Medicare B Update!
A Newsletter for Florida Medicare Part B Providers

Special Issue

Final Update to the 2002 Medicare Physician Fee Schedule Database

This special issue is to provide changes included in the final update to the 2002 Medicare Physician Fee Schedule Database (MPFSDB). ***Unless otherwise noted***, these changes are effective for services rendered on or after January 1, 2002, processed on or after October 1, 2002. Changes included in this final update to the 2002 MPFSDB are as follows:

The **procedure status** for the following codes has been changed to **"B"** (Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident [an example is a telephone call from a hospital nurse regarding care of a patient]):

A4206 A4207 A4208 A4209 A4213 A4214 A4215

The **procedure status** for the following codes has been changed to **"E**" (Excluded from physician fee schedule by regulation. These codes are for items and/or services that the Centers for Medicare & Medicaid Services [CMS] chose to exclude from the fee schedule payment by regulation. No RVUs or payment amounts are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, continues under reasonable charge procedures). **Note**: these codes are now subject to mandatory assignment and the 5% payment reduction for nonparticipating providers.

A9502 A9504 A9507 A9508 A9510 A9511 A9600 A9605 A9700

The **bilateral surgery** indicator for the following codes has been changed to **"1"** (150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier or is reported twice on the same day by any other means [e.g., with RT and LT modifiers or with a 2 in the units field], payment for these codes when reported as bilateral procedures is based on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code):

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CMS CENTERS for MEDICARE & MEDICAID SERVICES

FIRST COAST SERVICE OPTIONS, INC.
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- Physician/Provider
- Office Manager
- Billing/Vendor
- Nursing Staff
- Other _____

_____

_____

Bilateral = 1, continued

0005T	0006T	0007T	0012T	0013T	0014T	0016T	0017T	0020T	20526	24300	24332	25259
25275	25430	25651	25652	25671	26340	29824	36002	36533	36534	36535	36820	37208
38220	38221	61862	61880	61885	61888	63043	63044	64821	64822	64823	69300	75685

The **bilateral surgery** indicator for codes **75685, 75685 26,** and **75685 TC** has been changed to **"3"** (The usual payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or is reported for both sides on the same day by any other means [e.g., with RT and LT modifiers or with a 2 in the units field], payment for each side or organ or site of a paired organ is based on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any applicable multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures).

Effective for services performed on or after July 1, 2002, the **descriptors** for HCPCS codes **G0245** and **G0246** have been corrected (please refer to pages 20-21 of the Fourth Quarter 2002 *Medicare B Update!*). The **global period** indicator for HCPCS code **G0247** is "**ZZZ"** (Code related to another service and is always included in the global period of the other service.)

Effective for services performed on or after January 1, 2002, processed on or after July 1, 2002, fee allowances are changed for HCPCS codes **G0248, G0249,** and **G0250**. The revised allowances are as follows:

	Participating			Nonparticipating			Limiting Charge		
Code	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04
G0248	105.25	113.44	117.44	99.99	107.77	111.57	114.99	123.93	128.30
G0249	112.78	121.55	125.82	107.14	115.47	119.53	123.21	132.79	137.46
G0250	8.87	9.38	9.81	8.43	8.91	9.32	9.69	10.25	10.72

Effective for services performed on or after October 1, 2002, CMS has established HCPCS codes **G0252, G0253,** and **G0254** for breast cancer PET (positron emission tomography) scans (please refer to pages 23-24 of the Fourth Quarter 2002 *Medicare B Update!*). Listed below are allowances for these services, followed by MPFSDB indicators applicable to these new codes.

	Participating			Nonparticipating			Limiting Charge		
Code	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04
G0252	2067.92	2259.57	2376.64	1964.52	2146.59	2257.81	2259.20	2468.58	2596.48
G0252 TC	1992.60	2180.66	2295.02	1892.97	2071.63	2180.27	2176.92	2382.37	2507.31
G0252 26	75.32	78.91	81.62	71.55	74.96	77.54	82.29	86.21	89.17
G0253	2067.92	2259.57	2376.64	1964.52	2146.59	2257.81	2259.20	2468.58	2596.48
G0253 TC	1992.60	2180.66	2295.02	1892.97	2071.63	2180.27	2176.92	2382.37	2507.31
G0253 26	75.32	78.91	81.62	71.55	74.96	77.54	82.29	86.21	89.17
G0254	2067.92	2259.57	2376.64	1964.52	2146.59	2257.81	2259.20	2468.58	2596.48
G0254 TC	1992.60	2180.66	2295.02	1892.97	2071.63	2180.27	2176.92	2382.37	2507.31
G0254 26	75.32	78.91	81.62	71.55	74.96	77.54	82.29	86.21	89.17

Component:	Global	Professional (26)	Technical (TC)
Status:	C	A	C
PC/TC:	1	1	1
Facility pricing:	1	1	1
Global:	XXX	XXX	XXX
Pre-Op:	0.00	0.00	0.00
Intra-Op:	0.00	0.00	0.00
Post-Op:	0.00	0.00	0.00
Mult Surg:	0	0	0
Bilt Surg:	0	0	0
Asst Surg:	0	0	0
Co Surg:	0	0	0
Team Surg:	0	0	0
Bill Med:	0	0	0
Diag Supv:	09	09	09
No Rel Code:	0	0	0

CMS has established HCPCS codes **G0255, G0255 26**, and **G0255 TC** for current perception sensory nerve conduction threshold (sNCT). **Effective for services performed on or after October 1, 2002**, these codes are nationally noncovered (please refer to page 42 of the Fourth Quarter 2002 *Medicare B Update!*).

Effective for services performed on or after October 1, 2002, HCPCS code **J7316** is changed to procedure status **"G"** (Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. Code subject to a 90-day grace period.). A new HCPCS code, **Q3030** (sodium hyaluronate injection, per 20 to 25 mg dose, for intra articular injection) is established **effective for services performed on or after July 1, 2002,** with procedure status of **"E"** (Excluded from physician fee schedule by regulation. These codes are for items and/or services that the Centers for Medicare & Medicaid Services (CMS) chose to exclude from the fee schedule payment by regulation. No RVUs or payment amounts are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, continues under reasonable charge procedures.).

The allowance for Q3030 will be 142.50 for participating providers (135.38 for nonpar). **Note: code Q3030 will not be available for use until October 1, 2002.** Providers may hold their claims and submit them using Q3030 starting October 1, 2002. Alternatively, they may continue to submit them using J7316 through September 30, 2002 (for more information please refer to page 28 of the Fourth Quarter 2002 *Medicare B Update!*).

In the 2001 Medicare Physician Fee Schedule Database the PC/TC indicator was inadvertently changed from a '1' to a '2' for *CPT* codes **76012, 76013, 75952,** and **75953**, and the related professional and technical portions of these services were deleted. The PC/TC indicators have subsequently been changed back to a '1' and the professional and technical portions reinstated for **services provided in 2001, effective January 1, 2002**.

The **short descriptor** for *CPT* codes **76075, 76075 26,** and **76075 TC** has been changed to read: "Dual energy x-ray study."

Effective for services performed on or after October 1, 2002, the **procedure status** for codes **78459, 78459 26,** and **78459 TC** has been changed. Listed below are fee allowances for these services, followed by MPFSDB indicators applicable to these new codes.

	Participating			Nonparticipating			Limiting Charge		
Code	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04
78459	2067.92	2259.57	2376.64	1964.52	2146.59	2257.81	2259.20	2468.58	2596.48
78459 TC	1992.60	2180.66	2295.02	1892.97	2071.63	2180.27	2176.92	2382.37	2507.31
78459 26	75.32	78.91	81.62	71.55	74.96	77.54	82.29	86.21	89.17

Code:	78459	78459 26	78459 TC
ProcStat:	C	R	C
PC/TC:	1	1	1
SOS:	1	1	1
Global:	XXX	XXX	XXX
Pre-Op:	0.00	0.00	0.00
Intra-Op:	0.00	0.00	0.00
Post-Op:	0.00	0.00	0.00
Mult Surg:	0	0	0
Bilt Surg:	0	0	0
Asst Surg:	0	0	0
Co Surg:	0	0	0
Team Surg:	0	0	0
Bill Med:	0	0	0
Diag Supv:	09	09	01
No Rel Code:	0	0	0

The **global period** indicator for *CPT* codes **78478, 78478 26, 78478 TC, 78480, 78480 26,** and **78480 TC** has been changed to **"XXX"** (Global concept does not apply).

The diagnostic supervision requirement indicator for *CPT* codes **92270, 92270 TC, 92275, 92275 TC, 92286,** and **92286 TC** has been changed to **"01"** (Procedure must be performed under the general supervision of a physician).

Source: CMS Transmittal AB-02-112, CR 2282

Billing for Implanted Durable Medical Equipment, Prosthetic Devices, Replacement Parts, Accessories and Supplies

This instruction clarifies an operational policy on the proper billing for implanted durable medical equipment (DME), implanted prosthetic devices, replacement parts, accessories and supplies.

Claims for implanted DME, implanted prosthetic devices, replacement parts (external or internal), accessories, and supplies for the implanted DME must be billed to local carriers, not to durable medical equipment regional carriers (DMERCs). Bills for these items submitted to DMERCs will be returned to the supplier under current operating procedures.

Source: CMS Transmittal B-02-041, CR 2227

Implementation of Certain Initial Determination and Appeal Provisions of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000

Section 1869 of the Social Security Act (the Act), as amended by section 521 of BIPA, substantially revises the Medicare claim appeals process. The changes described herein that do not require system changes by Medicare contractors are effective October 1, 2002. Additional system changes will be made effective January 1, 2003, allowing the date by which an appeal must be filed with a contractor to be automatically calculated and listed on the Medicare Summary Notice (MSN). Changes will be made to paper and electronic remittance advice (RA) and standard appeals information contained on the back of the MSN to reflect the new filing timeframes for appeals of initial determinations.

New Time Limits for Filing a Request for Appeal

Section 1869(a)(3)(C) of the Act eliminates the distinction between the time limits for requesting a Part A reconsideration and Part B review by creating a 120-day time limit for filing requests for appeal of all initial determinations.

Changes to the MSN and RA

The MSN specifies the date by which a beneficiary must file an appeal of a denied claim. Although the RA codes do not identify a particular filing date for provider or supplier appeals, the codes do identify the applicable Part A and Part B filing timeframes.

Remittance Advice (RA)

The following RA remark codes have been updated to reflect the changes in the filing deadlines: M25, M26, M27, MA01, and MAO2. The changes to the messages are identified in the chart below in bold typeface.

RA Remark Code	Message
M25	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim either **within 6 months of the date of this notice, if this notice is dated September 30, 2002 or earlier, or within 120 days of the date of this notice, if this notice is dated October 1, 2002 or later**. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.
M26	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to the refund requirement in two cases: • If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or • If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days. Your request for review should include any additional information necessary to support your position. If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request review at any time **within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later.** However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.

The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program.

Please contact this office if you have any questions about this notice.

M27 The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.

You may appeal this determination provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the patient or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal.

You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed **within 60 days of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later (or, for a medical insurance review, within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later).** You may make the request through any Social Security office or through this office.

MA01 (Initial Part B determination, Medicare carrier or intermediary)—If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us **within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later**, unless you have a good reason for being late. If you meet the criteria for a telephone review, you should phone this office if you wish to request a telephone review.

MA02 (Initial Medicare Part A determination)—If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration **within 60 days of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later.** Decisions made by a QIO must be appealed to that QIO **within 60 days.** (An institutional provider, e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 879 of the Social Security Act, and the patient chooses not to appeal.)

These five codes will be revised again during the Web posting update scheduled for the last week of October 2002. At that time, the references to the Part A 60-day filing timeframe and Part B 6-month filing timeframe will be removed.

Medicare Summary Notice (MSN)

Contractors will make the standard systems changes identified below to the MSN by January 1, 2003. All other technical specifications will remain the same.

In the Appeals section of the MSN,

- if only Part B claims information is on the MSN, only Part B appeals language will be printed
- if if only Part A claims information is on the MSN, only Part A appeals language will be printed
- if the MSN includes both Part A and Part B claims information, the language currently used will be replaced with the following language:

Appeals Information – Part A (Inpatient) and Part B (Outpatient)
If you disagree with any claims decision on either PART A or PART B of this notice, you can request an appeal by (insert appeal date; the date format remains month, day, and year).

Additionally, the appeal timeframe for both Part A and B appeals is now 120 days from the date shown on the front of this notice. Again, the date format remains month, day, and year.

The rest of the appeals instruction language, beginning with "Follow the instructions below", is not being changed.

On the back of the Part B MSN, in the second sentence of the YOUR RIGHT TO APPEAL paragraph, "6 months" will be replaced with "120 days."

Reduction of the Amount in Controversy (AIC) Required to Request a Part B Administrative Law Judge (ALJ) Hearing

Beneficiaries, physicians, and suppliers wishing to file appeals must satisfy the AIC requirement in order to obtain a Part B ALJ hearing. To be consistent with the AIC requirement for Part A ALJ hearings, the AIC requirement for Part B ALJ requests will be $100, for initial determinations made on or after October 1, 2002.

Source: CMS Transmittal AB-02-111, CR 2251

Notice of Interest Rate for Medicare Overpayments and Underpayments

Medicare Regulation 42 CFR section 405.378 provides for the assessment of interest at the higher of the private consumer rate (PCR) or the current value of funds rate (5 percent for calendar year 2002). The Secretary of the Treasury has notified the Department of Health and Human Services that the PCR has been changed to **12.625 percent**, effective August 8, 2002. The notice of the PCR was published in the *Federal Register* (see Vol. 67, No. 153 dated August 8, 2002). Therefore, the PCR will remain in effect until a new rate change is published.

INTEREST RATE TABLE

Period	Interest Rate
August 8, 2002	**12.625%**
May 8, 2002 - August 7, 2002	11.75%
February 1, 2002 - May 7, 2002	12.625%
October 31, 2001 - January 31, 2002	13.25%
August 7, 2001 - October 30, 2001	13.25%
April 26, 2001 - August 6, 2001	13.75%
February 7, 2001 - April 25, 2001	14.125%
October 24, 2000 - February 6, 2001	13.875%
August 1, 2000 - October 23, 2000	13.875%
May 3, 2000 - July 31, 2000	13.75%
February 2, 2000 - May 2, 2000	13.5%
October 28, 1999 - February 1, 2000	13.375%
August 04, 1999 - October 27,1999	13.25%
May 05, 1999 - August 03, 1999	13.375%
February 01, 1999 - May 04. 1999	13.75%
October 23, 1998 - January 31, 1999	13.50%
July 31, 1998 - October 22, 1998	13.75%
May 13, 1998 - July 30, 1998	14.00 %
January 28, 1998 - May 12, 1998	14.50%
October 24, 1997 - January 27, 1998	13.875%
July 25, 1997 - October 23, 1997	13.75%
April 24, 1997 - July 24, 1997	13.50%
January 23, 1997 - April 23, 1997	13.625%

Source: CMS Transmittal AB-02-118, CR 1899

Policy Clarification for Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes

Information concerning billing and coverage for peripheral neuropathy with LOPS in people with diabetes was published in the Third Quarter 2002 *Medicare B Update!* (pages 22-23). Since that time, the Centers for Medicare & Medicaid Services (CMS) has advised contractors that the note at the end of the definition for G0245 was incomplete. The note should read:

> For carriers, each physician or physician group of which that physician is a member may receive reimbursement only once for G0245 for each beneficiary. However, should that beneficiary need to see a new physician, that new physician may also be reimbursed once for G0245 for that beneficiary as long as it has been at least 6 months from the last time G0245 or G0246 was paid for the beneficiary, regardless of who provided the service.

Clarification of Billing Requirement for G0247

In order for claims to be processed correctly, G0247 must be billed on the same claim with the same date of service as either G0245 or G0246 in order to be considered for payment.

For more information concerning LOPS, please refer to the local medical review policy published in the Fourth Quarter 2002 *Update!* (pages 32-34).

Source: CMS Transmittal AB-02-109, CR 2150

MEDICARE B UPDATE!

FIRST COAST SERVICE OPTIONS, INC. P.O. BOX 2078 JACKSONVILLE, FL 32231-0048

*** ATTENTION BILLING MANAGER***