMS website at <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/> to identify codes for devices that must be billed by hospitals for services paid under OPPS, and use the CMS web site at <http://www.cms.hhs.gov/HospitalOutpatientPPS> to identify the device codes that must be reported *with* specific procedure codes for a claim to be accepted by OCE. Once at that page, the file of edits is under “Downloads” at the bottom of that page. 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 can be found on the CMS website at <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/>.

### 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 can be found on the CMS website at <http://www.cms.hhs.gov/HospitalOutpatientPPS>.

The link to the file of edits is under the “Downloads” at the lower half of the page at that Web address.

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

**Billing for Devices Under the Hospital Outpatient Prospective Payment System (continued)**

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:

**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 OPPS (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/Transmittals/downloads/R658CP.pdf>.

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/apps/contacts/>.

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

Medlearn Matters Number: MM4017 – Revised  
 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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**Problem with Billing HCPCS Tracer Code A9552**

Effective for claims billed with service dates on and after January 1, 2006, the tracer HCPCS code C1775 has been replaced with tracer HCPCS code A9552.

It has been determined that the Fiscal Intermediary Shared System (FISS) is editing these claims with reason codes 32440 and 32438 inappropriately. Claims were being returned-to-provider (RTP) in error.

Until FISS corrects this problem, claims will now be suspended. Providers may resubmit claims that were previously returned in error. Once this problem is resolved, all suspended claims will be released for processing.

If you have questions, please contact Customer Service at 1-877-602-8816. ❖

Source: CMS Pub. 100-4, Transmittal 804, CR 4250



# THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

## Termination of the Medicare HIPAA Incoming Claim Contingency Plan Also, Addition of a Self-Assessable Unusual Circumstance, Modification of the OTAF Exception, and Modification of ASCA Exhibit Letters A, B and C

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

### Provider Types Affected

Physicians, providers, and suppliers who submit claims to the Centers for Medicare & Medicaid Services (CMS) Medicare contractors (carriers, fiscal intermediaries (FIs), durable medical equipment regional carriers (DMERCs) or regional home health intermediaries (RHHIs))

### Background

This article, based on CR 4119, summarizes some of the key revisions to electronic data interchange (EDI) requirements contained in the *Medicare Claims Processing Manual*, Chapter 24 (General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims). Some of these changes have already been reported in earlier Medlearn Matters articles and are mentioned here only as reminders.

The EDI policy revisions are necessary for:

- HIPAA compliancy, including contingency plan termination, and free claim software changes.
- Administrative Simplification Compliance Act (ASCA) compliancy, including unusual circumstance, “Obligated to Accept as Payment in Full” (OTAF) modification, and modified ASCA letters.

Medicare providers must adhere to these electronic data interchange requirements. Electronic transactions that do not fully comply with the implementation guide requirements for these formats will be rejected.

### Key Points

#### Medicare HIPAA Incoming Claim Contingency Plan

The Medicare HIPAA incoming claim contingency plan has been terminated. All electronic claims sent to Medicare on or after October 1, 2005, that do not comply with the 837 version 4010A1 IG or the National Council for Prescription Drug Program (NCPDP) Telecommunication Standard requirements and the Batch Standard 5.1 (DMERCs only) will be rejected. Please refer to the *Additional Information* section of this article for more information.

Until the Medicare contingency plan for **HIPAA mandated transaction types other than claims sent to Medicare is terminated**, Medicare contractors **will support** the pre-HIPAA electronic transaction formats listed in the *Medicare Claims Processing Manual*, Chapter 24, Section 40.2 (attached to CR 4119).

Please refer to the *Additional Information* section of this article for more information.

### NCPDP Claims

NCPDP claims submitted to DMERCs may contain modifiers for compound drugs in the **narrative portion** in the prior authorization segment on the NCPDP standard since it does not currently support reporting modifiers in the compound segment. Please refer to the attachment to CR4119, *Medicare Claims Processing Manual*, Chapter 24, Section 40.2 – B, for further instructions and a list of the modifiers.

Currently Coordination of Benefits (COB) trading partners are not able to accept NCPDP format transmissions for **secondary payment**. CMS is working with the NCPDP to develop a “workaround” to resolve this problem, however, until then; NCPDP claims will not be crossed over to other payers. **Retail pharmacies will need to bill secondary payers directly to collect supplemental benefits that may be due for those claims.** Transmission of pre-HIPAA electronic format claims to other payers under a COB agreement will end when (the earliest of the date) a trading partner completes successful testing on the use of the X12 837 version 4010A1 and /or the HIPAA NCPDP format (as appropriate); or the Medicare HIPAA COB contingency plan ends.

### Other Issues

Medicare secondary payer claims may be submitted **nonelectronically** when a primary payer has made an “Obligated to Accept as Payment in Full” (OTAF) adjustment, **and there is more than one primary payer**. Providers have been directed to report OTAF adjustments in a CN1 segment of a claim, but it is not possible to either identify which primary payer owns a reported OTAF adjustment, or to report more than one OTAF adjustment in the event they apply to each primary payer.

The free billing software (from your Medicare contractor) should be able to **identify when Medicare is a secondary payer**. It should also be able to collect standard claim adjustment reason codes and adjustment amounts made by a primary payer when Medicare is the secondary payer. If it is not collecting this information, the software must be modified to enable this requirement.

### Unusual Circumstances

Certain “unusual circumstances” are automatically **waived** from the electronic claim submission requirement for either the indicated claim type, or for the period when an “unusual situation” exists. CMS has added a circumstance to the self assessable Unusual Circumstance list in which **paper claim submission is permitted**. **Home oxygen**

*Termination of the Medicare HIPAA Incoming Claim Contingency Plan (continued)*

**therapy claims** for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO<sub>2</sub> is more than 60 mmHg but a combination of factors necessitates use of oxygen. The X12 work group responsible for development of the version 4010A1 implementation guide recognizes that there is a deficiency in the guide pertaining to home oxygen therapy claims. This will be corrected in a later version of that implementation guide, but in the interim, covered entities are bound by the existing version 4010A1 requirements. As result, CMS will permit claims that meet this situation to be submitted on paper.

Modified examples of ASCA exhibit letters A, B, and C can be found in the manual attachment to CR4119 (*Medicare Claims Processing Manual*, Chapter 24, Exhibits of Form Letters). Your Medicare contractor will send these revised letters, as appropriate.

- Exhibit A—Response to a non- “unusual circumstance” waiver request
- **Exhibit B—Denial of an “unusual circumstance” waiver request**
- Exhibit C—Request for Documentation from Provider Selected for Review to Establish Entitlement to Submit Claims on Paper

**Additional Information****Medicare HIPAA Incoming Claim Contingency Plan Termination**

All electronic claims sent to Medicare on or after October 1, 2005, that do not comply with the 837 version 4010A1 IG or the NCPDP requirements will be rejected. The Medicare contingency plan for the X12 835, 276/277 (version 4010 support will need to be terminated), 837 claims that Medicare sends to another payer as provided for in a trading partner agreement, and the 270/271 version 4010A1 transactions remain in effect pending further notice. CMS will issue advance notice to the health care industry when a decision is reached to terminate the remaining Medicare contingency plans.

**HIPAA Mandated Transaction Types Other Than Claims Sent to Medicare**

Until the Medicare contingency plan (mentioned above) is terminated, Medicare contractors will support the pre-HIPAA electronic transaction formats listed in the *Medicare*

*Claims Processing Manual*, Chapter 24, Section 40.2. These include for claims submitted to:

- All Medicare contractors – UB – 92 version 6.0 claims for coordination of benefits (COB) sent to other payers under trading partner agreements; proprietary format for eligibility data responses using the CMS standard eligibility data set; and X12 276/277 version 4010.
- FIs – X12 837 institutional version 4010 and 3051; X12 835 versions 3030Ma, 3051.3A, and 3051.4A for remittance advice.
- Carriers and DMERCs – X12 837 professional version 4010 and 3051; National Standard Format (NSF) version 3.01; X12 835 IG versions 3030Mb, 3051.3B, and 3051.4B for remittance advice; and NSF version 3.01.
- Carriers only - X12 270/271 IG version 3051 for eligibility query and response.
- Please note - Specifications for each of these transactions can be found the Washington Publishing Company website at <http://www.wpcedi.com/HIPAA> for those X12 IGs (other than the NCPDP) adopted as national standards under HIPAA.

The official instruction, CR4119, issued to your FI/RHHI, or carrier/ DMERC, regarding this change may be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R802CP.pdf>

Attached to CR 4119, you will find the revised portions of the *Medicare Claims Processing Manual* referenced in this article.

Please refer to your local FI/RHHI or carrier/DMERC if you have questions about this issue. To find the toll-free phone number, go to CMS website <http://www.cms.hhs.gov/apps/contacts/>.

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

Medlearn Matters Number: MM4119  
 Related Change Request (CR) Number: 4119  
 Related CR Release Date: December 30, 2005  
 Related CR Transmittal Number: R802CP  
 Effective Date: April 1, 2006  
 Implementation Date: April 3, 2006

Source: CMS Pub. 100-4, Transmittal 802, CR 4119

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# ELECTRONIC DATA INTERCHANGE

## Claim Status Category Code and Claim Status 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 contractors (carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs))

### Provider Action Needed STOP – Impact to You

This article is based on change request (CR) 4256, which provides the April 2006 updates of the claim status codes and claim status category codes for use by Medicare contractors (carriers, DMERCs, FIs, and RHHIs).

### CAUTION – What You Need to Know

Medicare contractors are to use codes with the “**new as of 4/06**” designation and prior dates and inform affected providers of the new codes. CR 4256 applies to Chapter 31, Section 20.7, Health Care Claim Status Category Codes and Health Care Claims Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277.

### GO – What You Need to Do

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

### Background

Claim status category codes indicate the general category of a claim’s status (accepted, rejected, additional information requested, etc.), which is then further detailed by the claim status code(s). Under the Health Insurance Portability and Accountability Act (HIPAA), all payers (including Medicare) must use claim status category and claim status codes approved by a recognized code set maintainer (instead of proprietary codes) to explain any status of a claim(s) sent in the Version 004010X093A1 Health Care Claim Status Request and Response transaction.

The Health Care Code Maintenance Committee maintains the claim status category and claim status codes, and as previously mentioned, the Committee meets at the beginning of each X12 trimester meeting and makes decisions about additions, modifications, and retirement of existing codes.

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**Note:** The updated list is posted three times a year (after each X12 trimester meeting) at the Washington Publishing Company website at <http://www.wpc-edi.com/codes>. Once at the Washington Publishing Company website, select “Claim Status Codes” or “Claim Status Category Codes” to access the updated code list. Included in the code lists are specific details, including the date when a code was added, changed or deleted. All code changes approved in February 2006 are to be listed at this above website approximately thirty days after the meeting concludes. For this update, Medicare will begin using the codes in place as of April 2006.

### Implementation

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

### 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/Transmittals/downloads/R814CP.pdf>.

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/apps/contacts/>.

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

Medlearn Matters Number: MM4256  
Related Change Request (CR) Number: 4256  
Related CR Release Date: January 20, 2006  
Related CR Transmittal Number: R814CP  
Effective Date: April 1, 2006

Source: CMS Pub. 100-4, Transmittal 814, CR 4256

## Attestation Form for Conducting Medicare Real Time Eligibility Inquiries

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

### Provider Types Affected

Providers who access the 270/271 health care eligibility inquiry and response application in real time

### Provider Action Needed

#### STOP – Impact to You

Beginning September 1, 2005, an on-line attestation form (*Trading Partner Agreement for Submission of 270s to Medicare on a Real-Time Basis*) must be completed by submitters authenticated by the Centers for Medicare & Medicaid Services (CMS) to conduct 270/271 transactions with CMS before providers may access the real-time 270/271 health care eligibility inquiry and response application.

#### CAUTION – What You Need to Know

Submitters requesting access to the Medicare beneficiary database must follow the procedure outlined in the *Additional Information* section below.

#### GO – What You Need to Do

Please be sure to fill out this new agreement form located at <http://www.cms.hhs.gov/it> so you can conduct 270/271 transactions with Medicare.

### Background

The purpose of change request (CR) 4093 is to alert Medicare providers to the revision in the *Medicare Claims Processing Manual*, Chapter 31 (ANSI X12N Formats Other than Claims or Remittance).

This revision addresses the standards for Medicare beneficiary eligibility inquiries, and creates the database and infrastructure needed to provide a real-time, centralized Health Insurance Portability and Accountability Act (HIPAA) compliant Health Care Eligibility Benefit Inquiry and Response Transaction (270/271).

### Additional Information

#### Access Process for Clearinghouses/Provider

Beginning September 1, 2005:

- The Medicare eligibility integration contractor (MEIC) will e-mail the on-line attestation form outlining security and privacy procedures for submitters already submitting authenticated 270 transactions on a real time basis.
- Each Submitter should complete the form in its entirety and transmit it back via e-mail to [MCAREHD@emdeon.com](mailto:MCAREHD@emdeon.com).

Beginning October 1, 2005:

- Submitters will be able to access the appropriate forms for the CMS 270/271 Medicare Eligibility transaction at: <http://www.cms.hhs.gov/AccessToDataApplication>.
- The submitter must provide the information requested on the form electronically and click on the appropriate assurances. If the submitter does not consent to the terms of the agreement, by appropriately completing the form, the access process will be terminated.
- A copy of the appropriately completed form must be electronically submitted to CMS. Once CMS has the completed form, it will be authenticated, at which time

the submitter will then be directed to complete a Medicare Data Communications Network (MDCN) connectivity form and submit it electronically in order to be connected to the 270/271 eligibility database.

CMS staff will make sure that all of the necessary information is provided on the form, and will ensure the complete connectivity to the 270/271 application.

A CMS contractor known as the Medicare eligibility integration contractor (MEIC) will contact the submitter in order to authenticate the accessing entity's identity.

Once authentication has been completed, the MEIC will provide the clearinghouses, providers, and trading partners with a submitter identification (ID) that must be used on all 270/271 transactions.

The MDCN extranet application is suitable for many providers that can create, send, and receive complete X12 eligibility transactions. CMS will soon offer a second solution for providers that desire to conduct the transaction using the direct data entry (DDE) version. The DDE version will allow all approved providers to conduct eligibility transactions over the public Internet at no cost to the provider.

Please note that in order to access the MDCN, an entity must obtain the necessary telecommunication software from the AT&T reseller on its own. AT&T Resellers and contact numbers include the following:

- IVANS: <http://www.ivans.com>; telephone: 1-800-548-2675
- McKesson: <http://www.mckesson.com>; telephone: 1-800-782-7426; key option 5, then key option 8 **MEIC Helpdesk Support**

You may also contact the MEIC help desk for connectivity issues on Monday through Friday, 7:00 a.m. - 9:00 p.m. EST; Telephone: 1-866-324-7315; E-mail address: [MCARE@cms.hhs.gov](mailto:MCARE@cms.hhs.gov).

#### Related Links

The official instruction issued to your fiscal intermediary (FI), regional home health intermediary (RHHI), carrier, or durable medical equipment regional carrier (DMERC) regarding this change may be found by going to the CMS website <http://www.cms.hhs.gov/Transmittals/downloads/R700CP.pdf>.

Please refer to your local FI, RHHI, Carrier or DMERC for more information about this issue. To find the toll free phone number, go to on the CMS website <http://www.cms.hhs.gov/apps/contacts/>.

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

Medlearn Matters Number: MM4093  
 Related Change Request (CR) Number: 4093  
 Related CR Release Date: October 7, 2005  
 Related CR Transmittal Number: 700  
 Effective Date: October 1, 2006  
 Implementation Date: November 7, 2005

Source: CMS Pub. 100-4, Transmittal 700, CR 4093



### Advantages of Submitting Electronic Claims

One obvious advantage of submitting claims to Medicare electronically is “**It’s the Law!!**” The Administrative Simplification Compliance Act (ASCA), effective October, 2003, mandates that all Medicare claims, unless they meet one of the exception criteria specified within the Act, be submitted in the approved HIPAA electronic format to Medicare.

Even if you meet one of the exception criteria (primarily small provider exception), you should consider obtaining the capability to transmit your claims electronically to Medicare for these **additional advantages**:

- Control over input of claims information – you enter the data.
- Eliminates mailing costs (paper, envelopes, stamps)
- Earlier payment of electronic claims improves cash flow (14 day payment floor), which saves time and money compared to (27-day payment floor) paper claims.
- Part A online correction of errors.
- The benefit of earlier detection of errors by an immediate 997 report verifying receipt of claim submission and next day availability of an electronic batch detail control listing showing acceptance into the Medicare processing system or identifying errors that need correcting.
- The relative ease of EDI and help desk support available to assist in EDI transactions.
- Ability to submit/retrieve electronic transactions 24 hours a day, 7 days a week.
- Take advantage of other electronic applications such as electronic remittance notification (ERN), electronic funds transfer (EFT), and electronic claim status (ECS).

### No Electronic Capability?

Free Medicare software (PC-ACE PRO32®) is available for your use in submitting claims.

**Contact Medicare EDI today** at (904) 791-8767 option 1, if you are interested in finding out more about electronic claims submission, or if you have any questions concerning any of the information above. ❖

**Use Electronic Transactions Today!**



## FRAUD AND ABUSE

### OIG Reports \$35.4 Billion in Savings and Recoveries

The Department of Health & Human Services (HHS) Office of Inspector General (OIG) Semiannual Report to Congress reported total fiscal year (FY) 2005 savings and expected recoveries of nearly \$35.4 billion, more than doubling savings and recoveries since FY 2000. Specifically, OIG's FY 2005 \$35.4 billion in savings encompasses \$32.6 billion in implemented recommendations to put funds to better use, \$1.2 billion in audit receivables, and \$1.6 billion in investigative receivables. Also for this reporting period, OIG reported exclusions of 3,806 individuals and entities for fraud or abuse of federal health care programs and/or their beneficiaries; 537 criminal actions against individuals or entities that engaged in crimes against departmental programs; and 262 civil actions, which include False Claims Act and unjust enrichment suits filed in district court, Civil Monetary Penalties Law settlements, and administrative recoveries related to provider self-disclosure matters. OIG continues to be an aggressive force within HHS to improve the efficiency and effectiveness of the Department and to punish those who defraud its programs. OIG is dedicated to maintaining public credibility of HHS programs. OIG enforcement action in the second half of FY 2005 included the HealthSouth Corporation fraud settlement of \$325 million plus interest paid to the U.S. Government. HealthSouth also entered into a five-year corporate integrity agreement with OIG. The settlement resolved allegations of Medicare Part A cost report fraud uncovered during the Government's investigation of the company's financial statements. The settlement also resolved allegations that the company submitted false claims to Medicare Part B for certain outpatient physical therapy services.

Also among OIG FY 2005 accomplishments were two audits of New York City's Medicaid claims for school-based services. One report found that 86 sampled claims for speech services did not comply with federal and state

requirements. In the second report, none of the sampled claims for transportation services complied with all federal and state requirements. OIG recommended that the state refund \$532 million to the federal government, resolve an additional \$12 million in set-aside claims, and provide proper and timely guidance on federal Medicaid criteria to New York City. OIG testified before the Senate Finance Committee in late June regarding states' use of Medicaid financing mechanisms and pricing of Medicaid prescription drugs. Intergovernmental transfers (IGT), one such state financing mechanism, are transfers of non-federal public funds between local public Medicaid providers and state Medicaid agencies. Misuse of IGTs circumvents the federal/state Medicaid partnership and increases federal payments to states at the expense of the intended beneficiaries. One example of IGTs involves upper-payment-limit (UPL) funds, which are intended to reimburse Medicaid providers but are often retained by the states. OIG audits identified several nursing homes in which the quality of care was adversely affected because they were not allowed to retain enough UPL funds to provide adequate staffing. In addition, OIG, in a series of three evaluation reports, found that statutorily defined prices for prescription drugs in the Medicare and Medicaid programs based on actual sales were substantially lower than published prices (average wholesale price) and wholesale acquisition costs. The semiannual report describes OIG investigations and evaluation and audit reports finalized during the reporting period. This publication is a significant indicator of the progress OIG has made and the challenges the Department faces in achieving even greater economy and efficiency. To read more about OIG activities to identify fraud and abuse involving HHS programs, go to: <http://oig.hhs.gov/publications/docs/semiannual/2005/SemiannualFall05.pdf>. ❖

Source: Office of Inspector General News, December 2, 2005

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## **OIG Publishes Supplemental Voluntary Compliance Program Guidance for Hospitals**

The Office of Inspector General (OIG) of the Department of Health and Human Services has issued the updated voluntary compliance program guidance for hospitals that was first issued in 1998 to promote compliance with the rules and regulations for participation in Medicare and other federal health care programs. The document is on display at the *Federal Register* and was published on January 31, 2005.

The document, entitled "OIG Supplemental Compliance Program Guidance for Hospitals," is available on the OIG home page at <http://oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf>. It takes into account recent changes to hospital payment systems and evolving industry practices.

While the original guidance focused on how hospitals could design effective voluntary compliance programs, the supplemental guidance focuses on measuring and improving the effectiveness of existing compliance efforts and identifies additional fraud and abuse risk areas for hospitals.

Risk areas discussed in the supplement include: billing under the outpatient prospective payment system, the physician self-referral law, the federal anti-kickback statute, relationships between hospitals and physicians, relationships between hospitals and other providers, joint ventures, practitioner recruitment, and the furnishing of substandard care. The guidance also identifies practical measures hospitals can use to gauge the effectiveness of their compliance programs.

The supplemental guidance was developed by OIG following two *Federal Register* notices soliciting public comment. The notices produced a large number of recommendations, primarily addressing fraud and abuse risk areas, and many were incorporated into the final version of the document.

Besides the hospital guidance, OIG has issued voluntary compliance program guidance for clinical laboratories; home health agencies; third-party medical billing companies; suppliers of durable medical equipment, prosthetics and orthotics; hospices; Medicare +Choice[Advantage] organizations; nursing homes; individual and small group physician practices; ambulance service providers, and pharmaceutical manufacturers. Guidance for recipients of National Institutes of Health research grants is in development.

Each guidance <http://www.oig.hhs.gov/fraud/complianceguidance.html> highlights risk areas particular to that industry sector and provides comprehensive guidance on establishing and operating an effective voluntary compliance program. ❖

Source: Office of Inspector General News, January 27, 2005

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# PRESCRIPTION DRUG COVERAGE

## Essential Information and Resources for Prescribing Health Care Professionals

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

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

### Provider Types Affected

All health care professionals who prescribe prescription medications for Medicare beneficiaries.

### Impact on Providers

The new Medicare prescription drug coverage began on January 1st. Already, pharmacists have filled millions of prescriptions for people with Medicare. During this important transition period to the new prescription drug coverage, the Centers for Medicare & Medicaid Services (CMS) understands that there is much that prescribing health care professionals need to know about this new coverage in order to help their Medicare patients.

### Essential Information for Prescribing Health Care Professionals

CMS has compiled a list of information, resources, and tools that will allow health care professionals and their support staff to help their Medicare patients during this transition period.

### Finding formulary Information

CMS has a formulary finder that provides direct access to all plan websites at

<http://formularyfinder.medicare.gov/formularyfinder/selectstate.asp>.

In addition, we have worked with Epocrates to provide free software which makes the formulary selection process very simple. You can load this program into your PDA or run the software on a desktop. This tool is available on the Web at <http://www.epocrates.com/>.

### Coverage Determination

CMS defines a coverage determination as the first decision made by a plan regarding the prescription drug benefits an enrollee is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request, and a decision on the amount of cost sharing for a drug.

An exception request is a type of coverage determination request. Through the exceptions process, an enrollee can request an off-formulary drug, an exception to the plan’s tiered cost sharing structure, and an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction, or prior authorization requirement).

CMS does not have the authority to mandate a standard exception process for each Medicare drug plan or MA-PD; however, the Agency is working to simplify the exceptions process. Like typical commercial payers, health care

professionals may occasionally need to help a patient file a prior authorization for a medication or appeal a medication’s tier. CMS is working with medical specialty societies to address these issues.

A form has been created by a coalition of medical societies and advocacy groups that can be faxed to your office by a pharmacist when he or she is given a prescription that is either not on the formulary or on a higher tier.

This form streamlines communication between the pharmacist and the physician and reduces the need for time consuming telephone calls to the doctor’s office.

The form is located on CMS website at <http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartDPharmacyFaxForm.pdf>, as well as at several medical society websites.

### Expedited Review Process

There is an expedited review process that CMS has outlined to ensure that drug plans can move an appeal quickly, i.e., within a 24-hour turnaround time, to provide medicines to patients with an immediate need. Beyond this expedited review process, the standard appeals process to challenge a plan’s coverage determination has five levels:

- Redetermination by the plan
- Reconsideration by a Medicare drug coverage qualified independent contractor (QIC)
- An Administrative law judge (ALJ) hearing
- Review by the Medicare Appeals Council
- Review by federal district court.

Visit [http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04\\_Formulary.asp](http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp) for a list of plan contacts you can use to query your patient’s plan should you need to pursue an appeal or require clarification on an issue.

### Part B Drugs vs. Drugs Covered under Medicare Prescription Drug Coverage (Part D)

A previous Medlearn Matters article explains the difference between drugs covered under Part B versus those covered under Part D.

This article may be found on the CMS website at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0570.pdf>.

Additionally, a chart explaining specific drugs may be found on the CMS website at <http://www.cms.hhs.gov/pharmacy/downloads/partsbdcovageissues.pdf>.

## Essential Information and Resources for Prescribing Health Care Professionals (continued)

### Verifying Beneficiary Enrollment in a Medicare Drug Plan

Office staff can use the Medicare Prescription Drug Plan Finder, located at <http://www.medicare.gov>, to verify a beneficiary's enrollment in a Medicare drug plan. By entering all information provided on a beneficiary's Medicare card, the Plan Finder will identify the plan in which the beneficiary is enrolled.

Pharmacists have access to a new computer tool called "E1" that provides real time enrollment and eligibility information. This tool provides both eligibility and billing information at the point of sale and is constantly updated by CMS.

### Obtaining Prior Authorizations

A prior authorization can only be obtained by calling the drug plan directly. 1-800-MEDICARE cannot process a prior authorization.

### Ensuring Coverage for a Dual Eligible Beneficiary Who Needs To Be Enrolled in a Plan

CMS has ensured that people with Medicare and full Medicaid benefits (full dual) will have drug coverage by enabling customer service representatives at 1-800-MEDICARE to enroll these beneficiaries in WellPoint, a national plan.

If these beneficiaries have **immediate prescription needs**, they should visit their local pharmacies. The pharmacist can enroll them in WellPoint at the pharmacy.

To find out more about what happens with Medicare prescription drug coverage in certain situations, visit on CMS website <http://www.cms.hhs.gov/Pharmacy/Downloads/whatif.pdf>.

### Providing a 30-day Supply of Transitional Prescription Medication

CMS has instructed all Medicare-approved plans to provide patients who are on stabilized drug regimens with at least a 30-day supply of their current medication, even if their particular drug is not on their plan's formulary. Plans have also been instructed to extend this temporary coverage on a case-by-case basis.

### Important Contact Information to Report Problems with Medicare Prescription Drug Coverage

**Health Care Professionals:** E-mail [priit@cms.hhs.gov](mailto:priit@cms.hhs.gov) with problems and issues encountered. Please take advantage of CMS' regular conference call at 2PM EST every Tuesday. This call gives health care professionals an opportunity to ask questions of CMS staff. Call 1-800-619-2457; Passcode: RBDML.

**Pharmacists:** Call 1-866-835-7595, a CMS dedicated line designed to help answer questions regarding billing and beneficiary enrollment information.

### Additional Information

Health care professionals can visit on CMS website [http://www.cms.hhs.gov/MedlearnProducts/23\\_DrugCoverage.asp#TopOfPage](http://www.cms.hhs.gov/MedlearnProducts/23_DrugCoverage.asp#TopOfPage).

The redesigned Web page contains all the latest information on Medicare prescription drug coverage.

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## Clarification on Part D and Fee-for-Service Providers, New Web-based Educational Products—Medicare Prescription Drug Coverage

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 11, 2006, to provide new Web addresses that reflect changes in the new CMS website. All other information remains the same.

This article was originally published in the First Quarter 2006 Medicare A Bulletin (pages 125-126).

*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



*Clarification on Part D and Fee-for-Service Providers, New Web-based Educational Products (continued)*

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 Medicare Fee-for-Service (FFS) 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 Medicare FFS 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/HistPartBDrugPricingFiles/01\\_overview.asp](http://www.cms.hhs.gov/HistPartBDrugPricingFiles/01_overview.asp).)

**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 Medicare FFS program and billing Medicare for Medicare FFS 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 the 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 CMS website at [http://www.cms.hhs.gov/MedlearnProducts/23\\_drugcoverage.asp](http://www.cms.hhs.gov/MedlearnProducts/23_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 CMS website at <http://www.cms.hhs.gov/MedlearnProducts/downloads/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 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>.



**Clarification on Part D and Fee-for-Service Providers, New Web-based Educational Products (continued)****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/Partnerships/MMAOP/list.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/MedlearnProducts/downloads/answerkey-8-18-f>.

**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.medicare.gov/Publications/Pubs/pdf/11146.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/MedlearnProducts/23\\_drugcoverage.asp](http://www.cms.hhs.gov/MedlearnProducts/23_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/PDI/>.

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

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

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## More Web-based Educational Products Available—Medicare Prescription Drug

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 11, 2006, to provide new Web addresses that reflect changes in the new CMS website. All other information remains the same. This article was originally published in the Fourth Quarter 2005 Medicare A Bulletin (pages 30-31).

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

### Provider Types Affected

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

### Important Points to Remember

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

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

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

- *Quick Facts about Medicare's New Coverage for Prescription Drugs* – Publication Number 11102. This fact sheet provides basic information about Medicare's new prescription drug coverage. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11102.pdf>.
- *Quick Facts about Medicare's New Coverage for Prescription Drugs for People with Limited Income and Resources* – Publication Number 11105. This fact sheet provides basic information about Medicare's new prescription drug coverage for a person with limited income and resources. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11105.pdf>.
- *Quick Facts about Medicare's New Coverage for Prescription Drugs If You Applied for Extra Help* – Publication Number 11130. This fact sheet explains what you need to know after applying for extra help paying Medicare prescription drug coverage costs. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11130.pdf>.
- *Quick Facts about Medicare's New Coverage for Prescription Drugs for People Who Get Supplemental Security Income* – Publication Number 11116. This fact sheet provides basic information about Medicare's new prescription drug coverage for a person who gets Supplemental Security Income benefits or help from their state Medicaid program paying their Medicare premiums. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11116.pdf>.
- *Quick Facts about Medicare's New Coverage for Prescription Drugs for People with Medicare and Medicaid* – Publication Number 11106. This fact sheet provides basic information about Medicare's new prescription drug coverage for a person with full Medicaid benefits. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11106.pdf>.
- *Quick Facts about Medicare's New Coverage for Prescription Drugs for People Who are Nursing Home Residents* – Publication Number 11121. This fact sheet explains how the new Medicare prescription drug coverage works for nursing home residents. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11121.pdf>.
- *Quick Facts about Medicare's New Coverage for Prescription Drugs for People Who Get Help From Their State Pharmacy Program* – Publication Number 11108. This fact sheet explains what people who get help from their state pharmacy program to pay for their prescriptions need to know about the new Medicare prescription drug coverage. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11108.pdf>.
- *Do You Have a Medigap Policy with Prescription Drug Coverage?* – Publication Number 11113. This fact sheet explains how the new Medicare prescription drug coverage works for people who have a Medigap policy with prescription drug coverage. (4 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11113.pdf>.
- *Medicare Covers America* – Publication Number 11141. This brochure provides basic information for people with Medicare about Medicare prescription drug coverage. This information includes how Medicare prescription drug coverage works, how to get coverage, and how to join a Medicare prescription drug plan. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11141.pdf>.
- *Introducing Medicare Prescription Drug Coverage* – Publication Number 11142. This brochure provides basic information to people with Medicare about Medicare prescription drug coverage. This information includes who can join, when people can join, and when more information will be available. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11142.pdf>.

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

### New Fact Sheets and Tip Sheets Available on the CMS website at

<http://www.cms.hhs.gov/medicarereform/factsheets.asp>.

- *The Facts about Medicare Prescription Drug Plans* – Publication Number 11065. This fact sheet provides basic introductory information about Medicare's new prescription drug coverage. (2 pages) <http://www.medicare.gov/Publications/pubs/pdf/11065.pdf>.
- *Quick Facts about Medicare's New Coverage for Prescription Drugs (en Espanol)* – Publication Number 11102-S. This fact sheet provides basic information about Medicare's new prescription drug coverage, in Spanish. <http://www.cms.hhs.gov/medicarereform/elnewcovpresdrug.pdf>.
- *Medicaid Spend Down – Tip Sheet* (3 pages) This tip sheet provides an example of the spend down requirement for patients who have Medicaid because of high medical expenses. This sheet shows the qualifications for patients to receive extra help. <http://www.cms.hhs.gov/partnerships/downloads/medicaidspenddown.pdf>.
- *Food Stamps – Tip Sheet* (3 pages) This tip sheet provides information on income limits, resource limits and qualifications for extra help for people who have Medicare and are also on food stamps. <http://www.cms.hhs.gov/partnerships/downloads/foodstamps.pdf>
- *Medicare Prescription Drug Coverage and other Federal Means – Tested Programs – Tip Sheet* (2 pages) This tip sheet is intended to help explain how Medicare prescription drug coverage will work with other federal means-tested programs such as food stamps, HUD housing assistance, Medicaid, low income home energy assistance, and supplemental security income <http://www.cms.hhs.gov/partnerships/downloads/LowIncome.pdf>

### Other Publications/Products

- *Introducing Medicare's New Coverage for Prescription Drugs (bi-fold)* – This pamphlet provides general information about the New Medicare Prescription Drug Coverage, such as who can join, when, and the cost to join, as well as providing sources for additional information. This pamphlet is available at <http://www.medicare.gov/Publications/Pubs/pdf/11103.pdf>.

- *Vignettes/Bios/Case Studies*– These vignettes may be used to help explain how Medicare prescription drug coverage works with and affects other types of health care coverage. They may be used to supplement other outreach materials. (10 pages). These vignettes are available at <http://www.cms.hhs.gov/partnerships/downloads/vignettesfinal.pdf>.

- *Introducing Medicare's New Coverage for Prescription Drugs (Russian, Korean, Vietnamese, and Chinese)* – To access this product, go to <http://www.socialsecurity.gov/multilanguage/CMS/index.htm>.

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

### Outreach Toolkit

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

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

### Additional Information

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

Detailed drug coverage information for CMS partners and advocates for people with Medicare can be found on the CMS website at <http://www.cms.hhs.gov/Partnerships/PDI/list.asp#TopOfPage>.

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

Further information on CMS implementation of the MMA may be found on the CMS website at <http://www.cms.hhs.gov/MMAUpdate/MMU/list.asp#TopOfPage>.

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## Medicare Prescription Drug—New Educational Products Available

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 11, 2006, to provide new Web addresses that reflect changes in the new CMS website. All other information remains the same. This article was originally published in the Fourth Quarter 2005 Medicare A Bulletin (page 29).

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

### Provider Types Affected

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

### Important Points to Remember

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

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

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

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

The notices will let these people know that Medicare prescription drug coverage is coming and that they will get extra help without needing to apply for it.

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

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

### Posters - Now Available for Display

Posters titled “Have Limited Income? Social Security Can Help with Prescription Costs” may be ordered free of charge on the CMS website. The posters are suitable for display in a physician’s, providers, or supplier’s office; a pharmacy; or other health care setting where Medicare beneficiaries will see this information. The posters direct Medicare beneficiaries with limited income and resources to a toll free number where they can find out if they are eligible for help with prescription drug costs.

To view and order the posters, go to the Medlearn Prescription Drug Coverage Web page located on the CMS

website at [http://www.cms.hhs.gov/MedlearnProducts/23\\_drugcoverage.asp](http://www.cms.hhs.gov/MedlearnProducts/23_drugcoverage.asp).

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

### Information Tool Available on Web

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

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

### Summary

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

### Additional Information

More information on provider education and outreach regarding drug coverage may be found on the CMS website at: [http://www.cms.hhs.gov/MedlearnProducts/23\\_drugcoverage.asp](http://www.cms.hhs.gov/MedlearnProducts/23_drugcoverage.asp).

Detailed drug coverage information for CMS partners and beneficiary advocates may be found on the CMS website at <http://www.cms.hhs.gov/Partnerships/PDI/list.asp#TopOfPage>.

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

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

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 Related CR Transmittal Number: N/A  
 Effective Date: N/A  
 Implementation Date: N/A

Source: CMS Special Edition Medlearn Article SE0537

## Your Important Role—Medicare Prescription Drug Plan

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 11, 2006, to provide new Web addresses that reflect changes in the new CMS website. All other information remains the same. This article was originally published in the Third Quarter 2005 Medicare A Bulletin (pages 25-26).

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

### Provider Types Affected

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

### Provider Action Needed

#### STOP – Impact to You

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

#### CAUTION – What You Need to Know

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

#### GO – What You Need to Do

Stay informed, visit on CMS website [http://www.cms.hhs.gov/MedlearnProducts/23\\_drugcoverage.asp](http://www.cms.hhs.gov/MedlearnProducts/23_drugcoverage.asp).

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

### Background

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

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

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

#### Your Role and Involvement – You Choose

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

- **Basic** – You know that Medicare Prescription Drug Coverage exists and where to send people to learn about benefit details. You may display a poster (available later this spring) in your office or clinic, and make beneficiary-focused materials available in your office.
- **Intermediate** – You know more about Medicare Prescription Drug Coverage, such as:
  - ♦ How beneficiaries can enroll
  - ♦ Copayment amounts
  - ♦ Where to find additional help for people with limited income and resources
  - ♦ Where to find information on the following websites:
    - <http://www.medicare.gov>
    - [http://www.cms.hhs.gov/MedlearnProducts/23\\_drugcoverage.asp](http://www.cms.hhs.gov/MedlearnProducts/23_drugcoverage.asp)
  - ♦ How to answer the basic questions.
- **Advanced** – You know detailed information about Medicare Prescription Drug Coverage and the plans available in your area. You, or someone on your staff, can answer detailed questions about the drug benefit. In some cases, you or your staff may counsel beneficiaries on their particular situation and the options that will work best for them.

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

- Pay attention to correspondence from your national professional associations – they are part of the information stream from CMS to the community of professionals who serve people with Medicare; sign up for their listservs and read their newsletters.
- Keep current with information from your Medicare fee-for-service claims processing contractor; bookmark their website, read their bulletins, and register to receive electronic listserv messages.
- Bookmark and visit on the Web the provider educational Web page on Medicare Prescription Drug Coverage [http://www.cms.hhs.gov/MedlearnProducts/23\\_drugcoverage.asp](http://www.cms.hhs.gov/MedlearnProducts/23_drugcoverage.asp).
- Register to receive listserv email messages to alert you when new *Medlearn Matters* articles have been released on the new drug benefit (and other Medicare information); register on the Web at <http://new.cms.hhs.gov/apps/maillinglists/default.asp?audience=11>.
- Participate in CMS open door forums, to hear from and ask questions of CMS leadership on topics of interest to



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

your particular provider type; for information about these forums visit the website [http://new.cms.hhs.gov/OpenDoorForums/23\\_ODF\\_PNAHP.asp](http://new.cms.hhs.gov/OpenDoorForums/23_ODF_PNAHP.asp).

**Get Your Staff Involved**

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

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

If you or your staff are willing to further advise and counsel people with Medicare, CMS will have tools to help you do this on CMS website at <http://www.cms.hhs.gov/partnerships/>.

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/MedlearnProducts/downloads/provtoolkit.pdf>.

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.

**Summary**

CMS asks you to:

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

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**The Facts for Providers Regarding the Medicare Prescription Drug Plans Available in 2006**

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this Medlearn Matters article on January 11, 2006, to provide new Web addresses that reflect changes in the new CMS website. All other information remains the same.

This article was originally published in the Third Quarter 2005 Medicare A Bulletin (pages 24-25).

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

**Provider Types Affected**

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

**Provider Action Needed**

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

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

**The Basic Plan**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Medicare prescription drug plans that add coverage to the original Medicare plan (these plans will be offered

by insurance companies and other private companies); and

- Medicare prescription drug plans that are a part of Medicare Advantage plans (like HMOs), in some areas.

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

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

This notice will explain their rights and choices.

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

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

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

- Keep their current drug plan, and join a Medicare prescription drug plan to give them more complete prescription drug coverage; or
- Keep their current drug plan. However, if they join a Medicare prescription drug plan later, they will have to pay more for the monthly premium; or
- Drop their current drug plan and join a Medicare prescription drug plan. However, they may not be able to get their employer or union drug plan back.

### **Additional Information**

More information on provider education and outreach regarding drug coverage can be found on CMS website at: [http://www.cms.hhs.gov/MedlearnProducts/23\\_drugcoverage.asp](http://www.cms.hhs.gov/MedlearnProducts/23_drugcoverage.asp).

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

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

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

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*NOTE: The Medicare A Bulletin is available free of charge online at [www.floridamedicare.com](http://www.floridamedicare.com).*

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**Addresses****CLAIMS STATUS****Coverage Guidelines****Billing Issues Regarding****Outpatient Services, CORE, ORF, PHP**

Medicare Part A Customer Service  
P. O. Box 2711  
Jacksonville, FL 32231-0021

**PART A REDETERMINATION**

Medicare Part A Redetermination and Appeals  
P. O. Box 45053  
Jacksonville, FL 32232-5053

**MEDICARE SECONDARY PAYER (MSP)****Information on Hospital Protocols****Admission Questionnaires****Audits**

Medicare Secondary Payer  
Hospital Review  
P. O. Box 45267  
Jacksonville, FL 32232-5267

**General MSP Information****Completion of UB-92 (MSP Related)****Conditional Payment**

Medicare Secondary Payer  
P. O. Box 2711  
Jacksonville, FL 32231-0021

**Automobile Accident Cases****Settlements/Lawsuits****Other Liabilities**

Auto/Liability Department – 17T  
P. O. Box 44179  
Jacksonville, FL 32231-4179

**PROVIDER EDUCATION**

Medicare Education and Outreach  
P. O. Box 45157  
Jacksonville, FL 32232-5157

**Seminar Registration Hotline**

1-904-791-8103

**ELECTRONIC CLAIM FILING “DDE Startup”**

Direct Data Entry (DDE)  
P. O. Box 44071  
Jacksonville, FL 32231-4071

**FRAUD AND ABUSE**

Complaint Processing Unit  
P. O. Box 45087  
Jacksonville, FL 32232-5087

**PART A RECONSIDERATION****Claims Denied at the Redetermination Level**

MAXIMUS  
QIC Part A East Project  
Eastgate Square  
50 Square Drive  
Victor, NY 14564-1099

**OVERPAYMENT COLLECTIONS****Repayment Plans for Part A Participating Providers****Cost Reports (original and amended)****Receipts and Acceptances****Tentative Settlement Determinations****Provider Statistical and Reimbursement (PS&R) Reports****Cost Report Settlement (payments due to provider or Program)****Interim Rate Determinations****TEFRA Target Limit and Skilled Nursing Facility Routine Cost Limit Exceptions****Freedom of Information Act Requests (relative to cost reports and audits)**

Provider Audit and Reimbursement Department (PARD)  
P.O. Box 45268  
Jacksonville, FL 32232-5268  
1-904-791-8430

**MEDICARE REGISTRATION****American Diabetes Association****Certificates**

Medicare Registration – ADA  
P. O. Box 2078  
Jacksonville, FL 32231-2078

**Telephone Numbers****PROVIDERS**

Customer Service Center Toll-Free  
1-877-602-8816  
Speech and Hearing Impaired  
1-877-660-1759

**BENEFICIARY**

Customer Service Center Toll-Free  
1-800-MEDICARE  
1-800-633-4227  
Speech and Hearing Impaired  
1-800-754-7820

**ELECTRONIC MEDIA CLAIMS**

EMC Start-Up  
1-904-791-8767, option 4

Electronic Eligibility  
1-904-791-8131

Electronic Remittance Advice  
1-904-791-6865

Direct Data Entry (DDE) Support  
1-904-791-8131

PC-ACE Support  
1-904-355-0313

Testing  
1-904-791-6865

Help Desk  
(Confirmation/Transmission)  
1-904-905-8880

**Medicare Websites****PROVIDERS**

Florida Medicare Contractor  
[www.floridamedicare.com](http://www.floridamedicare.com)  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)

**BENEFICIARIES**

Centers for Medicare & Medicaid Services  
[www.medicare.gov](http://www.medicare.gov)

**Other Important Addresses****REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY****Home Health Agency Claims Hospice Claims**

Palmetto Government Benefit Administrators – Gulf Coast  
34650 US Highway 19 North, Suite 202  
Palm Harbour, FL 34684-2156

**RAILROAD MEDICARE****Railroad Retiree Medical Claims**

Palmetto Government Benefit Administrators  
P. O. Box 10066  
Augusta, GA 30999-0001

**DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)****Durable Medical Equipment Claims Orthotic and Prosthetic Device Claims Take Home Supplies****Oral Anti-Cancer Drugs**

Palmetto Government Benefit Administrators  
P. O. Box 100141  
Columbia, SC 29202-3141





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