Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

Highlights In This Issue…

Features

To receive quick, automatic notification when new publications and other items of interest are posted to our provider education Web sites, subscribe to our *FCSO eNews* mailing list. It's very easy to do; go to *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com*, click on the "Join our Electronic Mailing List FCSO eNews" bar and follow the prompts. The *FCSO eNews* is sent at least every other week, more frequently as required.

The *Medicare B Update!* should be shared with all health care practitioners and managerial members of the provider/supplier staff. Publications issued beginning in 1997 are available at no cost from our provider education Web sites: *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*.

Routing Suggestions:

- ❑ Physician/Provider
- ❑ Office Manager
- ❑ Billing/Vendor
- ❑ Nursing Staff
- ❑ Other _____

_____

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

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The *Medicare B Update!* is published quarterly by the Medicare Communication and Education department of First Coast Service Options, Inc. (FCSO), to provide timely and useful information to Medicare Part B providers in Connecticut and Florida.

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

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MCE-Publications
P.O. Box 45270
Jacksonville, FL
32232-5270

A PHYSICIAN'S FOCUS

Combating Fraud and Abuse in the Medicare Program—A Provider Responsibility Too

The complexity of our current health care system precludes one from overreacting to reports of health care fraud and abuse. The Medicare program alone has over 100,000 pages of regulations that make billing errors problematic. Most Medicare billing errors are mistakes and are not the result of physicians, providers, or suppliers trying to take advantage of the Medicare system. The limited resources of the Department of Justice should be directed at those who violate the simple definition of fraud and abuse – lying, stealing, and cheating. However, the demands of the health care delivery system and the Medicare claim administration can sometimes seem to overlap the legal, ethical, and business obligations of physicians, providers, and suppliers.

Recognizing the conflicting incentives, Congress has set up information gathering for the public and specific stakeholders. The Department of Health and Human Services (DHHS) Office of Inspector General (OIG) conducts audits and investigations of the Medicare program with the goal of working with decision makers to minimize fraud and abuse. The OIG fiscal year 2004 work plan includes aspects of many common episodes of care such as inpatient hospital DRG (diagnosis related group) coding, inpatient rehabilitation payments, diagnostic testing in the emergency room, coding of E/M (evaluation & management) services, and services and supplies incident to physicians' services such as injectable drugs, to name a few (*http://oig.hhs.gov*). The OIG also detects abusers of Medicare and other HHS programs so appropriate remedies, including criminal investigations may be initiated.

The Centers for Medicare & Medicaid Services (CMS) uses its authority under the Medicare Integrity Program to contract with organizations to specifically address issues of Medicare fraud and abuse. These program safeguard contractors (PSCs) focus on developing fraud cases for referral to the OIG, responding to requests for Medicare data and support from law enforcement entities, and identifying and reporting program vulnerabilities to CMS. PSCs also work with the traditional Medicare contractors (now known as affiliated contractors [ACs]).

As an affiliated contractor, First Coast Service Options, Inc. (FCSO) administers the day-to-day operation of claim payment for Medicare Part A and B in Florida, and Part B for Connecticut based in Florida. FCSO has the responsibility to pay the right amount for covered, medically necessary, and correctly coded services rendered to eligible beneficiaries by properly enrolled providers.

FCSO also has responsibilities of coordinating and communicating information with external partners, including PSCs and law enforcement agencies. Information on possible fraud and abuse cases comes from multiple sources including data analysis, provider or beneficiary complaints, and provider failure to respond to persistent education efforts on medical review.

The basics of fraud and abuse (lying, stealing and cheating) are not the purview of routine medical review. **Fraud** is defined as intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The term **abuse** describes incidents or practices of providers that are inconsistent with accepted sound medical practice. Abuse may directly or indirectly result in unnecessary costs to the program, improper reimbursement, or program reimbursement for services that fail to meet professionally recognized standards of care or which are medically unnecessary. The type of abuse to which Medicare is most vulnerable is overutilization of medical services.

An example of a FCSO referral to the PSC for fraud and abuse is the extraordinary utilization of Rho (D) immune globulin specific to certain providers in Florida. Despite investigations and interventions by the PSC, TriCenturion, Inc, excessive utilization persisted in 2003. In the second half of 2003, the Florida carrier/nation ratio was 14.44 for Rho (D) immune globulin (1400+% more $ per beneficiary compared to other states.). Florida was 97 percent of the allowed nation dollars (153 million dollars) and these dollars were limited to certain providers. Queries to clinical experts using the drug in similar episodes of care found no justification for the utilization patterns.

Whether this overpayment is ever recouped and future abuse curtailed depends not only on good case development by the appropriate authorities and proactive contractor interventions, but also on the support of the provider community. Health care professionals such as physicians, nurses, administrators, executives, and others must seek to clarify legal, ethical, and business obligations especially if the incentives are clearly conflicting. Improving health care is a serious and continuing responsibility, and profitability can never be the driver for a service that has uncertain or no value for a patient. Also, physicians as the drivers of the patient-physician relationship have a responsibility beyond health care industry standards in ensuring balance, coordination, comprehensiveness, safety, and openness when addressing patient care. FCSO salutes the vast majority of physicians and allied providers that *do the right things the right way*.

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THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida *Medicare B Update!*

The *Medicare B Update!* is a comprehensive magazine published quarterly by First Coast Service Options, Inc. (FCSO) for Part B providers in Connecticut and Florida. In accordance with notification requirements established by the Centers for Medicare & Medicaid Services, approximate delivery dates for fiscal year 2004 are:

Publication Name	Publication Date	Effective Date of Changes
First Quarter 2004	Mid-November 2003	January 1, 2004
Second Quarter 2004	Mid-February 2004	April 1, 2004
Third Quarter 2004	Mid-May 2004	July 1, 2004
Fourth Quarter 2004	**Mid-August 2004**	**October 1, 2004**

Important notifications that require communication in between these dates will be posted to the FCSO Medicare provider education Web sites, *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*. In some cases, additional unscheduled special issues may be posted.

Who Receives the *Update?*

Anyone may view, print, or download the *Update!* from our provider education Web site(s). Providers who cannot obtain the *Update!* from the Internet are required to register with us to receive a complimentary hardcopy or CD-ROM .

Distribution of the *Update!* in hardcopy or CD-ROM format is limited to individual providers and professional association (PA) groups who have billed at least one Part B claim to either Connecticut or Florida Medicare for processing 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 registration form to us.*

For additional copies, providers may purchase a separate annual subscription in hardcopy or CD-ROM format (see order form on the inside back cover of this issue). All issues published since 1997 may be downloaded from the Internet, free of charge.

We use the same mailing address for *all* correspondence, and cannot designate that the *Update!* be sent to a specific person/department within a provider's office. 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.

Clear Identification of State-Specific Content

A header bar preceding articles clearly indicates whether the topic is applicable to both Connecticut and Florida, Connecticut only, or Florida only. Within articles, references to phone numbers, addresses, reimbursement amounts, past publications, etc., are state-specific as appropriate.

Publication Format

The *Update!* is arranged into distinct sections. Following the table of contents, a letter from the Carrier Medical Director, and an administrative information section, the *Update!* provides content applicable to both states, as noted previously. Within this section, information is categorized as follows.

- The **claims** section provides claim submission requirements and tips, plus correspondence (appeals and hearings) information.
- The **coverage/reimbursement** section discusses specific *CPT* and HCPCS procedure codes. It is arranged by specialty *categories* (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule and other pricing issues.
- The section pertaining to **electronic media claim** (EMC) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (**HIPAA**).
- The **general information** section includes fraud and abuse, provider registration, and Medicare Secondary Payer topics, plus additional topics not included elsewhere.

Local medical review and **comprehensive data analysis** will *always* be in state-specific sections, as will **educational resources**. Important **addresses, phone numbers**, and **Web sites** are also listed separately for each state

An **Index** to the year's previous issues of the *Update!* and a Part B materials order form are included in the back of the publication.

The *Medicare B Update!* Represents Formal Notice of Coverage Policies

Articles included in each *Update!* represent formal notice that specific coverage policies either 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. **The date the *Update!* is posted to the Web site is considered the notice date** in the event there is a dispute over whether a provider received advance notice regarding coverage of a specific service and the financial liability for it.

Advance Beneficiary Notices (ABNs)

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient. For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. ABNs advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment. ABNs allow beneficiaries to make informed consumer decisions about receiving items or services for which they may have to pay out-of-pocket, and to be more active participants in their own health care treatment decisions. An ABN must meet the following requirements:

- The ABN must be on an approved Form CMS-R-131 (see "New Patient Liability Notice" below).
- The ABN must be given in writing, in advance of furnishing the service or item.
- The ABN must include the patient's name, date(s) and description of the service or item, and the reason(s) why the service or item may not be considered medically reasonable and necessary (e.g., the service is not covered based on the patient's diagnosis, the frequency of the service was in excess of accepted standards of medical practice, etc.).
- The notice must be signed and dated by the patient, indicating the patient assumes financial responsibility for the service if payment is denied as being not medically reasonable and necessary for reason(s) indicated on the advance notice. The signature of the provider of service is not required.
- The ABN should be maintained with the patient's medical record.

New Patient Liability Notice

Form CMS-R-131 is the new approved ABN, ***required for services provided on or after January 1, 2003***. Form CMS-R-131 was developed as part of the Centers for Medicare & Medicaid Services' (CMS) Beneficiary Notices Initiative (BNI), and was approved by OMB (Office of Management and Budget) on June 18, 2002. The new ABNs are designed to be more beneficiary-friendly, more readable and understandable, with patient options more clearly defined.

There are two ABN forms - the General Use form (CMS-R-131G) and the Laboratory Tests form (CMS-R-131L). Both are standard forms that *may not be modified*; however, both contain customizable boxes for the individual requirements of users, following the guidance in CMS Program Memoranda (PM) AB-02-114 and AB-02-168, which may be found on the CMS Web site at *http://cms.hhs.gov/manuals/pm_trans/AB02114.pdf* and *http://cms.hhs.gov/manuals/pm_trans/AB02168.pdf*.

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found on CMS's BNI Web site at *http://www.cms.hhs.gov/medicare/bni*.

ABN Modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier **GA** (waiver of liability statement on file) or **GZ** (item or service expected to be denied as not reasonable and necessary) with the service or item.

Failure to report modifier **GA** in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Modifier **GZ** may be used in cases where a signed ABN is *not* obtained from the patient; however, when modifier **GZ** is billed, the provider assumes financial responsibility if the service or item is denied.

CLAIMS

Ambulatory Surgical Centers Reimbursement Guidelines for Bilateral and Add-on Procedures

When a surgical procedure is performed bilaterally in an Ambulatory Surgical Centers (ASC), the facility should bill in the following manner:

- The service should be billed on two separate detail lines on the claim
- The first line should be billed with the appropriate surgical procedure code and modifier RT (Right side of the body)
- The second line should be reported with the same procedure code and modifier LT (Left side of the body)

Modifier 50 should **not** be used by an Ambulatory Surgical Centers.

Surgical procedures billed by an ASC are allowed at 100 percent for the initial procedure and 50 percent for all subsequent procedures.

This payment methodology also applies to those procedures that are considered add-on codes by definition. The exemption to multiple surgery reimbursement guidelines for add on codes applies only to the physician charge.

Clarification - UPIN of Attending Physician and Date Last Seen Required for Podiatry Claims

This is a clarification to an article published on page 9 of the Third Quarter *Medicare B Update!* titled "Reminder - UPIN of Attending Physician and Date Last Seen Required for Podiatry and Physical/Occupational Therapy Claims". The first paragraph states

"Claims for podiatry services require the UPIN (unique physician identification number) of the attending physician and the date the patient was last seen to be reported in item 19 on Form CMS-1500 (or electronic equivalent)".

This requirement only applies to **routine foot care** services, not all podiatry services. We apologize for any confusion this may have caused.

Elimination of Regulations for Written Statement of Intent

Provider Types Affected

All Medicare providers

Provider Action Needed

STOP – Impact to You

Effective with the claims filing period ending on December 31, 2004 and thereafter, Medicare will no longer accept Statements of Intent (SOIs) to extend the timely filing limit for filing initial claims.

CAUTION – What You Need to Know

Know the Medicare timely filing requirements for submitting claims. These requirements are in Chapter 1, Section 70 of the Medicare Claims Processing Manual, which may be found at:
http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

GO – What You Need to Do

To ensure accurate claims processing, please submit filings in a timely manner and make certain that you will no longer utilize SOIs.

Background

Medicare regulations at 42 CFR Part 424.45 allowed for the submission of written SOIs to claim Medicare benefits. The purpose of an SOI was to extend the timely filing period for the submission of an initial claim. An SOI, by itself, did not constitute a claim, but rather was used as a placeholder for filing a timely and proper claim.

A Final Rule published in the Federal Register, dated April 23, 2004, Volume 69, Number 79, pages 21963- 21966, amended 42 CFR Part 424 by removing the SOI provision at 424.45, effective May 24, 2004. Therefore, for the claims filing period ending on December 31, 2004, and all periods thereafter, Medicare carriers, intermediaries, and Medicare Regional Offices will no longer accept SOIs to extend the timely filing period for claims.

Additional Information

If you have questions regarding this issue, you may also contact your carrier or intermediary by their toll-free number. If you bill for Medicare Part A services, including outpatient hospital services, the toll-free number for your carrier/intermediary may be found online at: *http://www.cms.hhs.gov/providers/edi/anum.asp*

If you bill for Medicare Part B services, the toll-free number may be found online at: *http://www.cms.hhs.gov/providers/bnum.asp*

The official instruction issued to the carrier/intermediary regarding this change can be found online, referenced via CR 3310, at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

On the above online page, scroll down while referring to the CR NUM column on the right to find the link for CR3310. Click on the link to open and view the file for the CR.

Related Change Request (CR) #: 3310
Medlearn Matters Number: 3310
Related CR Release Date: June 18, 2004
Related CR Transmittal #: 211
Effective Date: May 24, 2004
Implementation Date: July 19, 2004

Health Professional Shortage Areas

Physicians are eligible for a 10% bonus when they render service(s) in certain medically underserved areas. These areas, known as Health Professional Shortage Areas (HPSAs), may cover an entire county or a portion of a county or city, and are designated as either rural or urban HPSAs. HPSA designations are made by the Division of Shortage Designation (DSD) of the Public Health Service (PHS) and can be accessed queried at: *http://belize.hrsa.gov/newhpsa/newhpsa.cfm*.

The incentive payments are based on 10% of the paid amount for both assigned and nonassigned claims for services performed by the physician. The incentive payment is not made on a claim-by-claim basis; rather, payments are issued quarterly.

Eligibility

A physician is eligible for the HPSA incentive payment *when services are furnished in an area designated as a HPSA*, regardless of where the physician's office is located. For example, a physician's office may be located in an area not designated as a HPSA; however, the physician may treat a patient in a nursing facility located in a HPSA. In this instance, the physician would be eligible for the HPSA incentive payment. Likewise, the physician's office may be in a HPSA; however, the physician may treat a patient in his/her home that is not located in a HPSA. In this case, the physician is *not* eligible for the HPSA incentive payment.

Only physicians are eligible for the HPSA incentive payments. The following degrees/credentials are considered physicians eligible for the incentive payments: M.D., D.O., D.C., D.P.M., D.D.S., and O.D.

Claims Filing Requirements

To report services furnished in a HPSA, one of the following procedure code modifiers should be reported with the service:

QB Physician service rendered in a rural HPSA
QU Physician service rendered in an urban HPSA

In addition, item 32 of Form CMS-1500 (or electronic equivalent) must be completed when either the QB or QU modifiers is billed. The physical location where the service was furnished must be indicated, if it is other than the patient's home.

Appeal of HPSA Incentive Payments

The incentive payments do not include remittance advice notices; only a list of the claims to which the incentive payment applies is provided with the payment. As a result, physicians have not been provided with an opportunity to challenge the amounts of their HPSA incentive payments on nonassigned claims or to challenge nonassigned claims where incentive has not been paid.

CMS has provided clarification of these issues:

- In cases where a physician is not satisfied with the amount of the incentive payment on either assigned or nonassigned claims, he or she may request a review of the incentive payment. The review request must be made within 60 days of the date when the incentive payment was issued.
- In cases where an incentive payment was not made on a claim (assigned or nonassigned), but the physician believes that one should have been made, he or she may request a reopening of that particular claim. The request must be within one year of the claim payment.

  Note: If the physician is unsure of the date a nonassigned claim was *processed*, the request for reopening may be made within one year of the date the claim was *submitted*, to ensure the request for the reopening is made within the one-year time limit.

Florida Only

Liberty County has been added to the HPSA designation with an effective date of July 1, 2004.

Incident-to-Services

The following "Medlearn Matters... Information for Medicare Providers" article was previously posted to CMS' Web site on April 30, 2004.

Provider Types Affected

Physicians, suppliers, and providers.

Provider Action Needed

STOP – Impact to You

This instruction clarifies and standardizes the method of indicating the ordering and supervising professionals on the Centers for Medicare & Medicaid Services Health Insurance Claim Form (CMS-1500). Note that the CMS-1500 is the paper form, however, and is superceded now by the electronic form.

CAUTION – What You Need to Know

This instruction and the CMS Claims Processing Manual update clarifies where physician's Provider Information Numbers and names should be reported when both an ordering provider and a supervising provider are involved in a service.

GO – What You Need to Do

Please refer to the Background and Additional Information sections of this instruction for further details.

Background

The Centers for Medicare & Medicaid Services (CMS) Health Insurance Claim Form (CMS-1500) is the basic form prescribed by CMS for the submission of claims from physicians and suppliers for the Medicare program. It is used by non-institutional providers and suppliers to bill Medicare Part B covered services and it is also used for billing some Medicaid covered services. It answers the needs of many health insurers and is the basic form prescribed by CMS for the submission of claims on behalf of Medicare patients. (However, please note that the CMS-1500 paper form is superceded by HIPAA electronic formats.)

Because of the multiple requests in Open Door Forums and correspondence, CMS is issuing this instruction to clarify and standardize the method of indicating the ordering and supervising professionals on the CMS-1500.

The Preamble of the Proposed Rule for the Medicare Physician Fee Schedule on November 1, 2001 (66 Fed Reg. 55267) stated "the billing number of the ordering physician (or other practitioner) should not be used if that person did not directly supervise the auxiliary personnel." This instruction incorporates the rule into the CMS Claims Processing Manual.

The update to the Medicare Claims Processing Manual (Pub 100-4) (referred to in the Web link below) further clarifies where physician's Provider Information Numbers and names should be reported when both an ordering provider and a supervising provider are involved in a service.

Implementation

The implementation date is May 24, 2004.

Additional Information

The CMS Manuals Index can be found at the following CMS Web site:
http://www.cms.hhs.gov/manuals/cmsindex.asp

Also, the Medicare Claims Processing Manual (Pub 100-4) which was revised can be found at:
http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp.

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

From that Web page, look for CR3138 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp

If you need to contact your Medicaid State Agency for more details, a list of toll-free telephone numbers exists for each Medicaid State Agency at: *http://www.cms.hhs.gov/medicaid/tollfree.pdf*

Related Change Request (CR) #: 3138
Medlearn Matters Number: MM3138
Related CR Release Date: April 23, 2004
Related CR Transmittal #: 148
Effective Date: May 24, 2004
Implementation Date: May 24, 2004

Proper Use of Modifiers 22, 52, 53, 73, and 74

The purpose of this article is to clarify the use of modifiers 22 and 52, as well as commonly misused modifiers 53, 73, and 74.

Modifier	Definition
22	***Unusual procedural services:*** When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by appending modifier 22 to the procedure code. The use of modifier 22 *may* result in additional payment. Medical documentation indicating the unusual circumstance must be provided upon request (the biller must provide a concise statement about how the service differs from the usual, to include an operative report and other appropriate documentation). If documentation is not returned, the service will be reimbursed according to the fee schedule. **Note:** This modifier is only acceptable for procedures with 0, 10, or 90 global surgery follow-up days.
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 modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Medical documentation explaining the reduced service(s) must be provided upon request (the biller must provide a concise statement about how the service differs from the usual, to include an operative report or diagnostic procedure report, and other appropriate documentation). If documentation is not returned, the service will be denied. **Note**: Do not bill this modifier with evaluation and management (E/M) services. Instead, a lower level E/M service should be billed. For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstance or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers "73" and "74". (see modifiers approved for ASC hospital outpatient use). This modifier should not be confused with the 53 modifier, which is used for discontinued services.
53	***Discontinued services:*** Under certain circumstances, the physician or nonphysician practitioner may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those circumstances that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Medical documentation (to include an operative report or diagnostic procedure report, and other appropriate documentation) must be provided upon request. If documentation is not returned, the service will be denied. This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. **Note: do not use modifier 53 to identify a terminated ambulatory surgery center (ASC) facility service.** For outpatient hospital/ASC reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.
73	***Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia:*** 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). Under these circumstances, the intended service that is prepared for but canceled can be reported by its usual procedure number and the addition of modifier 73. Medicare will generally allow 50 percent of the appropriate ASC facility rate in these cases. The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53. **Note**: modifier 73 is only intended for use by the ASC facility. Physicians should not bill this modifier.
74	***Discontinued Outpatient Hospital/ Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia:*** 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). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier "74". . Medicare will generally allow the full ASC facility reimbursement in these cases, since the resources of the facility are consumed in essentially the same manner and to the same extent as they would have been had the surgery been completed. In either case, however, if

the procedure involved would have used an intraocular lens implant (IOL), the allowance for the unused IOL will be deducted from the ASC facility rate prior to reimbursement. The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

Note: modifier 74 is only intended for use by the ASC facility. Physicians should not bill this modifier.

Connecticut Only

Incorrect information regarding modifiers 73 and 74 was communicated in the January 2003 *Medicare B Update! Special Issue – Conversion to Medicare's Multi-Carrier System*. We erroneously reported that these modifiers were deleted. This is not the case; ASCs should follow the instructions in the preceding table pertaining to modifiers 73 and 74. Modifier 53 may not be used by ASCs.

Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 10.2, Effective July 1, 2004

Provider Types Affected

Physicians

Provider Action Needed

This is a reminder for physicians to take note of the quarterly updates to the coding initiatives. The next round of Correct Coding Initiative (CCI) edits will be effective on July 1, 2004.

Physicians can find the current CCI edits and the current Mutually Exclusive Code (MEC) Edits on the Centers for Medicare & Medicaid Services (CMS) Web site at: *http://www.cms.hhs.gov/physicians/cciedits*

The Web site will be updated with the Version 10.2 edits as soon as they are effective.

Background

The National Correct Coding Initiative developed by CMS helps to promote national correct coding methodologies and controls improper coding. The coding policies developed are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

The latest package of CCI edits, Version 10.2, is effective on July 1, 2004.

This version will include all previous versions and updates from January 1, 1996 to the present and will be organized in two tables: Column 1/Column 2 Correct Coding Edits and MEC Edits.

Additional Information

The CCI and MEC files will be maintained in the Internet Only Manual, Chapter 23, Section 20.9 which can be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*

Related Change Request (CR) #: 3244	Medlearn Matters Number: MM3244
Related CR Release Date: April 30, 2004	Related CR Transmittal #:150
Effective Date: July 1, 2004	Implementation Date: July 6, 2004

SG Modifier with Prosthetic Devices

ASCs are encouraged to bill for prosthetic devices on the same claim as the covered facility fee code. These codes **DO NOT** require the use of the SG modifier. When billing for prosthetic devices that require the submission of an invoice (e.g., HCPCS codes A4301, V2785, and V2790), ASCs may submit the charges for the facility fees electronically.

Patient Liability for CCI Claim Denials

CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment on Part B claims. The purpose of the NCCI edits is to ensure the most comprehensive groups of codes are billed rather than the component parts. NCCI edits also check for mutually exclusive code pairs.

If a procedure denies because of a NCCI edit, the patient is NOT liable for the charge. The provider may only bill a Medicare beneficiary for the comprehensive service. NCCI denials are not denials based on statutory exclusions or medical necessity; they are coding denials. Therefore, neither an Advance Beneficiary Notice (ABN) nor a Notice of Exclusions for Medicare Benefits (NEMB) can be used for NCCI denials.

Additional information on the NCCI edits is posted at *http://www.cms.hhs.gov/physicians/cciedits/default.asp*.

COVERAGE/REIMBURSEMENT

MEDICARE PHYSICIAN FEE SCHEDULE

Correction to the Second Update to the 2004 Medicare Physician Fee Schedule Database—Connecticut Only

This instruction corrects the allowance for procedure 88358 26 published in the *Medicare B Update!* Special Issue (page 4). The correct allowances for this procedure code/modifier are:

CODE/MOD	PAR	NPAR	L Chg
88358 26	59.55	56.57	65.06

AMBULANCE

Ambulance Fee Schedule – MMA Section 414

Note: This is a re-release of this article to reflect the changes made in the re-release of the CR3099. The changes are shown in this article are bold and italicized.

Providers Affected

All Ambulance services including volunteer, municipal, private, independent, and institutional providers such as hospitals, critical access hospitals and skilled nursing facilities.

Provider Action Needed

STOP– Impact to You

The new Medicare Prescription Drug, Improvements, and Modernization Act of 2003 (MMA) makes a number of important changes to Medicare payment for ambulance services rendered on or after July 1, 2004.

CAUTION – What You Need to Know

During the five – year period, July 1, 2004 – December 31, 2009 Fee Schedule will include certain temporary increases in payment.

GO – What You Need to Do

Make sure your billing staff understands the new changes and bill according to those changes to assure receipt of accurate payment.

Background

The MMA provides several changes to the payment for ground ambulance services under Section 414 of the Act. Specifically, this section establishes a floor amount for the fee schedule portion of the payment, provides increased payments for urban and rural services, adds an increased payment for ambulance transports originating in certain low density population areas, and provides a 25 percent bonus on the mileage rate for ground transports of 51 miles or greater. These payment changes apply to ground transports only and the air ambulance base and mileage rates remain unchanged. ***All increases are percentage increases and are cumulative.***

More details on these changes are as follows:

Year	National FS Percentage	Regional FS Percentage
7/1/04 - 12/31/04	20%	80%
CY 2005	40%	60%
CY 2006	60%	40%
CY 2007 – CY 2009	80%	20%
CY 2010 and thereafter	100%	0%

Regional Ambulance FS Payment Rate Floor for Ground Ambulance Transports

To discuss these changes further, we begin with the provision regarding the regional ambulance fee Schedule (FS) payment rate floor for ground transport services. For services furnished during the period of July 1, 2004, through December 31, 2009, the base rate portion of the payment under the ambulance FS for ground transports is subject to a minimum amount. This minimum depends upon the area of the country in which the service is furnished.

Basically, the country is divided into 9 census divisions and each of those divisions has a regional FS that is constructed using the same methodology as the national FS. Where the regional FS is greater than the national FS, the base rates for ground ambulance transports are determined by a blend of the national FS rate and the regional rate in accordance with the following schedule:

Where the regional rate is not greater than the national rate, there is no blending and only the national FS amount applies.

Adjustment to the Ground Mileage Payment Amount for Miles Greater than 50

For services furnished during the period July 1, 2004 through December 31, 2008, a 25 percent increase is applied to the appropriate ambulance FS mileage rate for each mile of a transport (both urban and rural points of pickup (POP) that exceeds 50 miles (i.e., 51 miles or greater) when the beneficiary is onboard the ambulance.

The 50 percent increase applied to the rural ambulance FS mileage rate for the first 17 miles of a rural point of pickup (POP) continues to apply as it always has under the FS.

For services furnished during the period January 1, 2004 through June 30, 2004, for all ground miles greater than 17 miles, the FS rate equals the urban mileage rate per mile.

Adjustments for FS Payment Rate for Certain Rural Ground Ambulance Transports

For services furnished during the period July 1, 2004 through December 31, 2009, ***there is a 22.6 percent increase in the FS portion of the base payment for ground ambulance services in low population density rural areas. This increase applies where the POP is in a rural county (or Goldsmith Area) that is comprised by the lowest quartile by population of all such rural areas arrayed by population density. These rural areas are identified by a zip code with a "B" indicator on the national zip code file.***

Adjustments for FS Payment Rates for Ground Ambulance Transports

The payment rates under the FS for ground ambulance transports (both the FS base rates and the mileage amounts) are increased for services furnished during the period of July 1, 2004, through December 31, 2006. For services furnished where the POP is urban, the rates are increased by 1 percent and for services furnished where the POP is rural, the rates are increased by 2 percent.

The following chart summarizes the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 payment changes for ground ambulance services that becomes effective on July 1, 2004. This chart will give you the increase percentage on miles, along with the effective dates of service.

	Effective Dates	Payment Increase*
All rural miles	7/1/04 - 12/31/06	2%
Rural miles 51+	7/1/04 - 12/31/08	25%**
All urban miles	7/1/04 - 12/31/06	1%
Urban miles 51+	7/1/04 - 12/31/08	25% **
All rural base rates	7/1/04 - 12/31/06	2%
Rural base rates (lowest quartile)	7/1/04 - 12/31/09	*22.6%***
All urban base rates	7/1/04 - 12/31/06	1%
All base rates (regional fee schedule blend)	7/1/04 - 12/31/09	Floor

Note: * All payments are percentage increases and all are cumulative.

*****Carrier/intermediary systems perform this calculation. All other increases are incorporated into the Medicare Ambulance FS file. However, carriers and intermediaries will continue to apply the applicable FS and reasonable charge/cost blended percentages to determine the payment rates through December 31, 2005, in accordance with the rules of the transition period.***

Important Dates

These changes will sunset on different dates but all apply beginning with services furnished on July 1, 2004.

Additional Information

Reimbursement for ambulance services will be based on two ***blended amounts. First, the FS portion of the payment is based on a blend of the national and regional FS amounts. Second, the FS portion is then blended with the reasonable charge/reasonable cost portion during the transition period.***

For further information, you may wish to view the actual re-released instruction issued to your Medicare contractor. That instruction can be seen at: *http://www.cms.hhs.gov/manuals/pm_trans/R220CP.pdf*

Revised Connecticut Ambulance Fee Schedule Amounts Effective July 1, 2004:

Procedure	Urban	Rural
A0425	5.71	5.76
A0426	291.89	294.78
A0427	462.15	466.73
A0428	243.24	245.65
A0429	389.18	393.03
A0430	2575.46	3863.19
A0431	2994.35	4491.52
A0432	425.67	429.88
A0433	668.9	675.53
A0434	790.52	798.35
A0435	6.78	10.17
A0436	18.07	27.11
Q3019	389.18	393.03
Q3020	243.24	245.65

Revised Florida Ambulance Fee Schedule Amounts Effective July 1, 2004:

	Loc 01/02		Loc 03		Loc 04	
Procedure	Urban	Rural	Urban	Rural	Urban	Rural
A0425	5.71	5.76	5.71	5.76	5.71	5.76
A0426	205.30	207.33	216.05	218.19	221.13	223.32
A0427	325.05	328.27	342.08	345.46	350.12	353.58
A0428	171.08	172.77	180.04	181.82	184.27	186.10
A0429	273.73	276.44	288.07	290.92	294.84	297.75
A0430	2324.60	3486.91	2410.61	3615.92	2451.23	3676.84
A0431	2702.69	4054.04	2802.69	4204.03	2849.91	4274.86
A0432	299.39	302.35	315.07	318.19	322.48	325.67
A0433	470.47	475.13	495.11	500.01	506.75	511.77
A0434	556.01	561.51	585.13	590.93	598.89	604.81
A0435	6.78	10.17	6.78	10.17	6.78	10.17
A0436	18.07	27.11	18.07	27.11	18.07	27.11

Source: CMS Pub. 100-04, Transmittal 220, CR 3099, MM3099

Ambulance Reminders

Mandatory Assignment and Beneficiary Signature Requirements

When an ambulance provider/supplier, or a third party under contract with the provider/supplier, furnishes a Medicare-covered ambulance service to a Medicare beneficiary and the service is not statutorily excluded under the particular circumstances, the provider/supplier must submit a claim to Medicare and accept assignment of the beneficiary's right to payment from Medicare.

Medicare requires the signature of the beneficiary, or that of his/her representative, for both the purpose of accepting assignment and submitting a claim to Medicare. If the beneficiary is unable to sign because of a mental or physical condition, a representative payee, relative, friend, representative of the institution providing care, or a government agency providing assistance may sign on his/ her behalf. A provider/supplier (or his/her employee) cannot request payment for services furnished except under circumstances fully documented to show that the beneficiary is unable to sign and that there is no other person who could sign.

Medicare does not require that the signature to authorize claim submission be obtained at the time of transport for the purpose of accepting assignment of Medicare payment for ambulance benefits. When a provider is unable to obtain the signature of the beneficiary, or that of his/her representative, at the time of transport, the provider may obtain this signature any time prior to submitting the claim to Medicare for payment. (Per 42 CFR section 424.44, there is a 15 to 27 month period for filing a Medicare claim.) If the beneficiary/representative refuses to authorize the submission of a claim, including a refusal to furnish an authorizing signature, then the ambulance provider/supplier may not bill Medicare, but may bill the beneficiary (or his/ her estate) for the full charge of the ambulance items and services furnished. If, after seeing this bill, the beneficiary/ representative decides to have Medicare pay for these items and services, then a beneficiary/representative signature is required and the ambulance provider/supplier must afford the beneficiary/representative this option within the claims filing period.

Point of Pickup ZIP Code Determines Fee Schedule Amounts

The point of pickup determines the basis for payment under the fee schedule, and the point of pickup is reported by its five-digit ZIP code. Thus, the ZIP code of the point of pickup determines both the applicable locality fee schedule amount, and whether a rural adjustment applies. If the ambulance transport requires a second or subsequent leg, then the ZIP code of the point of pickup of the second or subsequent leg determines both the applicable fee for such leg and whether a rural adjustment applies.

Accordingly, the ZIP code of the point of pickup must be reported on every claim to determine both the correct fee schedule amount and, if applicable, any rural adjustment.

Change to the Skilled Nursing Facility Consolidated Billing Edits for Ambulance Transports to and from a Diagnostic or Therapeutic Site other than a Hospital

Provider Types Affected

Skilled Nursing Facilities (SNF) and suppliers of ambulance services.

Provider Action Needed

STOP – Impact to You

Your claim will be denied for ambulance transportation of a Medicare beneficiary in a Part A SNF stay to or from a diagnostic or therapeutic center other than a hospital.

CAUTION – What You Need to Know

Ambulance transports of beneficiaries in Part A SNF stays are considered to be paid as part of the SNF PPS rate, and may not be billed as Part B services to the carrier, except in specific instances. Effective October 1, 2004, your carrier has been instructed to deny your Part B claims for ambulance transports of your Medicare Part A residents to or from a diagnostic or therapeutic site other than a hospital (e.g., a non-hospital setting, such as an IDTF, or a freestanding cancer center, radiation therapy center, or wound care center).

GO – What You Need to Do

Make sure your billing staff are aware that, for beneficiaries in a Part A stay, a separate Part B claim for the ambulance transport of Medicare Part A residents to or from a diagnostic or therapeutic center other than a hospital will be denied.

Background

Section 4432(b) of the Balanced Budget Act (BBA) requires consolidating billing (CB) for SNFs. Under the CB requirement, the SNF must submit all Medicare claims for all the services its residents receive under Part A (except for certain excluded services). In addition, the SNF must also submit Medicare claims for all physical and occupational therapies, and speech-language pathology services its residents receive under Part B.

All Medicare-covered Part A services that are deemed to be within a SNF's scope or capability are considered paid in the SNF PPS rate. As mentioned above, ambulance transports to or from diagnostic or therapeutic sites other than a hospital are considered paid in the SNF PPS rate and may **not** be billed as Part B services to the carrier.

In addition, please note that transport of beneficiaries in Part A stays from one SNF to another before midnight of the same day is also included in the SNF PPS rate and may **not** be billed separately as a Part B service. In this instance, payment is bundled in the first SNF's PPS rate and it is responsible for the costs of the transport.

Please note that this change does not replace existing CB policies as they relate to Critical Access Hospitals (CAHs) and End-Stage Renal Disease (ESRD) facilities.

Additional Information

You can find additional material related to this CR on the CMS Web site at:
http://www.cms.hhs.gov/manuals/transmittals/cr_num_dsc.asp

From that Web page, look for 3196 in the CR NUM column on the right, and click on the file for that CR. Attached to that CR, you can find the revised Medicare manual pages for the Medicare Claims Processing Manual (Publication 100-4), Chapter 6, Section 20.3.1 – Ambulance Services, and Chapter 15, Section 30.2.3 – SNF Billing. These pages will provide further detail on this issue.

Related Change Request (CR) #: 3196
Medlearn Matters Number: MM3196
Related CR Release Date: April 30, 2004
Related CR Transmittal #: 163
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

ANESTHESIA

Clarification of Change Request 2631

Provider Types Affected

All physicians, non-physician practitioners, and suppliers billing for services paid under the Medicare physician fee schedule and for anesthesia services.

Provider Action Needed

On August 1, 2003, the Centers for Medicare & Medicaid Services (CMS) released Change Request (CR) 2631 to enforce the carrier jurisdiction rules effective for claims with dates of service on or after April 1, 2004. The CR has resulted in some confusion and has generated a number of calls to carrier call centers. This article provides some further clarification and, hopefully, will eliminate the confusion.

Background

Medicare carriers process Part B fee-for-service claims for covered services furnished in specific geographic areas (e.g., Florida). Services paid under the Medicare Physician Fee Schedule (MPFS) and anesthesia services are paid by the Medicare carrier with jurisdiction over the geographical area where the services are furnished. Jurisdiction is based on the zip code of the area where the service was rendered.

Physicians, suppliers, and group practices that provide physician fee schedule services at more than one office/practice location may submit their claims through one office to the carrier for processing. However, the ***specific location where the services are provided*** must be entered on the claim so that the correct jurisdiction and correct MPFS amount can be applied to the claim.

Effective for claims with dates of service on or after April 1, 2004, this applies to all **places of service (POS**) except "home." For POS "home," the Medicare carriers will use the beneficiary address on file to determine geographical payment.

Electronic Claims

As reflected in the implementation guide of the 4010/4010A1 version of the ASC X12N 837 electronic claims format, it is acceptable for claims to contain the code for POS home and any number of additional POS codes. If different POS codes are used for services on the claim, a corresponding service facility location and address must be entered for each service at the line level, if that location is different from the billing provider, the pay-to provider, or claim level service facility location.

Refer to the current implementation guide of the ASC X12N 837 to determine how information must be entered on a claim.

The following information is based on the implementation guide:

- On version 4010/4010A of the ASC X12N 837 electronic claim format, the Billing Provider loop 2010AA is required and must always be entered. If the Pay-To Provider Name and Address loop 2010AB is the same as the Billing Provider, ***only*** the Billing Provider must be entered. If no Pay-To Provider Name and Address is entered in loop 2010AB, and the Service Facility Location loop 2310D (claim level) or 2420C (line level) is the same as the Billing Provider, then only the Billing Provider must be entered.
- If the Pay-To Provider Name and Address loop 2010AB is ***not*** the same as the Billing Provider, ***both*** must be entered. If the Service Facility Location loop 2310D is not the same as the Billing Provider or the Pay-To Provider, the Service Facility Location loop 2310D (claim level) must be entered.
- When the same POS code and same service location address is applicable to each service line on the claim, the service facility location name and address must be entered at the claim level loop 2310D.
- If the POS code is the same for all services, but the services were provided at different addresses, each service must be submitted with line-level information. This will provide a zip code to price each service on the claim.

Paper Claims Submitted on the Form CMS-1500

It is acceptable for claims to contain POS "home" and an additional POS code. No service address for POS "home" needs to be entered in Item 32 in this situation because the address will be drawn from the beneficiary file and the information on the claim will apply to the other POS.

The specific name, address, and zip code of the location where the services were furnished must be entered on the claim in Item 32. **This applies even if the place of service is "office."** The zip code of the address entered in Item 32 will be used to price the claim.

For carriers to be able to correctly determine where services were provided and pay correct locality rates, no more than one name, address, and zip code may be entered in Item 32 of the Form CMS-1500. Assigned claims with more than one address entered in Item 32 will be rejected and unassigned claims will be denied.

If POS "home" and more than one additional POS code is entered, assigned claims will be rejected and unassigned claims will be denied.

Physicians, non-physician practitioners, and suppliers that have had claims rejected or denied must resubmit the claims with the correct information entered in Item 32 in order to have the claims considered for payment.

Additional Information

To view CR2631, go to: *http://www.cms.hhs.gov/manuals/pm_trans/R169CP.pdf*

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0429
Implementation Date: N/A

CHIROPRACTIC

New Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy

Provider Types Affected

Chiropractic care providers.

Provider Action Needed

STOP – Impact to You

Chiropractors have been submitting a very high rate of incorrect claims to Medicare. Medicare only pays for chiropractic services for active/corrective treatment (those using HCPCS codes 98940, 98941, or 98942). Claims for medically necessary services rendered on or after October 1, 2004, must contain the Acute Treatment (AT) modifier to reflect such services provided or the claim will be denied.

CAUTION – What You Need to Know

On or after October 1, 2004, when you provide acute or chronic active/corrective treatment to Medicare patients, you must add the AT modifier to every one of your claims that use HCPCS codes 98940, 98941, or 98942. If you don't add this modifier, your care will be considered maintenance therapy and will be denied because maintenance chiropractic therapy is not medically reasonable or necessary under Medicare. Additionally, your billing staff should be aware of any local policy (LMRP/LCD) for these services in your area that might limit the frequency or circumstances under which active/corrective chiropractic can be paid. If you exceed that limit, you shall not use the AT modifier.

GO – What You Need to Do

Make sure that your billing staff are aware that they must apply the AT modifier to HCPCS codes 98940, 98941, or 98942 when your clinical documentation reflects that the care you provided to a Medicare patient consists of active/corrective treatment.

Background

Chapter 15, Section 30.5 of the Benefits Policy Manual states that chiropractic maintenance therapy is not medically reasonable or necessary, and is not payable under the Medicare program. Further, Medicare data indicates that chiropractors file claims incorrectly almost a third of the time, ranking chiropractor claims among the highest Provider Compliance Error Rates in Medicare. To bill Medicare correctly, use the AT modifier for each claim you submit that is for active/corrective therapy. For services rendered on or after October 1, 2004, all of your claims for active/corrective therapy (HCPCS codes 98940, 98941, 98942) that do not contain the AT modifier will be denied. Claims above your contractors' frequency limits must be billed without the AT modifier (you may still add the GA or GZ modifier as appropriate), and will be denied.

Important Dates to Know

Effective Date: October 1, 2004
Implementation Date: October 4, 2004

Related Instructions

For more information about using the AT modifier, consult Chapter 15, Section 30.5 and 240.1.3 of the Benefits Policy Manual. In early October, you can access Chapter 15 at:

http://www.cms.hhs.gov/manuals/102_policy/bp102c15.pdf.

You can view this instruction before then at:

http://www.cms.hhs.gov/manuals/future.asp

Also, you may check any LMRP/LCDs that may apply to you at:

http://www.cms.hhs.gov/mcd.

Related Change Release (CR) #: 3063 Medlearn Matters Number: MM3063
Related CR Release Date: May 28, 2004 Related CR Transmittal #: 12
Effective Date: October 1, 2004 Implementation Date: October 4, 2004

Referral of Patients for X-rays by Chiropractors

Provider Types Affected

Chiropractic providers

Provider Action Needed

STOP – Impact to You

If you order an X-ray in the course of treating a Medicare beneficiary, the provider who takes and/or interprets it for you may not be reimbursed. However, chiropractors are no longer required to obtain x-rays prior to initiating treatment.

CAUTION – What You Need to Know

Even if the laws of your state permit you to order X-rays, any that you use in the treatment of a Medicare beneficiary must be ordered by a physician **who is a doctor of medicine or osteopathy**. Not having a physician order the X-ray may result in lack of reimbursement.

Note: A "plain" X-ray may be ordered by any physician. It is the only exception to the requirement that all diagnostic tests must be ordered by the beneficiary's treating physician.

GO – What You Need to Do

Make certain that a physician orders any X-rays that you use in treating Medicare beneficiaries.

Background

A chiropractor, licensed or legally authorized by the state or jurisdiction of service, may provide treatment only in the form of manual spinal manipulation to correct a subluxation (provided such treatment is legal in the state where it is performed). Specifically, Medicare defines chiropractors, based on §18601(r) of the Act, as physicians with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to perform by the state or jurisdiction in which treatment is provided.

This article addresses ordering of X-rays for your patients. When you treat Medicare beneficiaries you don't have to obtain X-rays prior to initiating treatment, since treatment based upon clinical evaluation alone is a covered service. But if you do use an X-ray in a patient's treatment, you must have a physician who is a doctor of medicine or osteopathy order it.

Why? Because as with all diagnostic tests for beneficiaries, Medicare regulations require that X-rays be ordered by a physician. Further, except for X-rays, diagnostic tests must be ordered by the physician actually treating the patient's specified condition at the time. To this point, Medicare considers tests not ordered by the beneficiary's treating physician to be neither reasonable nor necessary.

The specific regulatory language from the regulation (42 CFR 410.32(a)) states as follows:

> (a) Ordering diagnostic tests. All diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary.

Note: The only exception to this "treating physician" rule is the plain X-ray. Medicare does allow a physician other than the one actually treating the beneficiary for the disorder of the spine (such as the radiologist or beneficiary's primary care physician) to order an X-ray to be used by a chiropractor for patient treatment.

In the regulation at 42 CFR 410.32(a)(1), this exception is mentioned as follows:

> (1) Chiropractic exception. A physician may order an x-ray to be used by a chiropractor to demonstrate the subluxation of the spine that is the basis for a beneficiary to receive manual manipulation treatments even though the physician does not treat the beneficiary.

The thing to remember is that even though the laws in your state might permit you to order X-rays and other services or tests, Medicare providers may not be reimbursed for performing them from your order. Specifically, Medicare may not reimburse for X-rays that you order, regardless of the qualifications or status of the provider who takes and interprets it for you.

To ensure that all providers are reimbursed for X-rays that you use in patient care, you should refer the beneficiary to a radiologist, or other physician, who would then order the X-ray. The physician would enter his own name and UPIN on the claim as the ordering physician and referring UPIN.

The documentation for the X-ray should be maintained by that physician, in the beneficiary's medical records. Documentation might consist of a written referral from you that includes:

- The X-ray test requested;
- A summary of the patient's complaints including symptoms and location of pain, and other relevant findings;
- A summary of your findings on physical examination;
- A diagnosis and level of spine involvement; and
- The name and address of a primary care physician, if any, to whom a copy of the report may be sent as a courtesy (this must be authorized by the beneficiary). This provider may not be indicated as the ordering provider for the x-ray(s) on the submitted claim, unless there is an actual written order for the test from him/her.

Additional Information

You can find more information about the use of X-rays in your practice from the Internet Only Manual, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services, Section 240.1.1-Manual Manipulation Chiropractic Services, which you can find online at:
http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp

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

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0416
Effective Date: N/A This article is informational only.

DIAGNOSTIC TESTS

NCD: Sensory Nerve Conduction Threshold Test (sNCTs)

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed

This instruction reaffirms the existing Medicare noncoverage policy on any type of Sensory Nerve Conduction Threshold Test (sNCT), and the device(s) used to perform the test, to diagnose sensory neuropathies or radiculopathies. This instruction constitutes a technical correction to previously issued Change Request (CR) 2988, and CR2988 should be discarded and replaced with this instruction. CR2988 was issued on March 19, 2004.

Background

As a result of reconsideration, this instruction reaffirms the existing Medicare noncoverage policy on any type of sNCT, and the device(s) used to perform the test, to diagnose sensory neuropathies or radiculopathies.

The revision to Section 160.23 of Pub. 100-03 is a National Coverage Determination (NCD), and NCDs are binding on all Medicare carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans. Under 42 CFR 422.256(b), an NCD that expands coverage is also binding on a Medicare Advantage Organizations. In addition, an administrative law judge may not review an NCD. (See the Social Security Act, Section 1869(f)(1)(A)(i))

Note that this instruction constitutes a technical correction to previously issued CR 2988. CR2988 should be discarded and replaced with this instruction.

Implementation

The implementation date is April 1, 2004.

Related Instructions

The updated manual instructions are also included in the official instruction issued to your carrier, and it can be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

From that Web site, look for CR3339 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp.*

Additional Information

The following is the revision to the Medicare National Coverage Determinations Manual, Pub. 100-03,

Chapter 1 (Coverage Determinations), Section 160 (Nervous System), Subsection 160.23 (Sensory Nerve Conduction Threshold Tests (sNCTs). Revised sections are ***bolded and italicized***.

Medicare National Coverage Determinations Manual
Chapter 1 - Coverage Determinations
160 - Nervous System
160.23 - Sensory Nerve Conduction Threshold Tests (sNCTs)
160.23 - *Sensory Nerve Conduction Threshold Tests (sNCTs)*

A. General

sNCT is a psychophysical assessment of both central and peripheral nerve functions. It measures the detection threshold of accurately calibrated sensory stimuli. This procedure is intended to evaluate and quantify function in both large and small caliber fibers for the purpose of detecting neurologic disease. Sensory perception and threshold detection are dependent on the integrity of both the peripheral sensory apparatus and peripheral-central sensory pathways. In theory, an abnormality detected by this procedure may signal dysfunction anywhere in the sensory pathway from the receptors, the sensory tracts, the primary sensory cortex, to the association cortex.

This procedure is different and distinct from assessment of nerve conduction velocity, amplitude, and latency. It is also different from short-latency somatosensory evoked potentials.

Effective October 1, 2002, CMS initially concluded that there was insufficient scientific or clinical evidence to consider the sNCT test and the device used in performing this test reasonable and necessary within the meaning of section 1862(a)(1)(A) of the law.

Therefore, sNCT was noncovered.

Effective April 1, 2004, based on a reconsideration of current Medicare policy for sNCT, CMS concludes that ***the use of any type of sNCT device (e.g. "current output" type device used to perform current perception threshold (CPT), pain perception threshold (PPT), or pain tolerance threshold (PTT) testing or "voltage input" type device used for voltagenerve conduction threshold (v-NCT) testing) to diagnose sensory neuropathies or radiculopathies in Medicare beneficiaries is not reasonable and necessary.***

B. Nationally Covered Indications

Not applicable.

C. Nationally Noncovered Indications

All uses of sNCT to diagnose sensory neuropathies or radiculopathies are noncovered.

(This NCD last reviewed ***June*** 2004.)

Related Change Request (CR) #: 3339
Medlearn Matters Number: MM3339
Related CR Release Date: June 18, 2004
Related CR Transmittal #: 15
Effective Date: April 1, 2004
Implementation Date: April 1, 2004

DURABLE MEDICAL EQUIPMENT

Most claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are processed by the durable medical equipment regional carriers (DMERCs). The DMERC that serves Connecticut is HealthNow (http://www.umd.nycpic.com); for Florida, the DMERC is Palmetto Government Benefits Administrators (http://www.palmettogba.com). The article that follows is intended to provide information to those providers who bill to the DMERC as well as to local carriers.

Clarification for Billing Left Ventricular Assist Devices

Provider Types Affected

All providers who bill Medicare for Left Ventricular Assist Systems (LVAS) and the medically necessary supplies and replacement accessories.

Provider Action Needed

STOP – Impact to You

Manufacturer(s) may have erroneously suggested that the Centers for Medicare & Medicaid Services (CMS) instructions on page 8 of Program Memorandum AB-02-152 allow providers to bring a recently discharged patient back for an outpatient visit to replace the Left Ventricular Assist Device (LVAD) equipment that was furnished under Part A in order to receive extra payment under Part B.

CAUTION – What You Need to Know

This erroneous suggestion may lead hospitals to believe that they can get extra Part B payment for the LVAD equipment in cases where the replacement or supplies are not medically necessary.

GO – What You Need to Do

Please note that Medicare payment is made under Part B for additional **medically necessary** supplies and replacement accessories required after the patient has been discharged from the hospital. Cases without medical need for replacement would be considered double billing. Please also refer to the *Background* section below.

Background

The program memorandum described in CR 2378 contains instructions regarding payment for the Left Ventricular Assist System (LVAS) or Left Ventricular Assist Device (LVAD) (page 8 of AB-02-152).

The LVAS is implanted in an inpatient setting and Medicare payment is made under Part A for:

- Hospital inpatient services; and
- Supplies and all necessary accessories for the LVAS (provided in the inpatient setting).

Medicare payment is made under Part B for additional ***medically necessary*** supplies and replacement accessories required after the patient has been discharged from the hospital.

Claims for replacement of supplies and accessories used with the LVAS that are furnished by suppliers should be billed to the local carriers. Claims for replacement of supplies and accessories that are furnished by hospitals should be billed to the intermediary. It is the responsibility of the local carrier or intermediary to determine whether the replacement supplies and accessories can be covered and to provide instructions, as needed, on how often these items can be replaced.

Manufacturer(s) may have erroneously suggested that CMS instructions in AB-02-152 allow providers to bring a recently discharged patient back for an outpatient visit to replace the LVAD equipment that was furnished under Part A in order to receive extra payment under Part B. This erroneous suggestion may lead hospitals to believe that they can get extra Part B payment in cases where the replacement or supplies are not medically necessary.

CMS reminds providers, suppliers, and Medicare intermediaries and carriers that payment under Part B can only be made for replacement of components and accessories that are reasonable and necessary.

If the intermediary or carrier gets claims for replacement of items within a relatively short period of time following discharge from the hospital, they will be aware that this may just be an attempt to obtain additional reimbursement for the LVAD under Part B (in those cases where there is not a true replacement need).

For example, the batteries or power sources for these devices require periodic replacement. The manufacturers have indicated that these items should last approximately 6 months to a year, depending on the brand of device. Therefore, it would not be reasonable and necessary to replace these items anytime before these minimum, expected product lifetimes have expired. For other components and accessories, the product lifetimes will be even longer. Cases without medical need for replacement would be considered double billing.

Additional Information

To view page 8 of the program memorandum AB-02-152, visit:
http://www.cms.hhs.gov/manuals/pm_trans/AB02152.pdf
Related Change Request (CR) #: 2378
Medlearn Matters Number: SE0424
Implementation Date: N/A

DRUGS AND BIOLOGICALS

MMA - Medicare Replacement Drug Demonstration

Provider Types Affected

All Medicare physicians and providers.

Provider Action Needed

STOP – Impact to You

A new demonstration mandated under Section 641 of the Medicare Modernization Act lets up to 50,000 people with Medicare who have certain life-threatening diseases obtain specified drugs they can take themselves at home for their condition.

CAUTION – What You Need to Know

A physician certification will need to be filled out for any of your patients who are interested in applying to participate in this demonstration. By signing this certification, you are certifying that the patient has the condition indicated and

you have prescribed, or intend to prescribe, a coverable drug for this condition in accordance with the demonstration requirements. Your signed certification is necessary for the patient's application to participate in the demonstration to be considered complete.

GO – What You Need to Do

Review the list below of coverable conditions and drugs available under this demonstration. If you have any patients you think might be interested and eligible to apply, let your patients know. If they have any questions about the demonstration, they can call a toll free number: 1-866-563-5386 (TTY number: 1-866-563-5387) or visit our Web site (www.medicare.gov) for more information or an application package. In addition, if any of your patients contact you about the demonstration and the required physician certification form, please complete the form in a timely manner. Enrollment in the demonstration is limited and all applications must be received by September 30, 2004, to be considered. Those who have submitted completed applications by August 16, 2004, may be eligible for coverage by September 1, 2004. An application is not considered complete without the physician certification form, so your prompt attention is appreciated.

Background

The Medicare Replacement Drug Demonstration is a time-limited Medicare demonstration that will cover certain drugs and biologicals that are prescribed as replacements for existing covered Medicare drugs and biologicals before Medicare's prescription drug program begins in 2006. This demonstration was authorized by Section 641 of the MMA.

The Centers for Medicare & Medicaid Services (CMS) has contracted with TrailBlazer Health Enterprises, a Medicare carrier, to assist in implementing the demonstration. TrailBlazer will manage the eligibility determination and enrollment process, as well as coordinate outreach efforts to beneficiary advocacy groups, physicians, and others interested in this demonstration. TrailBlazer has sub-contracted with AdvancePCS, a Caremark company, to administer the drug benefit.

Medicare realizes the important role drugs play in treating serious diseases.

When Medicare first began, drugs played a much smaller role in medical care. Only drugs that are administered in a physician's office have been covered under Medicare Part B. In recent years, many new medications have been developed that replace some of these drugs, allowing patients with serious and lifethreatening illnesses to take these drugs in their own home.

For a beneficiary to be eligible for this demonstration, he or she must meet the following criteria:

- The beneficiary must have Medicare Part A and Part B.
- Medicare must be the beneficiary's primary health insurance.
- The beneficiary must reside in one of the 50 states or the District of Columbia.
- The beneficiary must have a signed certification form from his or her doctor stating that he or she has prescribed or intends to prescribe for the beneficiary one of the covered medications for the specified condition.
- The beneficiary may not have any other insurance that has comprehensive drug coverage (such as Medicaid, an employer or union group health plan, or TRICARE) that would cover this medication.

The table below shows the drugs and conditions that will be covered under the demonstration.

Drugs Covered Under the Medicare Replacement Drug Demonstration

Demonstration Covered Indication	Drug/Biological—Compound Name (Brand Name)
Rheumatoid Arthritis	Adalimumab (Humira) Anakinra (Kineret) Etanercept (Enbrel)
Multiple Sclerosis	Glatiramer acetate (Copaxone) Interferon beta –1a (Rebif, Avonex) Interferon beta –1b (Betaseron)
Osteoporosis (patient must be homebound)	Calcitonin – nasal (Miacalcin – nasal)
Pulmonary Hypertension	Bosentan (Tracleer)
Secondary Hyperparathyroidism	Doxercalciferol (Hectoral)
Paget's Disease	Alendronate (Fosamax) Risedronate (Actonel)
Hepatitis C	Pegylated interferon alfa-2a (Pegasys) Pegylated interferon alfa-2b (PEG-Intron)
CMV Retinitis	Valcyte (Valganciclovir)
Anti-Cancer	
·Cutaneous T-cell Lymphoma ·Non-small cell lung cancer ·Epithelial ovarian cancer ·Chronic Myelogenous Leukemia ·GI Stromal Tumor ·Multiple Myeloma	Bexarotene (Targretin) Gefitinib (Iressa) Altretamine (Hexalen) Imatinib Mesylate (Gleevec) Imatinib Mesylate (Gleevec) Thalidomide (Thalomid)

Breast Cancer	Hormonal therapy
·Stage 2-4 only	Anastrozole (Arimidex) Exemestane (Aromasin) Letrozole (Femara) Tamoxifen (Nolvadex) Toremifene (Fareston)

For more information on this demonstration, please visit *http://www.medicare.gov* or call our toll free number: 1- 866-563-5386 (TTY number: 1-866-563-5387) between 8 am and 7:30 pm Eastern time, Monday – Friday.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0443
Effective Date: Immediately
Implementation Date: Immediately

Drug Pricing Update—Payment Limits for J7308 (Levulan Kerastick) and J9395 (Faslodex)

Provider Types Affected

Physicians, suppliers, and providers.

Provider Action Needed

STOP – Impact to You

New payment limits have been set for HCPCS drug codes J7308 (Levulan Kerastick) and J9395 (Faslodex) when these codes are not paid on a cost or prospective payment basis.

CAUTION – What You Need to Know

Medicare carriers are instructed to replace the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) payment limits for HCPCS drug codes J7308 (Levulan Kerastick) and J9395 (Faslodex) with the new rates listed in this instruction for dates of service on or after January 1, 2004.

GO – What You Need to Do

Be aware of the new payment limits for these two codes.

Background

This article informs providers that Medicare carriers will apply new payment limits for these HCPCS codes (J7308 [Levulan Kerastick] and J9395 [Faslodex]) for claims processed with dates of service on or after January 1, 2004 and on or before December 31, 2004.

From January 1, 2004, through December 31, 2004, the Medicare payment limits for the specific HCPCS drug codes listed below (that are not paid on a cost or prospective payment basis) apply.

HCPCS	Short Description	AWP%	2004 Payment Limit for Drug other than ESRD drugs separately billed by independent ESRD Facilities and drugs infused through DME)
J7308	Aminolevulinic acid hcl top	85	$111.47
J9395	Injection, Fulvestrant	85	$81.57

Note: The payment limits listed in the table above supercede the payment limits published in Change Request 3105 (Transmittal 75) dated January 30, 2004, only for these particular HCPCS drug codes for this time period. Also note that the absence or presence of an HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug.

Implementation

The implementation date for this instruction is July 25, 2004. The effective date of the change is January 1, 2004. However, Medicare contractors will not adjust any claims previously processed in order to apply these new payment limits unless the provider requests such an adjustment.

Related Change Request (CR) #: 3312
Related CR Release Date: June 25, 2004
Effective Date: January 1, 2004
Medlearn Matters Number: MM3312
Related CR Transmittal #: 90
Implementation Date: July 25, 2004

HCPCS Codes J1563 and J1564

Due to a coding error, procedure codes J1563 and J1564 may have been denied in error as non-covered when billed with ICD-9-CM code 042 (acute poliomyelitis). This coding error affected claims processed from May 28, 2004 through June 23, 2004.

Providers do not need to take any action. We have identified the impacted claims and will perform the necessary adjustments.

END-STAGE RENAL DISEASE (ESRD)

End Stage Renal Disease (ESRD) Reimbursement for Automated Multi-Channel Chemistry (AMCC) Tests

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed

Physicians, suppliers, and providers should note that this instruction expands the implementation of certain processing rules to all bill types for Automated Multi-Channel Chemistry (AMCC) Tests for End Stage Renal Disease (ESRD) beneficiaries.

Background

The Office of Inspector General (OIG) conducted several studies that identified Medicare payments for End Stage Renal Disease (ESRD) laboratory related services which were not being paid in compliance with Medicare payment policy.

In response to the payment vulnerabilities identified by the OIG, the claims processing instructions contained in the *Medicare Claims Processing Manual (Pub 100-04, Transmittal 79, Chapter 16, Section 40.6.1)* directed all contractors to implement changes to ensure that all ESRD laboratory claims are paid in accordance with Medicare payment policy.

This instruction expands the implementation of procedures for reimbursement of Automated Multi-Channel Chemistry (AMCC) Tests to all bill types for ESRD beneficiaries.

Implementation

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

Related Instructions

Medicare will apply the rules identified in the Medicare Claims Processing Manual, Pub 100-04, Chapter 16 (Laboratory Services from Independent Labs, Physicians, and Providers), Section 40.6.1 (Automated Multi- Channel Chemistry (AMCC) Tests for ESRD Beneficiaries - FIs) to all bill types for AMCC tests for ESRD beneficiaries. This chapter can be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*

An extract of Section 40.6.1 is included as follows:

40.6.1 – Automated Multi-Channel Chemistry (AMCC) Tests for ESRD Beneficiaries - FIs

This section will be updated Jul 04 – Visit *http://www.cms.hhs.gov/manuals/pm_trans/R79CP.pdf* to view updated section.

(Rev. 1, 10-01-03)

A-03-033

Medicare will apply the following rules to Automated Multi-Channel Chemistry (AMCC) tests for ESRD beneficiaries:

- Payment is at the lowest rate for services performed by the same provider, for the same beneficiary, for the same date of service.
- The facility must identify, for a particular date of service, the AMCC tests ordered that are included in the composite rate and those that are not included. See Chapter 8 for the composite rate tests for Hemodialysis, Intermittent Peritoneal Dialysis (IPD), Continuous Cycling Peritoneal Dialysis (CCPD), Hemofiltration, and Continuous Ambulatory Peritoneal Dialysis (CAPD).
- If 50 percent or more of the covered tests are included under the composite rate payment, then all submitted tests are included within the composite payment. In this case, no separate payment in addition to the composite rate is made for any of the separately billable tests.
- If less than 50 percent of the covered tests are composite rate tests, all AMCC tests submitted for that Date of Service (DOS) for that beneficiary are separately payable.
- A noncomposite rate test is defined as any test separately payable outside of the composite rate or beyond the normal frequency covered under the composite rate that is reasonable and necessary.

(See §100.6 for details regarding pricing modifiers.)

The FI shared system must calculate the number of AMCC tests provided for any given date of service. The FI sums all AMCC tests with a CD modifier and divides the sum of all tests with a CD, CE, and CF modifier for the same beneficiary and provider for any given date of service

If the result of the calculation for a date of service is 50 percent or greater, the FI does not pay for the tests.

If the result of the calculation for a date of service is less than 50 percent, the FI pays for all of the tests.

All tests for a date of service must be billed on the monthly ESRD bill. Providers must send in an adjustment if they identify additional tests that have not been billed.

The organ and disease oriented panels (80049, 80051, 80054, and 80058) are subject to the 50 percent rule. Laboratory tests that are not covered under the composite rate and that are furnished to CAPD end stage renal disease (ESRD) patients dialyzing at home are billed in the same way as any other test furnished to home patients.

Additional Information

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

From that Web page, look for CR3239 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp

Related Change Request (CR) #: 3239
Medlearn Matters Number: MM3239
Related CR Release Date: May 28, 2004
Related CR Transmittal #: 190
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

LABORATORY/PATHOLOGY

Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2004

Provider Types Affected

Clinical Diagnostic Laboratories

Provider Action Needed

STOP – Impact to You

Laboratories must be aware of changes being made to the ICD-9-CM codes as part of the NCD Edit Software Update in October, 2004.

CAUTION – What You Need to Know

These changes are necessary so that the lab edit module will appropriately process claims using the most current ICD-9-CM codes effective October 1, 2004. They also implement changes to the list of covered codes developed through the coding analysis public process.

GO – What You Need to Do

Adopt the new codes in your billing process effective October, 2004 and begin using them for services on or after that time to assure prompt and accurate payment of your claim.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory, negotiated rulemaking committee, and published as a final rule on November 23, 2001. Nationally uniform software has been developed by Computer Sciences Corporation and incorporated in the Medicare's claims processing systems so that laboratory claims subject to one of the 23 NCDs are processed uniformly throughout the nation effective January 1, 2003.

The laboratory edit module for the NCDs is being updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. (See Pub. 100-4, Chapter 16, §120.2.)

Implementation

This article describes upcoming changes to the list of codes associated with the 23 negotiated laboratory NCDs. Most of the changes are a result of new ICD-9-CM codes that become effective on October 1, 2004. A few changes are the

result of coding analysis that were conducted through the public process announced in the December 24, 2003 Federal Register.

In accordance with the coding analysis, the following laboratory services will have coding changes:

1 Deleting the following diagnosis codes from the list of "ICD-9-CM Codes Covered by Medicare" for the urine culture NCD:
   - 584.5 Acute renal failure with lesion of tubular necrosis;
   - 584.9 Acute renal failure, unspecified; and
   - 586 Unspecified renal failure.

   Coverage for these codes will terminate for services furnished on or after October 1, 2004.
2. Adding diagnosis code *729.81 Swelling of limb*, to the list of "ICD-9-CM Codes Covered by Medicare" for the prothrombin time (PT) and partial thromboplastin time (PTT) NCDs. Coverage for this code will begin for services furnished on or after October 1, 2004.
3. Adding diagnosis code *600.01, Benign prostate hypertrophy with urinary obstruction*, to the list of "ICD-9- CM Codes Covered by Medicare" for the prostate specific antigen (PSA) test NCD. Coverage for this code will begin for services furnished on or after October 1, 2004.

In order to accommodate the new ICD-9-CM coding changes that become effective on October 1, 2004, the Centers for Medicare & Medicaid Services (CMS) is making the following changes to the edit module. These changes become effective for services furnished on or after October 1, 2004.

- CMS is adding new ICD-9-CM code 788.38 to the list of ICD-9-CM codes covered by Medicare for urine culture NCD.
- CMS is adding new ICD-9-CM codes 070.70, 070.71, 588.81, 588.89, V01.71 and V01.79 to the list of ICD-9-CM codes covered by Medicare for HIV testing (diagnosis). CMS is terminating coverage of ICD-9-CM codes V01.7 and 588.8 with services furnished on or after October 1, 2004.
- CMS is adding the following new ICD-9-CM codes to the list of ICD-9-CM codes that do not support medical necessity for the blood counts NCD: 521.06, 521.07, 521.08, 521.10-521.15, 521.20-521.25, 521.30-521.35, 521.40-521.42, 521.49, 524.07, 524.20-524.37, 524.39, 524.50-524.57, 524.59, 524.64, 524.75, 524.76. 524.81, 524.82, 524.89, 525.20-525.26, 618.00-618.05, 618.09, 618.81- 618.83, 618.89, 692.84, V72.40 and V72.41. CMS is removing the following ICD-9-CM codes that are no longer valid from that list: 521.1, 521.2, 521.3, 521.4, 524.2, 524.3, 524.5, 524.8, 525.2, 618.0, 618.8 and V72.4.
- CMS is adding the following new ICD-9-CM codes to the list of ICD-9-CM codes covered by Medicare for the partial thromboplastin time NCD: 070.70, 070.71 and 453.40-453.42.
- CMS is adding the following new ICD-9-CM codes to the list of covered diagnoses for the prothrombin time NCD: 070.70, 070.71, 453.40-453.42, 530.86 and 530.87.
- CMS is adding the following new ICD-9-CM codes to the list of covered diagnoses for the serum iron studies NCD: 070.70 and 070.71.
- CMS is adding the following new ICD-9-CM codes to the list of covered diagnoses for the collagen crosslinks NCD: 252.00-252.02 and 252.08. CMS is removing ICD-9-CM code 252.0, which is no longer a valid code, from that list.
- CMS is adding the following new ICD-9-CM codes to the list of covered diagnoses for the blood glucose testing NCD: 491.22, 707.00-707.07, 707.09, and V58.67. CMS is removing ICD-9-CM code 707.0, which is no longer a valid code, from that list.
- CMS is adding new ICD-9-CM code V58.67 to the list of covered diagnoses for glycated hemoglobin NCD.
- CMS is adding new ICD-9-CM codes to the list of covered diagnoses for the lipid testing NCD: 588.81 and 588.89. CMS is removing ICD-9-CM code 588.8, which is no longer a valid code, from that list.
- CMS is adding new ICD-9-CM codes to the list of covered diagnoses for the digoxin therapeutic drug assay NCD: 588.81 and 588.89. CMS is removing ICD-9-CM code 588.8, which is no longer a valid code, from that list.
- CMS is adding new ICD-9-CM code 273.4 to the list of covered diagnoses for alpha-fetoprotein NCD.
- CMS is adding the following new ICD-9-CM codes to the list of covered diagnoses for the gamma glutamyl transferase NCD: 070.70, 070.71, 252.00-252.02, 252.08, 273.4, 453.40-453.42, 588.81 and 588.89. CMS is removing ICD-9-CM code 252.0 and 588.8, which are no longer valid codes, from that list.
- CMS is adding the following new ICD-9-CM codes to the list of covered diagnoses for the hepatitis panel NCD: 070.70 and 070.71.
- CMS is adding new ICD-9-CM code V58.66 to the list of covered diagnoses for the fecal occult blood test NCD.

Related Instructions

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

From that Web page, look for CR3358 in the CR NUM column on the right, and click on the file for that CR.

Additional Information

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date-of-service compliant. Since ICD-9-CM is a medical code set, effective for dates of service on and after October 1, 2004, CMS

will no longer provide a 90-day grace period for providers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims.

The updated ICD-9-CM codes are published in the Federal Register in April/May of each year as part of the Proposed Changes to the Hospital Inpatient Prospective Payment Systems in Table 6 and effective each October 1.

Carriers and DMERCs must eliminate the ICD-9-CM diagnosis code grace period from their system effective with the October 1, 2004 update. Carriers and DMERCs will no longer accept discontinued diagnosis codes for dates of service October 1 through December 31 of the current year. Claims containing a discontinued ICD-9-CM diagnosis code will be returned as unprocessable.

Physicians, practitioners, and suppliers must use the current and valid diagnosis code that is in effect beginning October 1, 2004. After the ICD-9-CM codes are published in the Federal Register, CMS places the new, revised, and discontinued codes on the following Web site: *http://www.cms.hhs.gov/medlearn/icd9code.asp.*

Related Change Request (CR) #: 3358
Medlearn Matters Number: MM3358
Related CR Release Date: July 9, 2004
Related CR Transmittal #: 225
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

NONPHYSICIAN PRACTITIONERS

Diabetes Self-Management Training Services

Provider Types Affected

Physicians, suppliers, and providers.

Provider Action Needed

STOP – Impact to You

Physicians, suppliers, and providers should note that the definition for diabetes mellitus has been changed.

CAUTION – What You Need to Know

This instruction revises the current Internet Only Manual (IOM) for Diabetes Self-Management Training (DSMT), and changes the definition for diabetes mellitus. Also, material that was not originally included from previous instructions has been added to the IOM.

GO – What You Need to Do

Refer to the Background and Additional Information sections of this instruction for additional information regarding these changes.

Background

This instruction, recently issued by the Centers for Medicare & Medicaid Services (CMS), revises the current IOM for DSMT (Section 300 through 300.5), and the definition for diabetes mellitus has been changed per Volume 68, #216, November 7, 2003, page 63261 of the *Federal Register*.

Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of DSMT services when a certified provider who meets certain quality standards furnishes these services. This program is intended to educate beneficiaries in the successful self-management of diabetes. The program includes instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin dependent; and motivation for patients to use the skills for self-management. Diabetes self-management training services may be covered by Medicare only if the treating physician or treating qualified non physician practitioner who is managing the beneficiary's diabetic condition certifies that such services are needed. The referring physician or qualified non-physician practitioner must maintain the plan of care in the beneficiary's medical record and documentation substantiating the need for training on an individual basis when group training is typically covered, if so ordered. The order must also include a statement signed by the physician that the service is needed as well as the following:

- the number of initial or follow-up hours ordered (the physician can order less than 10 hours of training);
- the topics to be covered in training (initial training hours can be used for the full initial training program or specific areas such as nutrition or insulin training); and
- a determination that the beneficiary should receive individual or group training.

The provider of the service must maintain documentation in file that includes the original order from the physician and any special conditions noted by the physician.

Beneficiaries Eligible for Coverage and Definition of Diabetes

Medicare Part B covers (not to exceed) 10 hours of initial training for a beneficiary who has been diagnosed with diabetes. Diabetes is defined as diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria:

- A fasting blood sugar greater than or equal to 126 mg/dL on two different occasions;
- A two-hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions; ***or***
- A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Related Instructions

The following sections of the Medicare Benefit Policy Manual (Pub 100-2), Chapter 15 (Covered Medical and Other Health Services) have been revised:

- Section 300 (Diabetes Outpatient Self-Management Training Services)
  - Subsections 300.1 (Coverage Requirements)
  - 300.2 (Certified Providers)
  - 300.3 (Frequency of Training)
  - 300.4 (Outpatient Diabetes Self-Management Training).

The Medicare Benefit Policy Manual, Chapter 15 can be found at the following CMS Web site:
http://www.cms.hhs.gov/manuals/102_policy/bp102c15.pdf

Additional Information

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

From that Web page, look for CR3185 in the CR NUM column on the right, and click on the file for that CR.
If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp

Related Change Request (CR) #: 3185
Medlearn Matters Number: MM3185
Related CR Release Date: May 28, 2004
Related CR Transmittal #: 13
Effective Date: January 1, 2004
Implementation Date: June 28, 2004

MMA- Nurse Practitioners as Attending Physicians in the Medicare Hospice Benefit

Provider Types Affected

Nurse practitioners and hospices

Provider Action Needed

STOP – Impact to You

Nurse practitioners and hospices should note that nurse practitioners are being added to the definition of an attending physician for beneficiaries who have elected the hospice benefit.

CAUTION – What You Need to Know

Beginning December 8, 2003, Medicare pays for services provided by nurse practitioners to Medicare beneficiaries who have elected the hospice benefit and have selected a nurse practitioner as his/her attending physician.

GO – What You Need to Do

Refer to the Background and Additional Information sections of this instruction for more information regarding these changes.

Background

This instruction implements Section 408 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), which amends the Social Security Act (Section 1861[dd][3][B] and (Section 1814[a][7] to include nurse practitioners to the definition of an attending physician for beneficiaries who have elected the hospice benefit.

Beginning December 8, 2003, Medicare pays for services, with the exception of certifying the terminal illness with a

prognosis of 6 months or less, if the illness runs its usual course, provided by nurse practitioners to Medicare beneficiaries who have elected the hospice benefit and have selected a nurse practitioner as his/her attending physician. A physician will be required to certify the terminal illness and 6 month prognosis.

Hospice agencies will bill their Regional Home Health Intermediary (RHHI) for attending physician services performed by a nurse practitioner employed by or under contract to the hospice agency. Also, nurse practitioners providing attending physician services, who are not employed by or under contract with a hospice agency, will bill the Medicare Local Part B carrier.

Medicare Local Part B carriers and intermediaries will pay for these physician services rendered by nurse practitioners on or after December 8, 2003, at the lesser of actual charges or 85% of the physician fee schedule.

Instructions for care plan oversight for this provision will be provided under separate instruction.

Implementation Instructions/Dates

Medicare carriers have been instructed to search for and reopen denied claims for professional services of nurse practitioners serving as the hospice beneficiary's attending physician that were billed with the GV modifier and where the services were furnished on or after December 8, 2003.

Where such services were not billed with the GV modifier, Medicare carriers **will not reopen** the claims unless the nurse practitioner brings such claims to the attention of the carrier. If the nurse practitioner prefers, they can rebill such services rendered on or after December 8, 2003, with the GV modifier in order to have the claims reprocessed.

RHHIs will accept all claims for attending physician services performed by a nurse practitioner in a hospice on or after 12/8/03.

Hospice agencies are no longer required to submit copies of Notices of Election (NOEs) to Medicare carriers; ***however***, when such agencies bill RHHIs, the hospice agency should continue submitting the NOEs to the RHHIs.

The implementation date for this instruction is June 28, 2004 for providers who bill Local Part B carriers.

For providers billing intermediaries, use of the GV modifier is also to be implemented on June 28, 2004, as presented in the Medicare Claims Processing Manual update in the transmittal, section 30.2, Form Locator (FL) 42, revenue code 0657.

Related Instructions

The following Internet Only Medicare Manuals (IOM) have been edited with revised and new sections to reflect the requirements to implement section 408 of the MMA of 2003:

- The Medicare Claims Processing Manual (Pub. 100-4), Chapter 11 (Processing Hospice Claims), and
- The Medicare Benefit Policy Manual (Pub. 100-2), Chapter 9 (Coverage of Hospice Services Under Hospital Insurance).

Additional Information

The official instruction (CR3226) issued to your carrier/intermediary regarding this change may be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

From that web page, look for CR3226 in the CR NUM column on the right and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*

Transmittal 1728 (Change Request 1910), which became effective April 1, 2002, specifies use of modifiers GW (service not related to the hospice patient's terminal condition) and GV (attending physician not employed by or paid under agreement by the patient's hospice provider). For more information:

- **Connecticut providers**, please refer to the February 2002 The Connecticut *Medicare B Update! Special Issue* (page 2) for more information at: *http://www.connecticutmedicare.com*.
- **Florida providers**, please refer to the February 2002 The Florida *Medicare B Update! Special Issue* (page 8) for more information at: *http://www.floridamedicare.com*.

Related Change Request (CR) #: 3226
Medlearn Matters Number: MM3226
Related CR Release Date: June 15, 2004
Related CR Transmittal #: 205
Effective Date: December 8, 2003

RADIOLOGY

MSN Messages for Mammography Claims, Pub 100-04, Chapter 18, Section 20 and Chapter 21, Section 50

Provider Types Affected

Providers and suppliers who bill for mammography services.

Provider Action Needed

Suppliers and providers should note that this article discusses changes in Medicare Summary Notice (MSN), which are sent to Medicare beneficiaries, and Remittance Advice messages and related situations where both film and digital screening mammography or film and digital diagnostic mammography areperformed on the same day.

Background

Screening mammography tests can be performed by both film and digital technology. Because of this, some suppliers/providers have assumed the annual frequency rule did not apply in situations where both a film and digital screening is performed. That is not the case, however; Medicare will only pay for one screening test annually, whether performed by film or digital technology. Additionally, Medicare will pay only once for a screening test for a woman between the ages of 35 and 39. Further, Medicare will only pay for one mammography diagnostic test per day, not two.

The revised manual instructions include Medicare Claims Processing Manual updates regarding which Medicare Summary Notice (MSN) message and ANSI X-12 835[1] Adjustment Reason Code will be used on the Remittance Advice when Medicare denies a claim based on film and digital screening or film and digital diagnostic mammography services performed on the same day.

Currently, there are no established comparable MSN messages that can be used to explain why the claim is being denied. Without these new messages, beneficiaries would receive very general messages for denial of claims. The new MSN Messages are to be used when both film and digital screening mammography or film and digital diagnostic mammography has been performed on the same day. The Spanish translation for each new MSN messages has also been added to the revised manual.

[1] American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X-12 transactions are part of the *Transactions and Code Sets Rule* selected by HIPAA.

Remittance Advice Messages

For providers/suppliers who bill carriers, the remittance advice messages will be as follows:

- If the claim is denied because two screening mammographies were performed on the same day, the claim will be denied with reason code *A1 "Claim Denied Charges,"* along with remark code *M90 "Not covered more than once in a 12 month period."*
- If the claim is denied because two diagnostic mammographies were billed on the same day, the claim is denied with reason code *A1 "Claim Denied Charges,"* along with remark code *M63 "Service denied because payment already made for same/similar procedure within set timeframe."*
- For claims submitted by a facility not certified to perform digital mammographies, the remittance advice will contain reason code *B6 "This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty,"* along with remark code *N92 "This facility is not certified for digital mammography."*
- For claims that were submitted with an invalid or missing FDA identification number, use existing reason code *16 "Claim/service lacks information which is needed for adjudication,"* along with remark code *MA128 "Missing/incomplete/invalid six digit FDA approved identification number."*

Implementation

The implementation date of these changes is September 25, 2004.

Related Instructions

The Medicare Claims Processing Manual (Pub 100-4), Chapter 18 (Preventive and Screening Services), Section 20 (Mammography Services), Subsection 20.8 (Beneficiary and Provider Notices), Subsubsections 20.8.1 (MSN Messages) and 20.8.2 can be found on the CMS Web site at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp*.

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

From that Web page, look for CR2617 in the CR NUM column on the right, and click on the file for that CR.

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

Related Change Request (CR) #: 2617
Medlearn Matters Number: MM2617
Related CR Release Date: June 25, 2004
Related CR Transmittal #: 214
Effective Date: September 25, 2004
Implementation Date: September 25, 2004

THERAPEUTIC SERVICES

Electrical Stimulation and Electromagnetic Therapy for the Treatment of Wounds

Provider Types Affected

Physicians, therapists, federally qualified health centers, rural health clinics, hospitals, and critical access hospitals.

Provider Action Needed

STOP – Impact to You

Effective July 1, 2004, under specific conditions Medicare will cover electromagnetic therapy for wound treatment for the same settings and conditions in which electrical stimulation (ES) for wound treatment is currently covered.

CAUTION – What You Need to Know

Be aware of the conditions under which Medicare will cover this procedure.

GO – What You Need to Do

You may file claims with Medicare for electromagnetic therapy for the treatment of certain wounds for services rendered on or after July 1, 2004. Be sure to use the correct HCPCS and revenue codes as specified below to assure timely and correct payment.

Background

Medicare conducted a reconsideration review of electromagnetic therapy used for the treatment of certain wounds. They found that wounds treated using either electrical stimulation (ES) therapy or electromagnetic therapy resulted in similar improvements. Therefore, CMS decided to cover electromagnetic therapy for wound treatment for the same settings and conditions in which electrical stimulation for wound treatment is currently covered.

Effective July 1, 2004, Medicare will cover ES or electromagnetic therapy for chronic stage III or stage IV pressure ulcers (ulcers that have not healed within 30 days of occurrence), arterial ulcers, diabetic ulcers, and venous stasis ulcers. Electromagnetic therapy services will be covered only when performed by a physician, physical therapist, or incident to a physician service. No other wound treatment using electromagnetic therapy will be covered.

ES and electromagnetic therapy for wound treatment will be covered only after appropriate standard wound treatment has been tried for at least 30 days with no measurable signs of healing. Additionally, the treating physician must evaluate wounds undergoing treatment by electromagnetic therapy at least monthly.

Medicare will not continue to cover the treatment if the wound shows no measurable signs of improvement within any 30-day period of treatment. Additionally, ES or electromagnetic therapy must be discontinued when the wound demonstrates a 100% epitheliliazed wound bed. Unsupervised therapy for wound treatment will not be covered, nor will ES and electromagnetic therapy be covered as an initial treatment modality.

Additional Information

The applicable Healthcare Common Procedure Coding System (HCPCS) code for electromagnetic therapy is as follows:

HCPCS G0329 – Electromagnetic Therapy, to one or more areas for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care. Effective date: July 1, 2004. **Note**: Medicare will not cover the device (Code E0761) used for electromagnetic treatment of wounds, nor will Medicare cover unsupervised home use of electromagnetic therapy.

The following revenue codes must be used in conjunction with the HCPCS code identified:

Revenue Code	Description
420	Physical Therapy
430	Occupational Therapy
520	Federal Qualified Health Center
521	Rural Health Center
977, 978	Critical Access Hospital – method II CAH professional services only.

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

From that Web page, look for CR 3149 in the CR NUM column on the right, and click on the file for that CR. The CR includes the revised portions of the Medicare National Coverage Determinations Manual, which further explain this change.

Related Change Request (CR) #: 3149
Medlearn Matters Number: MM3149
Related CR Release Date: March 19, 2004
Related CR Transmittal #: 7
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

OTHER SERVICES

Billing Requirements for Hyperbaric Oxygen Therapy for the Treatment of Diabetic Wounds of the Lower Extremities

Provider Types Affected

Providers who submit claims to Medicare fiscal intermediaries/carriers for Hyperbaric Oxygen (HBO) therapy.

Provider Action Needed

This instruction manualizes the billing requirements from two prior Program Memoranda, issued by the Centers for Medicare & Medicaid Services (CMS) regarding Hyberbaric Oxygen (HBO) therapy for the treatment of wounds of the lower extremities. Providers should not submit claims for HBO therapy with bill type 22X (Skilled Nursing Facility, Inpatient, Part B).

Background

Two prior Program Memoranda (Transmittals AB-02-183 [CR2388, December 27, 2002] and AB-03-102 [CR 2388 and CR 2769]) were issued by CMS regarding HBO therapy for the treatment of wounds of the lower extremities.

HBO therapy exposes the entire body to oxygen under increased atmospheric pressure. Effective April 1, 2003, a National Coverage Decision expanded the use of HBO therapy to include coverage for the treatment of diabetic wounds of the lower extremities. For specific coverage criteria for HBO therapy, refer to the National Coverage Determinations Manual, Chapter 1, Section 20.29.

This latest instruction also contains one revision regarding bill type 22X (Skilled Nursing Facility Inpatient Part B claim). Transmittal AB-03-102 instructed Fiscal Intermediaries to include bill type 22X for this benefit. However, this is **incorrect**. Bill type 22X is **not** acceptable for HBO therapy.

Providers: do not submit such claims with bill type 22X.

Also, please note that topical application of oxygen does not meet the definition of HBO therapy as stated above. Also, its clinical efficacy has not been established. Therefore, no Medicare reimbursement may be made for the topical application of oxygen.

The Coverage Issues Manual Section 35-10 contains the specific expanded coverage criteria of HBO therapy for the treatment of diabetic wounds of the lower extremities in patients including the specific diagnosis codes. This coverage information will soon appear in the National Coverage Determinations Manual, Chapter 1, Section 20.29. Revised instructions have also been issued for Chapter 32, Section 30 of the Medicare Claims Processing Manual. These instructions are attached to CR3172 which may be accessed by following the instructions on the following page.

Implementation

The implementation date for this instruction is June 28, 2004.

Additional Information

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

From that Web page, look for CR3172 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp

Transmittal AB-02-183, CR2388, "Coverage of Hyperbaric Oxygen (HBO) Therapy for the Treatment of Diabetic Wounds of the Lower Extremities" can be found at:
http://www.cms.hhs.gov/manuals/pm_trans/ab02183.pdf

Also, Transmittal AB-03-102, CR2769, "Clarification Regarding Coverage of Hyperbaric Oxygen (HBO) Therapy for the Treatment of Diabetic Wounds of the Lower Extremities," can be found at:
http://www.cms.hhs.gov/manuals/pm_trans/AB03102.pdf

Related Change Request (CR) #: 3172
Medlearn Matters Number: MM3172
Related CR Release Date: May 28, 2004
Related CR Transmittal #: 187
Effective Date: April 1, 2003
Implementation Date: June 28, 2004

Correction to Previous Transmittal Regarding HCPCS Codes for Low Osmolar Contrast Material

CMS Change Request 3053, Pub. 100-20, Transmittal 45, dated January 23, 2004, addresses coding for low osmolar contrast material (LOCM), specifically Healthcare Common Procedure Coding System (HCPCS) codes A4644, A4645, A4646, and A9525. We posted this information to our Web site on February 5, 2004, and subsequently published it in the Second Quarter 2004 *Medicare B Update!* (page 36).

This article is to advise you that code A4644 is typed incorrectly in the last sentence of the policy section of Transmittal 45 as A6444. The correct codes for LOCM are A4644, A4645, and A4646. Code A9525 is invalid, effective April 1, 2004.

Source: CMS Pub. 100-04 Transmittal: 129 Date: March 26, 2004 Change Request 3143

HIPAA - THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

This material provides a basic overview of the consumer privacy protection rules adopted by the United States Department of Health and Human Services in conformance with the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996. This material does not interpret these rules or attempt to apply the rules to your particular circumstances. The information provided is (1) for your information only, (2) subject to change without notice, and (3) provided "as is" without warranty of any kind, expressed or implied. FIRST COAST SERVICE OPTIONS, INC. DISCLAIMS RESPONSIBILITY FOR ANY CONSEQUENCES OR LIABILITY ATTRIBUTABLE TO OR RELATED TO ANY USE, NON-USE, OR INTERPRETATION OF INFORMATION CONTAINED OR NOT CONTAINED IN THIS MATERIAL. FIRST COAST SERVICE OPTIONS, INC. DISCLAIMS ANY LIABILITY FOR ANY DIRECT, SPECIAL, INDIRECT, INCIDENTAL, OR CONSEQUENTIAL LOSSES OR DAMAGES RELATED TO THE ACCURACY OR COMPLETENESS OF THIS MATERIAL. The information provided is no substitute for your own review and analysis of the relevant law.

Reporting Medicare Secondary Payer Information on the Health Insurance Portability and Accountability Act of 1996 X12N 837, Created Via the Free Billing Software

Provider Types Affected

All providers who use free billing software from Medicare for HIPAA 837.

Provider Action Needed

STOP – Impact to You

All providers who use free (or low cost) billing software from Medicare for the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 837 must receive a software upgrade related to Medicare Secondary Payer (MSP) from their carrier, durable medical equipment regional carrier, or intermediary. Changes included in the updated software will be required for electronic submission of such claims (when there is one primary payer to Medicare). **Note that the HIPAA 837 does not accommodate the data Medicare needs when there is more than one primary payer. Providers must submit these types of MSP claims to Medicare on paper.**

CAUTION – What You Need to Know

Please be sure to submit claims in the correct format to avoid delays in claims processing.

GO – What You Need to Do

If you use the billing software supplied by a Medicare carrier or intermediary, please obtain the required software upgrade after October 4, 2004 from your carrier/intermediary to ensure accurate electronic claims processing.

Additional Information

If you have questions regarding this issue, contact your carrier or intermediary on their toll-free number. If you bill for Medicare Part A services, including outpatient hospital services, the toll free number for your carrier/intermediary may be found online at: *http://www.cms.hhs.gov/providers/edi/anum.asp*

If you bill for Medicare Part B services, the toll-free number may be found at: *http://www.cms.hhs.gov/providers/bnum.asp*

The official instruction issued to the carrier/intermediary regarding this change can be found online, referenced via CR NUM 3284, at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

Once at that page, scroll down the CR NUM column on the right to find CR3284 and click on the file for that CR.

Related Change Request (CR) #: 3284
Medlearn Matters Number: 3284
Related CR Release Date: May 28, 2004
Related CR Transmittal #: 84
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

GENERAL INFORMATION

FRAUD, WASTE, AND ABUSE

The Medicare Integrity Program—How It Addresses Healthcare Fraud

Congress established the Medicare integrity program in 1996 to help reduce payment errors and protect and strengthen the Medicare trust fund. The Centers for Medicare & Medicaid Services (CMS) and its contractors work in a wide range of Medicare program areas such as cost report auditing, medical review, anti-fraud activities, and the Medicare secondary payer program to improve payment accuracy.

In 1996, the Inspector General's office estimated that 14 percent of Medicare payments were made improperly. Since then, that error rate has been cut roughly in half. The credit for such improvement in payment accuracy goes to all the stakeholders and partners in the system who have worked to improve it. The partners and stakeholders include healthcare providers, Medicare recipients, Medicare contractors, federal agencies such as the Department of Health and Human Services' Office of the Inspector General (DHHS OIG) and the U.S. Department of Justice (USDOJ), state agencies, Congress, and CMS.

What the Medicare Integrity Program Does Not Do

Healthcare providers and Medicare recipients should know about the Medicare integrity program and understand how it works. But first, there are misconceptions that must be dispelled:

- Many do not know how the program is funded and believe that funding is generated by recovered overpayments. Actually the program uses funding appropriated by Congress. Overpayments recovered, fines and penalties do not finance the Medicare integrity program – they are returned to the Medicare trust fund.
- There is a belief that healthcare providers are penalized for making "honest mistakes" and that providers who make errors are reported to law enforcement agencies, thus undermining the public's confidence in the healthcare community. To the contrary, healthcare providers are very seldom referred to law enforcement agencies for possible investigation and prosecution. Most payment problems and errors are addressed administratively.

Program Funding

Congress created the Medicare integrity program as part of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. In 1999, $560 million was provided to support a wide range of efforts by the Medicare program, including cost report audits, medical review, anti-fraud activities, and the Medicare secondary payer program. The total budget, although seemingly large in the absence of any context, is less than one percent of the total amount of paid claims for fiscal year 1999 ($170.1 billion).

The Medicare integrity program represents a breakthrough in how Medicare can support and sustain its integrity efforts. Prior to the Medicare integrity program, no special funds were set-aside for this purpose, and it was difficult to plan integrity work when program appropriations could vary from year to year. Recognizing how such efforts pay for themselves many times over, by preventing and recouping financial losses, Congress and the Department of Health and Human Services (DHHS) worked in a bipartisan effort to ensure that Medicare could undertake these critical activities.

It is a common misconception that CMS receives its funding only by generating "returns" through overpayment recoveries. In creating the Medicare integrity program, Congress and DHHS expressly rejected this approach, and instead set out in advance the amount available each year to fund program integrity activities. Overpayments recovered are returned to the Medicare trust fund.

Law Enforcement

At the same time it created the Medicare integrity program, Congress also provided more funds for law enforcement agencies, such as the DHHS OIG and USDOJ, for investigation and prosecution of healthcare fraud – not only for the Medicare program, but also for state Medicaid agencies and even private insurers. In 1999, these law enforcement agencies received $203 million for such activities.

CMS does not direct the activities or resources of law enforcement agencies. It only refers suspected fraud to DHHS OIG for investigation, and provides technical assistance to law enforcement (e.g., obtaining Medicare data or understanding Medicare program requirements) as cases are developed and pursued. Law enforcement agencies are an important partner with CMS in protecting the integrity of the Medicare program, but they are independent from CMS.

Key Activities Under the Medicare Integrity Program

The primary activities of the Medicare integrity program are:

- Cost report audits;
- Medical review;
- Anti-fraud activities; and
- Medicare secondary payer activities.

Taken together, these activities utilize the vast majority of the Medicare integrity program funds. The funds are also used to support special provider enrollment initiatives, education and outreach, and software to automatically review claims for errors. Contractors selected by CMS for these purposes carry out program integrity functions. In the past, these activities were carried out by the same contractors who process the Medicare claims and provide customer service functions.

What Is a Program Safeguard Contractor?

As part of HIPAA of 1996, CMS was granted the authority to separately contract with organizations other than the traditional Medicare contractors to perform program integrity functions. These companies are known as program safeguard contractors (PSC). In 1999, CMS selected 12 organizations to operate as PSCs for the Medicare program. A PSC can perform some, all, or any sub-set of the work associated with the following payment safeguard functions: medical review, cost report audit, data analysis, provider education, and fraud detection and prevention.

The functions performed by PSCs should be transparent to the healthcare community and Medicare recipients – most customer contact with Medicare remains with the Medicare carriers and intermediaries as they are responsible for claims processing and customer service functions. Although a PSC may be responsible for anti-fraud activities, allegations of suspected fraudulent activities should be reported to the Medicare contractor who processes the claim. It is the responsibility of the Medicare contractor to screen all initial allegations of fraud to rule out billing errors, processing errors, or misunderstandings. Allegations of fraud are forwarded to a PSC only after errors or misunderstandings have been ruled out.

The following table lists the PSCs/contractor benefit integrity units for Florida, Puerto Rico, and the U.S. Virgin Islands:

Claim Type	State(s)	Contractor Name(s)	Contractor Type
Part A (including home health/hospice)	FL	TriCenturion Integriguard	PSC
Part A – Home health & hospice only	PR VI	TrustSolutions	PSC
Part A – (except home health & hospice)	PR VI	TriCenturion	PSC
Part B (except DMEPOS)	FL PR VI	TriCenturion	PSC
Part B – DMEPOS only	FL PR VI	Palmetto GBA	Carrier – Benefit Integrity Unit

The majority of healthcare providers who furnish medical services and items to Medicare recipients are honest, careful, and conscientious. However, there are some who enter the Medicare program solely intending to run a scam. Some are drawn into illegal activity by others. There are those who consistently cheat the program by padding lots of bills " a little at a time." Some desire to participate in the Medicare program and receive payments, but "deliberately ignore" or "recklessly disregard" problems in their operations that lead to Medicare overpayments.

Healthcare providers sometimes express concern that, with the attention being paid to anti-fraud activities in healthcare by the government, two problems will result. First, they fear providers who make "honest mistakes" will be assumed to be fraudulent and penalized. Second, they are concerned that publicizing the problem and involving beneficiaries and others in identifying and reporting suspected fraud undermine the public's confidence in the healthcare community.

It is understood that honest mistakes can and do happen. In fact, most overpayments that Medicare contractors find, or that providers find and report themselves, are handled administratively. The Medicare program does not routinely refer providers to law enforcement agencies for investigation, except where there is a clear indication of fraud. Law enforcement agencies then evaluate the referral to determine if it merits further investigation. If the Medicare program has reliable evidence of fraud, it can initiate measures to protect the Medicare program from further losses. But most overpayment situations do not merit such actions. The Medicare program does not seek to penalize honest mistakes; but it does seek to recover overpayments when they are made, regardless of the reason the overpayment occurred. No matter the reason for the overpayment, the funds are collected solely for providing healthcare to the elderly and disabled; thus, the overpayments must be recovered.

Medicare recipients, healthcare providers, and other are encouraged to report suspected fraud. Often such complaints are resolved by communication and education, or by collecting an overpayment, without referral to law enforcement. In fact, Medicare recipients are encouraged to first contact the healthcare provider if they have questions about their bills or Medicare statements, since this simple step can often resolve their questions. While recognizing that fraud is a serious threat to the Medicare program which needs to be addressed, most questions can be resolved through simple communication with a healthcare provider. In addition, beneficiaries sometimes misunderstand their notices or question services that are otherwise proper and correct. Just as a person might review their credit card bill to check for errors, it is appropriate for Medicare beneficiaries to do the same when reviewing their Medicare notices and medical. ❖

Source: Source: CMS Division of Benefit Integrity, submitted by TriCenturion, Inc.

FINANCIAL SERVICES

Procedures for Reissuance and Stale Dating of Medicare Checks

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

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is clarifying the policy for reissuing, stale dating, and reporting outstanding Medicare checks.

CAUTION – What You Need to Know

This instruction updates the Medicare Financial Management Manual (Pub. 100-06) and incorporates Change Request (CR) 1364 (Transmittal AB-01-122, September 10, 2001) regarding CMS procedures for reissuance and stale dating of Medicare checks.

GO – What You Need to Do

Be aware of these instructions in the event you have a problem in the future regarding lost, stolen, defaced, mutilated, destroyed, forged, or uncashed checks from your Medicare carrier/intermediary.

Background

This instruction updates the *Medicare Financial Management Manual (Pub. 100-06)* and incorporates Change Request (CR) 1364 (Transmittal AB-01-122, September 10, 2001) regarding the CMS procedures for reissuance and stale dating of Medicare checks, which expired in September 2002. Legal authority for the CMS reissuance and stale dated check policy is contained in Medicare regulations published at 42 CFR 424.352.

Introduction

As part of the CMS effort to improve financial reporting, CMS is clarifying the policy for reissuing, stale dating, and reporting outstanding Medicare checks.

Reissuing Medicare Checks

In December 1993, CMS issued 42 *Code of Federal Regulations* (CFR) Subpart M – Replacement and Reclamation of Medicare Payments 424.352: Intermediary and carrier checks that are lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsements. All Medicare contractors must re-issue checks in accordance with 42 CFR 424.352.

The provisions of this regulation require that a Medicare contractor (fiscal intermediary or carrier) perform certain tasks upon notification by a payee that a check has been lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsements. These tasks are as follows:

A. The Medicare contractor must contact the financial institution on which the check was drawn to determine whether the check has been negotiated.

B. If the check **has** been negotiated:

1. The Medicare contractor will provide the payee with a copy of the check and other pertinent information (such as a claim form, affidavit, or questionnaire to be completed by the payee) required to pursue the claim in accordance with state law and commercial banking regulations.
2. To pursue the claim, the payee must examine the check and certify (by completing the claim form, affidavit, or questionnaire) that the endorsement is not the payee's.
3. The claim form and other pertinent information are sent to the Medicare contractor for review and processing of the claim.
4. The Medicare contractor reviews the payee's claim. If the Medicare contractor determines that the claim appears to be valid, it forwards the claim and a copy of the check to the issuing bank. The Medicare contractor takes further action to recover the proceeds of the check in accordance with state law and regulations.
5. Once the Medicare contractor recovers the proceeds of the initial check, the Medicare contractor issues a replacement check to the payee.
6. If the bank of first deposit refuses to settle on the check for good cause, the payee must pursue the claim on his or her own, and the Medicare contractor will not reissue the check to the payee.

C. If the check has not been negotiated:

1. The Medicare contractor arranges with the bank to stop payment on the check; and

2. Except as provided in paragraph (D) of 42 CFR 424.352, the Medicare contractor reissues the check to the payee.

D. No check may be reissued under (C)(2) unless the claim for a replacement check is received by the contractor no later than one year from the date of issuance of the original check, unless state law (including any applicable federal banking laws or regulations that may affect the relevant state proceeding) provides a longer period, in which case that state law will apply.
Medicare contractors may receive requests for reissuance of Medicare checks that are older than one year. Based on 42 CFR 424.352 (summarized above), Medicare contractors should inform beneficiaries and providers/physicians/suppliers regarding the possibility that state law may provide a more favorable time frame for re-issuance. Medicare contractors should forward requests for reissuance to their regional office based on state law. The regional office will work with the General Counsel regional office to resolve these requests on a case-by-case basis.
Medicare contractors regularly receive requests for reissuance of Medicare checks that are older than one year. Under 42 CFR 424.352 many of these requests must be denied. However, 42 CFR 424.352 applies **only** to checks that have been lost, stolen, defaced, mutilated, destroyed, or paid on a forged endorsement.
Accordingly, Medicare checks that are in the physical possession of the payee, have not been defaced or mutilated, and have not been negotiated are not subject to the one-year time limit for reissuance required by 42 CFR 424.352 (d). Therefore, if the below criteria below are met, such checks may be reissued by the Medicare contractor even if they are older than one year. The criteria are:

1. The payee (beneficiary, physician, supplier, provider, etc.) and/or authorized representative can present the physical check;

2. The Medicare contractor can confirm that the check was not previously reissued; and

3. Reissuance is not barred by a federal and/or state statute of limitations.

Any questions that the Medicare contractors have regarding application of the above criteria should be forwarded to their regional office. The regional office will work with the General Counsel regional office to resolve the questions.

Stale Dating of Checks

Medicare contractors are expected to continuously review all outstanding checks, take the appropriate action to stale date checks in conformance with federal and/or state/local banking regulations, and adjust financial reporting for these actions. Medicare contractors must advise their financial institution of the change in the status of a check.

Outstanding checks are checks that have been issued as payment for Medicare benefits and have not been presented for payment to a financial institution and subsequently drawn from the Medicare trust funds. Checks are "voided" by rendering them nonnegotiable either physically or by placing a stop payment on them.

Stale dated checks are checks that have reached a specific age from date of issue (e.g., one year from the date of issuance) and have not been presented for payment to a financial institution and subsequently drawn from the Medicare trust funds. Additionally, once a check has been stale-dated and is no longer negotiable, the financial institution must be notified in writing.

Undeliverable Checks

Medicare providers, physicians, suppliers, and beneficiaries are responsible for providing their Medicare contractor with their current and accurate mailing address.

The Medicare contractors must comply with the policy established by the "Do Not Forward (DNF) Initiative."

This policy requires Medicare contractors to re-issue the check based on the receipt of updated verified address information per Form CMS-855; and if no updated address information has been submitted, then Medicare contractors must void any returned checks. Checks voided due to DNF may be reissued in accordance with the instructions in the preceding section titled "Reissuing Medicare Checks."

Implementation

The implementation date for this instruction is August 16, 2004.

Related Instructions

The Medicare Financial Management Manual, Pub. 100-06, Chapter 5 (Financial Reporting/Section 420 – Procedures for Reissuance and Stale Dating of Medicare Checks) is new. These updated manual instructions will be incorporated into the new Internet-only Office of Financial Management Manual, but are available now as part of the official instruction issued to your carrier/intermediary. This instruction (CR 2951) can be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 2951 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*. The toll-free number for First Coast Service Options, Inc. customer service representatives is 1-877-602-8816. ❖

Related Change Request (CR) Number: 2951
Related CR Release Date: July 16, 2004
Related CR Transmittal Number: 49
Effective Date: August 16, 2004
Implementation Date: August 16, 2004

Source: CMS Pub 100-6 Transmittal 49, CR 2951, PCM #0419802

CMS Manual System – Payment to Bank

Provider Types Affected

Providers and suppliers.

Provider Action Needed

Become familiar with the revised policy regarding Medicare payments to be sent to a bank in the name of a provider/supplier.

STOP-Impact to You

There is a change in the policy allowing Medicare to send a payment to an individual provider or supplier's bank account for deposit.

CAUTION-What You Need to Know

If certain conditions are met, payments from Medicare to a provider or supplier may be sent to the provider's bank (or similar financial institution) for deposit into the provider's account. Please refer to the *Background* section for a review of these conditions.

GO-What You Need to Do

Follow these revised criteria if you want Medicare to deposit payments directly into your bank account.

Background

Medicare payments may be sent to a bank (or similar financial institution) to be deposited into a provider/supplier's account so long as the following requirements are met:

- The bank may provide financing to the provider/supplier as long as the bank states in writing, in the loan agreement, that it waives its right of offset. (This allows the bank to lend money to the provider, as well as deposit money from Medicare into the provider/supplier's account.)
- The bank account is in the provider/supplier's name and only the provider/supplier may issue instructions on that account.
- The bank should only be bound by the provider/supplier's instructions.
- No other agreement that a provider/supplier has with a third party can have any influence on the account. In other words, if a bank is under a standing order from the provider/supplier to transfer funds from the provider/supplier's account to the account of a financing entity in the same or another bank and the provider/supplier rescinds that order, the bank honors this rescission notwithstanding the fact that it is a breach of the provider/supplier's agreement with the financing entity.

Irrespective of the language in any agreement a provider/supplier has with a third party that is providing financing, that third party cannot purchase the provider/supplier's Medicare receivables.

Additional Information

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

Related Change Request (CR) #: 3079
Medlearn Matters Number: MM3079
Related CR Release Date: June 25, 2004
Effective Date: July 25, 2004
Implementation Date: July 25, 2004
Related CR Transmittal #: 213

MEDICARE REGISTRATION/ENROLLMENT

Distribution of the Annual Fee Schedule and 2005 Participation Packages

First Coast Service Options, Inc. (FCSO) will be sending the 2005 Medicare Physician Fee Schedule (MPFS) CD-ROM in early November 2004. There are many benefits to using CD-ROMs. FCSO will be able to offer information in a more timely fashion while allowing for the information to be more widely shared within each office.

The CD-ROM will contain the Participation Announcement, Fact Sheet, Participating (PAR) Agreement, and fee schedules for Florida and Connecticut in a state-specific arrangement to allow the information to be easily identified by state/locality. In addition, the CD-ROM will contain supplemental information and links to various Web sites. The CD-ROM takes up less office space and can be printed and distributed. You can view and print only those articles important to your practice.

The annual Fee Schedule and Participation Packages will be distributed to all providers currently receiving the *Medicare B Update!* via the internet or CD-ROM. Hardcopy packages, by contrast, nationally cost Medicare a substantial amount of money for printing and postage. Reducing the number of hardcopies produced is one way Medicare contractors can reduce costs that may be better utilized elsewhere.

Providers Must Qualify and Register to Receive the Annual Fee Schedule and 2005 Participation Packages in Hardcopy Format

Hardcopy or distribution of the Annual Fee Schedule and 2005 Participation Packages is limited to individual providers and professional association groups who billed at least one Part B claim (to either Connecticut or Florida Medicare) for processing during the twelve months prior to the release of each issue. **Medicare providers who meet these criteria have to register with us to receive the hardcopy format.** Qualifying providers will be eligible to receive one hardcopy *if* a valid reason can be shown why the CD-ROM format cannot be utilized. "I just prefer hardcopy" is an invalid reason – a valid reason might be lack of a CD-ROM drive, or another technical or other barrier.

If you believe you meet these criteria and wish to receive hardcopies, you must complete and return the registration form on the following page. If you are able to utilize the CD-ROM format of Annual Fee Schedule and 2005 Participation Packages, you do not need to reply to us.

Annual Fee Schedule and 2005 Participation Package Hardcopy Registration Form

To receive the Annual Fee Schedule and 2005 Participation Package in hardcopy format, you must complete this registration form. Please complete and fax or mail it to the number or address listed at the bottom of this form. To receive a hardcopy Annual Fee Schedule and 2005 Participation Package, your form must be faxed or postmarked on or before September 30, 2004.

Provider/Professional Association Name:

Medicare Provider Identification Number (PIN):

Address:

City, State, ZIP Code:

Contact Person/Title:

Telephone Number:

Rationale for needing a hardcopy:

Does your office have Internet access? YES ❑ NO ❑

Do you have a PC with a CD-ROM drive? YES ❑ NO ❑

Other technical barrier or reason for needing hardcopy:

Mail your completed form to:

Medicare Communication and Education - Publications
P.O. Box 45270
Jacksonville, FL 32232-5270

or fax to 1 (904) 791-6292

Please let us know your concerns or questions regarding this initiative:

Please do not contact our customer service call center regarding this initiative. Additional questions or concerns may be submitted via the Web site in the "contact us" section.

MEDICARE SECONDARY PAYER (MSP)

Medicare Secondary Payer Policy for Hospital Reference Lab Services and Independent Reference Lab Services

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

Clarification for CR 3064 – MMA

The Medlearn Matters article related to Change Request 3064 was published in the Third Quarter 2004 Medicare B Update! (page 44).

Provider Types Affected

Hospitals, critical access hospitals (CAH), and independent reference laboratories

Provider Action Needed

Stop – Impact to You

Hospitals are no longer required to collect Medicare secondary payer (MSP) information where there is no face-to-face encounter with a beneficiary because independent reference laboratories no longer need the information to bill Medicare for reference laboratory services.

Caution – What You Need to Know

This clarification of CR3064 and Medlearn Matters article MM3064 provides additional information regarding preparation of the claim Form CMS-1500.

Compliance with this instruction will help assure prompt and correct processing of reference laboratory claims.

GO – What You Need to Do

Affected providers should ensure that billing staff enters "None" in block 11 of the Form CMS-1500 when filing claims to Medicare for reference laboratory services when there is not a face-to-face encounter with the Medicare beneficiary.

Background

Section 943 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates that:

"The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to Medicare secondary payer provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory."

Prior to the enactment of MMA, hospitals were required to collect MSP information every 90 days in order to bill Medicare for reference lab services.

Further, those providers billing carriers are reminded to enter "None" in Block 11 of the claim Form CMS-1500 for reference laboratory services in order to bill Medicare for the reference laboratory services, as described in Section 943(b).

Additional Information

Because of these policy changes, Medicare intermediaries have been instructed to not include claims for reference laboratory services, as described in Section 943(b) of MMA, in the sample of claims that are reviewed during MSP hospital audits. This is effective for reference laboratory service claims with dates of service of December 8, 2003 and later.

To view the actual instruction issued to your carrier/intermediary, go to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

Once at that site, scroll down the right hand CR NUM column to find CR 3267 and click on the link for that CR. ❖

Related Change Request (CR) Number: 3267
Related CR Release Date: July 16, 2004
Related CR Transmittal Number: 17
Effective Date: December 8, 2003
Implementation Date: August 16, 2004

Source: CMS Pub 100-4 Transmittal 228, CR 3267, PCM #0420101

SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB)

Correction to CR 2944, Transmittal 90, Issued on February 6, 2004

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed

STOP – Impact to You

Change Request (CR) 2944, Transmittal 90, issued on February 6, 2004, entitled "Implementation of SNF CB CWF Edit for Therapy Codes Considered Separately Payable Physician Services" incorrectly indicated that services provided in a non covered SNF stay are reimbursed through the PPS.

CAUTION – What You Need to Know

This instruction corrects the business requirements of CR 2944 and the relevant Internet Only Manual (IOM). In addition, the associated Medlearn Matters article number MM2944 also was incorrect and will need to be reissued. Though this change is necessary, claims will be processed correctly according to the business requirements established in CR 2944 and CR 3156.

GO – What You Need to Do

Refer to the *Background* and *Additional Information* sections of this instruction for additional information regarding these changes.

Background

This instruction corrects Section 1B of the Business Requirements of CR 2944, Transmittal 90, issued on February 6, 2004, entitled *"Implementation of Skilled Nursing Facility Consolidated Billing CWF Edit for Therapy Codes Considered Separately Payable Physician Services,"* which incorrectly indicated that services provided in a non covered SNF stay are reimbursed through the PPS.

Language contained in CR 2944 incorrectly indicated that services provided in a non covered SNF stay are both subject to CB and reimbursed through the PPS. This instruction provides the corrected language (by removing the language indicating that the services are subject to the prospective payment system when provided to beneficiaries in a noncovered SNF stay) as follows:

"Physical, occupational, and speech therapy services are subject to consolidated billing when provided to beneficiaries in either a Part A covered SNF stay or during a non-covered stay. A small number of these services are considered surgery when performed by a physician and may be separately paid by the carrier. They are considered therapy when performed by a physical and occupational therapist and continue to be subject to consolidated billing."

A complete list of the services affected by SNF consolidated billing can be found on the CMS Web site at: *http://www.cms.hhs.gov/medlearn/snfcode.asp*

Lastly, the Medlearn Matters article number MM2944 associated with CR 2944 was incorrect and will need to be reissued.

Also, note that even though this change is necessary to correct the concept, claims will be processed correctly according to the business requirements established in CR 2944 and CR 3156.

Implementation

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

Related Instructions

The Medicare Claims Processing Manual (Pub 100-4), Chapter 6 (SNF Inpatient Part A Billing) Section 110 (Carrier Claims Processing for Consolidated Billing for Physician and Non-Physician Practitioner Services Rendered to Beneficiaries in a SNF Part A Stay), Subsection 2.6 (Edit for Therapy Services Separately Payable When Furnished by a Physician) is being revised. The updated manual instructions are included in the official instruction issued to your carrier, and it can be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*

From that Web site, look for CR3333 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp.*

Related Change Request (CR) #: 3333	Medlearn Matters Number: MM3333
Related CR Release Date: June 18, 2004	Related CR Transmittal #: 209
Effective Date: July 1, 2004	Implementation Date: July 6, 2004

GENERAL INFORMATION

New Address for Connecticut Individual Consideration Claims

This announcement applies to Connecticut only.

When submitting a claim for individual consideration, it is necessary to send the letter of medical necessity and the supporting medical literature requesting individual consideration, along with the Form CMS-1500, to the following address:

First Coast Service Options
Attention: Claims Department-Individual Consideration
321 Research Parkway
Meriden, CT 06450

The Office of the Medical Director (OMD) will review all the data and a decision will be made on the claim. If the claim is approved, it will automatically be adjudicated through the system and pay. If the claim is denied, your next option would be to resubmit for an appeal.

Each subsequent claim to be reviewed for individual consideration for the same circumstance will require the same data you may have already provided to the OMD.

The protocol will be when a drug or medical procedure does not have the usual Medicare coverage qualification, that is Federal Drug Administration or *Compendia* usage, it will now be necessary to make the determination with your patient as to the usage of the aforementioned drug or procedure. The patient needs to understand that Medicare may or may not cover such circumstance and therefore an advance beneficiary notice (ABN) must be discussed and completed with the patient. More information concerning ABNs is available at *http://www.cms.hhs.gov/medicare/bni/*.

New Address for All Medicare Connecticut Correspondence

This announcement applies to Connecticut only.

The address for Connecticut Medicare Part B providers to mail correspondence (Appeals, Overpayment Refunds, Provider Enrollment and General and MSP Inquiries) is changing.

First Coast Service Options, Inc. (FCSO) is completing the final phase in the consolidation of our Connecticut and Florida mail operations. The purpose of this transition is to take advantage of imaging technology, which will allow us to improve controls and gain efficiencies.

Effective July 1, 2004, providers should mail all Request for Reviews, Appeals and Hearings directly to the following address:

Medicare Part B CT Appeals/Hearings
Post Office 45041
Jacksonville, Florida 32232-5041

All other correspondence, checks, and provider enrollment forms should be addressed to:
Medicare Part B CT Correspondence
Post Office 45010
Jacksonville, Florida 32232-5010

Providers should continue to send claims to:

Medicare Part B CT Claims
Post Office Box 44234
Jacksonville, Florida 32231-4234

It is important that you discontinue using all previously established Connecticut Correspondence addresses effective immediately. Beginning July 1, 2004, the U.S. Postal Service will divert mail sent to former Connecticut addresses. This may cause a 7-10 day delay in Medicare's receipt of mail.

If you have any questions, please contact Connecticut Medicare Part B Customer Service at 1-866-419-9455.

MMA - National 1-800-MEDICARE (1-800-633-4227) Implementation (Section 923(d) of MMA)

Provider Types Affected

All providers

Provider Action Needed

STOP – Impact to You

Medicare carriers (including DMERCs) and fiscal intermediaries will no longer maintain their own individual **beneficiary** toll-free telephone numbers. Instead, all beneficiary calls should be directed to 1-800-MEDICARE (1-800-633-4227).

CAUTION – What You Need to Know

Effective June 1, 2004, carriers and FIs will begin to transition to **1-800-MEDICARE (1-800- 633-4227)** for all beneficiary questions that pertain to Medicare claims and services. The Centers for Medicare & Medicaid Services (CMS) will contact each carrier/FI on an individual basis to provide the specific migration/implementation date for that contractor (phase-in is planned for June - July 2004). As calls come in to the new centralized number, questions regarding specific claims will be routed to the appropriate Medicare carrier/FI for response.

GO – What You Need to Do

Medicare carriers/FIs will publish the new beneficiary toll-free telephone number on Medicare Summary Notices (MSNs), beneficiary correspondence, Medicare Redetermination Notices (formerly, appeals letters) and, if applicable, on Medicare beneficiary Web sites. On or after August 1, 2004, **when you advise your patients to call Medicare with questions, direct them to 1-800-MEDICARE. However, for calls regarding eligibility status or claims status, and other provider-initiated inquiries, providers should continue to use the existing provider toll-free numbers.**

Background

The change in policy, driven by the Medicare Modernization Act (MMA) of 2003 (section 923 (d)), requires all Medicare carriers/FIs to use one number—**1-800-MEDICARE (1-800-633-4227)**—for all Medicare questions from beneficiaries. By providing a single call-in number, Medicare aims to improve customer telephone service by connecting callers quickly with the correct Medicare contractor for their case and question, thereby reducing the number of calls and referrals overall.

Currently, an internal CMS workgroup is developing standard operating procedures for processes and exceptions to this new policy. All procedures will be communicated to contractors as soon as final decisions are made.

Additional Information

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

From that Web page, look for CR 3195 in the CR NUM column on the right, and click on the file for that CR number.

Also, remember that 1-800-MEDICARE is for beneficiary-initiated calls. Providers calling Medicare should continue using the numbers currently in use. If you do not have that number, you may find it at:
http://www.cms.hhs.gov/tollnums.asp

Related Change Request (CR) #: 3195
Medlearn Matters Number: MM3195
Related CR Release Date: April 30, 2004
Related CR Transmittal #: 159
Effective Date: June 1, 2004
Implementation Date: June 1, 2004 (Start date of phased implementation that should be completed on August 1, 2004.)

Instructions for Providing Supervisor's Information When a Service Incident to the Ordering Physician Is Supervised by Another Physician in the Group

Provider Types Affected

Physicians and non-physician practitioners

Provider Action Needed

Physicians and non-physician practitioners should note that this instruction clarifies that the supervisor's identification is required on a claim when a service performed incident to the service of one physician or non-physician practitioner is supervised by another member of the same group. It instructs how to report ordering physician and supervising physician information on the electronic claim form.

Background

The preamble of the proposed rule for the Medicare Physician Fee Schedule on November 1, 2001 (66 Fed Reg. 55267) stated: "The billing number of the ordering physician (or other practitioner) should not be used if that person did not directly supervise the auxiliary personnel."

This rule was included by the Centers for Medicare & Medicaid Services (CMS) to give instructions for providing the supervisor's information on the CMS ***paper claim form*** (CMS-1500). Details regarding how to complete the paper claim form 1500 can be found in the Medicare Claims Processing Manual, Publication 100-04, Chapter 26 (Completing and Processing Form CMS-1500 Data Set), Section 10.4 (Items 14-33 - Provider of Service or Supplier Information). This CMS manual can be found at the following CMS Web site:

http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

The requirement for direct supervision of a service incident to a physician or non-physician practitioner is not satisfied unless there is a specific physician or non-physician practitioner responsible for the supervision of the billed service. If more than one person supervises a service, the one who had the responsibility for the major part of the service should be identified on the claim. The claim is paid at the rate appropriate to the supervisor (at 85% if the supervisor is a non-physician practitioner).

This transmittal provides instructions in cases in which the ***electronic claim form*** is used. When filing electronic claims with incident to services, supply the:

- Ordering physician information for each line of service in the loop 2420E; and
- Supervising physician information in loop 2310E.

If the supervising physician information differs for a specific detail line, supply that detail line supervising physician information in **loop 2420D.**

Implementation

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

Additional Information

The official instruction issued to your carrier regarding this change may be found at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR3242 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier at their toll-free number, which may be found at:

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

Related Change Request (CR) #: 3242 Medlearn Matters Number: MM3242
Related CR Release Date: June 18, 2004
Related CR Transmittal #: 17
Effective Date: October 4, 2004
Implementation Date: October 4, 2004

Non-Physician Practitioner Questions and Answers

Provider Types Affected

Non-Physician Practitioners (NPPs), physicians, suppliers, and providers

Provider Action Needed

Be sure to understand the policies related to services for Skilled Nursing Facilities (SNF) and Nursing Facilities (NF) as they relate to Non-Physician Practitioners.

Background

The Balanced Budget Act of 1997 modified the way the Medicare program pays for Non-Physician Practitioner (NPP) services. Prior to January 1, 1998, these services were reimbursed by Medicare Part B only in certain geographical areas and health care settings. The Balanced Budget Act removed the restrictions on settings and effective January 1998, payment is allowed for non-physician practitioner services in all geographic areas and health care settings permitted under State licensing laws.

On November 13, 2003, CMS issued the Survey & Certification letter (S&C-04-08), which addresses the differences in requirements concerning the delegation of physician tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) from a survey and certification perspective. Please note that reimbursement requirements for NPPs may differ from the survey and certification requirements. The following questions (Q1 through Q17) have been asked by NPPs, and each question has been answered (A1 through A17) by the Centers for Medicare & Medicaid Services (CMS).

Q1. Why do new regulations from CMS governing physician delegation of services differ between Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)?

A1. The requirements addressing physician delegation of services are not new. The distinction made between the delegation of physician visits and tasks between SNFs and NFs is mandated by Congress in the law.

The original authority for 42 Code of Federal Regulations (CFR) § 483.40 was the sentence in section 1819(b)(6)(A) of the Social Security Act requiring that every SNF resident's medical care be under the supervision of a physician (the same sentence appeared in section 1919(b)(6)(A) of the Social Security Act for NFs). The requirements contained in 42 CFR, § 483.40, include a prescribed visit schedule and the requirement for the physician to perform the initial visit personally.

Section 483.40 of the CFR originally applied these same standards uniformly in both SNFs and NFs. However, in section 4801(d) of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Congress subsequently amended the Medicaid provisions of the law (section 1919(b)(6)(A) of the Social Security Act) to allow, at the option of the State, all physician tasks (including the initial visit) to be delegated to physician extenders who are not employed by the facility but who are working in collaboration with the physician. In response, CMS amended the regulations to reflect this broader authority for delegating physician tasks in NFs (see § 483.40(f)). Since Congress declined to make a similar change in the statutory requirements for SNFs at section 1819(b)(6)(A) of the Social Security Act, the corresponding SNF requirements in § 483.40(c) and (e) remain unchanged.

Q2 When may non-physician practitioners (NPPs) begin to bill for medically necessary visits that occur prior to the initial comprehensive visit in a SNF and in a NF?

A2. CMS defined "initial comprehensive visit" in the November 13, 2003 S&C-04-08 and stated that NPPs may perform any medically necessary visits even if they occur prior to the initial comprehensive visits in both SNFs and NFs. Medically necessary visits that NPPs perform on or after November 13, 2003, may be billed to the carrier when collaboration and billing requirements are met in the SNF and NF setting. The Survey & Certification letter S&C-04-08, may be found at: *http://www.cms.hhs.gov/medicaid/survey-cert/letters.asp*

Q3 If State regulations require a physician co-signature for orders and/or notes written by an NPP, may the physician bill for this action?

A3 No. CMS only pays for medically necessary face-to-face visits by the physician or NPP with the resident. Since the NPP is performing the medically necessary visit, the NPP would bill for the visit.

Q4 If State regulations require more frequent visits than those that are federally mandated, are NPPs able to bill for those visits?

A4 CMS only reimburses physicians and NPPs for medically necessary visits and federally prescribed visits. Visits required to fulfill or meet State requirements are considered administrative requirements and are not medically necessary for the resident. Medicare pays for services that are reasonable and medically necessary for the treatment of illness or injury only, as stated in the Social Security Act, section 1862(a)(1)(A).

Q5 **May NPPs who are employed by the facility bill for medically necessary visits?**

A5 Payment for the services of NPPs who are employed by a SNF and furnished to SNF residents is bundled under the per diem rate.

However, payment may be made for the services of Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs) who are employed by a NF when their services are rendered to NF residents. If NPs and CNSs employed by a NF opt to reassign payment for their professional services to the NF, the NF can bill the appropriate Medicare Part B carrier under the NPs' or CNSs' UPINs for their professional services. Otherwise, the NPs or CNSs who are employed by a NF bill the carrier directly for their services to NF residents.

On the other hand, Physician Assistants (PAs) who are employed by an NF cannot reassign payment for their professional services to the NF because Medicare law requires the employer of a PA to bill for the PA's services. Hence, the NF must always bill the Part B carrier under the PA's UPIN for the PA's professional services to NF residents.

Q6. **May NPPs employed by the NF perform the initial comprehensive visit, sign initial orders, or perform other federally required visits in NFs?**

A6. No. The statute specifies that the NPPs are prohibited from providing these services when employed by the facility. The Social Security Act states at section 1919(b)(6)(A) that the health care of every resident must be provided under the supervision of a physician or under the supervision of an NPP not employed by the facility who is working in collaboration with a physician.

Q7. **May NPPs perform the initial comprehensive visit in SNFs?**

A7. No. The Social Security Act states at Section 1819(b)(6)(A) "that the medical care of every resident must be provided under the supervision of a physician." Congress did not extend this benefit to NPPs in an SNF as was done under 1919(b)(6)(A).

Q8. **When may NPPs sign the initial orders for a SNF resident?**

A8. NPPs may not sign initial orders for an SNF resident. However, they may write initial orders for a resident (only) when they review those orders with the attending physician in person or via telephone conversation and have the orders signed by the physician.

Q9 **Must a physician verify and sign orders written by an NPP who is employed by the NF?**

A9. Yes. The regulation at 42 CFR, § 483.40(b)(3) states, the physician must "Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications."

In accordance with 42 CFR, Section 483.40(f), required physician tasks, such as verifying and signing orders in an NF, can be delegated under certain circumstances to a physician assistant, nurse practitioner, or clinical nurse specialist who is not an employee of the facility but who is working in collaboration with a physician. Therefore, in order to comply with survey and certification requirements, the physician must sign all orders written by an NPP who is employed by the NF.

Q10. **Why must a physician verify and sign orders written by an NPP in the SNF?**

A10. 42 CFR, Section 483.40(e)(2), which applies to physician delegation of tasks in SNFs, states "A physician may not delegate a task when regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies." Therefore, in accordance with 42 CFR, § 483.40(b)(3), the physician must "Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications."

Q11. **Referring to S&C –04-08 issued on November 13, 2003, the chart under the "Other Medically Necessary Visits and Orders" column, it specifies the ability of the NPP to perform AND sign but in the column for "Other Required Visits" it does not address signing. Does CMS require a physician's signature in such cases?**

A11. 'Other Required Visits' refers to the federally required visits. During these required visits, it is not always necessary to write orders. However, during a "Medically Necessary Visit," which is when the resident's condition may have changed, thus, warranting a visit outside the federally required schedule, the resident is exhibiting signs and/or symptoms that require medical attention. In these cases, CMS believes orders will often be required and, thus, expect orders to address the resident's change in condition. Therefore, an NPP may sign the medically required orders. Please remain mindful that the survey and certification requirement that the physician must sign and date all orders remains in effect. (See Q&As 9 &10.)

Q12. Why can't a PA, regardless of employment, sign certifications/re-certifications for SNF residents?

A12. Congress amended section 1814(a)(2) of the Social Security Act in 1989. The Social Security Act specifies that NPs and CNSs who are not employed by the facility may certify (and recertify) that the services the beneficiary requires may only be performed in the SNF. They did not extend this benefit to PAs. Therefore, by statute, PAs may not sign SNF certifications/re-certifications.

Q13. If a physician extender is not employed by the NF but is employed by an organization related to the NF, may he/she still provide services in the nursing home?

A13. The requirement in 42 CFR, § 483.40(f), is specific in that the physician tasks may be performed by a NP, PA, or CNS "who is not an employee of the facility." In this case, the NPP is not an employee of the NF and, thus, can perform physician tasks as long as they work in collaboration with the physician.

Q14. If an NP or CNS is not employed by the SNF but is employed by an organization related to the SNF, may he/she sign the certification and re-certifications?

A14. The requirement in 42 CFR § 424.20(e) is specific in that an NP or CNS "neither of whom has a direct or indirect employment relationship with the facility" may sign the certifications and re-certifications. In this case, the NP or CNS is not an employee, but has an indirect employment relationship and, thus, are not permitted to sign the certifications and re-certifications. (Social Security Act section 1814(a)(2))

Q15. If physician delegation responsibilities are based on payment source, what are the physician delegation responsibilities for private pay resident, VA contracts or managed care?

A15. If the resident's stay is being paid for by a source other than Medicare or Medicaid AND the resident is residing in a Medicare/Medicaid dually-certified facility, follow the most stringent requirement. If the resident is residing in a Medicare only or a Medicaid only certified facility, then follow the requirements for that specific certified facility.

Q16. Are NPPs allowed to certify/recertify therapy plans of care under Medicare Part B?

A16. 42 CFR § 424.24(c)(3) states that if a physician or NPP establishes the plan of care, he/she must also certify the plan of care. If the plan of care is established by a physical or occupational therapist or speech language pathologist, a physician or NPP who has knowledge of the case must sign the plan of care. (This Q&A was not addressed in the November 13, 2003, Survey & Certification letter, S&C-04-08.)

Should you have any questions concerning this article, please submit your inquiry via the CMS Web site as follows:
1) Click on Feedback in top tool bar of *http://www.cms.hhs.gov* (from Home page or any page on cms.hhs.gov).
2) Select and click "Site Feedback" in last paragraph.
3) User should:
   a. Enter his/her email address;
   b. At Category, select "Providers" from the drop down menu;
   c. At the sub-category, select Nursing Home Quality Initiative;
   d. Enter feedback in space provided; and
   e. Submit feedback.

Related Instructions

The CMS Web site contains considerable information regarding SNF billing procedures and NPP billing processes. Some of the specific sites are as follows:

The *Medicare Claims Processing Manual, Pub. 100-04, Chapter 7 (SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule))* can be found at the following CMS Web site:
http://www.cms.hhs.gov/manuals/104_claims/clm104c07.pdf

The *Skilled Nursing Facility Manual, Chapter V (Billing Procedures)* is located at the following CMS Web site:
http://www.cms.hhs.gov/manuals/12_snf/sn500.asp

The Home Health Agency Manual, Chapter IV (Billing Procedures) Web site is located at:
http://www.cms.hhs.gov/manuals/11_hha/hh400.asp

Additional Information

The CMS Quarterly Provider Update Web sites for Non-Physician Practitioners (NPPs) for 2004 can be found at:
http://www.cms.hhs.gov/providerupdate/january2004/nonphys.asp
http://www.cms.hhs.gov/providerupdate/nonphys.asp

In addition, the CMS Quarterly Provider Update Web sites for NPPs for 2003 can be found at:
http://www.cms.hhs.gov/providerupdate/january2003/nonphys.asp
http://www.cms.hhs.gov/providerupdate/april2003/nonphys.asp
http://www.cms.hhs.gov/providerupdate/july2003/nonphys.asp
http://www.cms.hhs.gov/providerupdate/october2003/nonphys.asp

Acronyms

CFR = Code of Federal Regulations
CMS = Centers for Medicare & Medicaid Services
CNS = Clinical Nurse Specialist
NF = Nursing Facility
NP = Nurse Practitioner
NPP = Non-Physician Practitioner
(NPs, CNSs, & Pas are considered NPPs)
OBRA '90 = Omnibus Budget Reconciliation Act of 1990
PA = Physician Assistant
S&C = Survey & Certification
SNF = Skilled Nursing Facility
VA = Veterans Administration

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0418
Related CR Release Date: N/A
Effective Date: N/A- This is informational only.

Provider Education Web Site Access Change

Due to recent improvements to our Internet server, users of our Provider Education Web sites will be required to change their settings in order to access *www.floridamedicare.com* and *www.connecticutmedicare.com*.

In the past, users were not required to type the "www" at the beginning of these addresses. That has now changed. Users must now type the full address. For those users who have saved these sites within their browser's "Favorites", the link will need to be changed to include "www" in the URL. For example, *http://floridamedicare.com* needs to be changed to *http://www.floridamedicare.com* and from *http://connecticutmedicare.com* to *http://www.connecticutmedicare.com*.

Update to the Healthcare Provider Taxonomy Codes (HPTCs) Version 4.0

Provider Types Affected

Physicians, suppliers, and providers who bill carriers and durable medical equipment carriers (DMERCs).

Provider Action Needed

Affected providers should note that Medicare contractors (carriers and DMERCs) must obtain the Healthcare Provider Taxonomy Code (HPTC) list, Version 4.0, and use it to validate HPTCs in claims for services on or after May 17, 2004.

Background

The Health Insurance Portability and Accountability Act (HIPAA) directed the Secretary of the Department of Health and Human Services (HHS) to adopt standards for transactions to enable the electronic exchange of health information. Since the Healthcare Provider Taxonomy Code is a named code set in the 837 Professional Implementation Guide, contractors must validate the inbound taxonomy codes against their internal HPTC tables.

The summary of changes for the Healthcare Provider Taxonomy Code list, Version 4.0, is as follows:

Provider Taxonomy Value	Revision
208VP0000X	Modified title from Pain Management to Pain Medicine and added definition
106H00000X	Modified definition
207VM0101X	Added definition

Implementation

The implementation date for this instruction is May 17, 2004, when Version 4.0 of this code set will be used by carriers and DMERCs for claims with dates of service on or after May 17, 2004.

Additional Information

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

From that Web page, look for CR3188 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/DMERC at their toll-free number, which may be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp

Related Change Request (CR) #: 3188
Medlearn Matters Number: MM3188
Related CR Release Date: April 16, 2004
Related CR Transmittal #: 71
Effective Date: May 17, 2004
Implementation Date: May 17, 2004

CONNECTICUT MEDICAL REVIEW

This section of the *Medicare B Update!* features summaries of new and revised medical policies/coverage determinations 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 that the carrier's medical policies and review guidelines are consistent with accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), carriers no longer include full-text local medical review policies (LMRPs)/local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LMRPs are provided instead. Providers may obtain full-text LMRPs/LCDs on our provider education Web site, *http://www.connecticutmedicare.com*. Final LMRPs/LCDs, draft LMRPs/LCDs available for comment, LMRP/LCD statuses, and LMRP/LCD comment/response summaries may be printed from the Part B Medical Policy section.

Effective and Notice Dates

Effective dates are provided in each policy, and are based on the date of service (unless otherwise noted in the policy). Medicare contractors are required to offer a 45-day notice period for LMRPs/LCDs; the date the LMRP/LCD is posted to the Web site is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new and revised LMRPs/LCDs are posted to the Web site, subscribe to the FCSO *eNews* mailing list. It's very easy to do; simply sign on to the provider education Web site, *http://wwwconnecticutmedicare.com ;* click on the yellow "Join our electronic mailing list" bar and follow the prompts.

More Information

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

Attention: Medical Policy
First Coast Service Options, Inc.
P.O. Box 9000
Meriden, CT 06450-9000

Phone: 1-866-419-9455

Medical Review Table of Contents

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

Reminder to Providers to Supply Information to Medicare's Comprehensive Error Rate Testing (CERT) Program

Provider Types Affected

All Medicare providers.

Provider Action Needed

Providers are reminded that they must comply with requests from Medicare contractors for medical records needed for the CERT program.

Background

The CERT program produces national, contractor-specific, and service-specific paid claim error rates, as well as a provider compliance error rate. The paid claim error rate is a measure of the extent to which the Medicare program is paying claims correctly. The provider compliance error rate is a measure of the extent to which providers are submitting claims correctly. The program uses independent reviewers to review representative random samples of Medicare claims (including both paid claims and denied claims) to ensure that the decision was appropriate.

The CERT process begins at the Affiliated Contractor (AC) — your Medicare carrier or intermediary processing site — where claims have entered the Medicare claims processing system. The CERT contractor randomly selects and extracts claims from the claims processing system each day. The CERT contractor obtains medical records from providers (or from the AC, if the AC had previously subjected the claim to manually medical review).

The CERT contractor requests medical records from providers in a written format, including a checklist of the types of documentation required. In addition, the CERT contractor follows up on written requests with phone calls to providers. Providers must submit documentation to the CERT Operations Center via fax or by mail at the number/address specified in the *Additional Information* section below.

Although providers are required to send documentation to support claims as part of the CERT process, many providers do not comply with this requirement. Providers may believe that it is a HIPAA violation to send patient records to CERT, they may not understand the CERT process, or they may not understand the importance of sending documentation in a timely fashion. It is, however, important to respond in a timely fashion to CERT requests and to provide the CERT contractor with all applicable medical records used to support a sampled claim.

If providers do not respond to initial CERT requests for medial records, they will receive up to four letters and three phone calls from the CERT contractor. Providers who fail to submit medical documentation to the CERT contractor should expect to receive overpayment demand letters from their AC, as services for which there is no documentation are interpreted as services not rendered.

Additional Information

The fax numbers for the CERT contractor are:
804-864-3268;
804-864-9940; and
804-864-9979.

You can also mail documentation to:
AdvanceMed
CERT Operations Center
1530 E. Parham Road
Richmond, VA 23228

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

To learn more about the CERT program, you can view the manual instructions issued to your carrier/intermediary under CR 2976 by visiting:
http://www.cms.hhs.gov/manuals/pm_trans/R67PI.pdf

Recently, CMS issued additional clarifications (CR3229) to your carrier/intermediary. To view these clarifications, visit:
http://www.cms.hhs.gov/manuals/pm_trans/R77PI.pdf

To find future CERT manual instructions issued to your carrier/intermediary, visit:
http://www.cms.hhs.gov/manuals/108_pim/pim83c12.pdf

Related Change Request (CR) #: 2976
Medlearn Matters Number: MM2976
Related CR Release Date: February 27, 2004
Related CR Transmittal #: 67
Effective Date: March 12, 2004
Implementation Date: March 12, 2004

CORRECTIONS

33215: Implantation of Automatic Defibrillators

This local coverage determination (LCD) was published in the Third Quarter 2004 *Medicare B Update* as a new policy. Since that time, ICD-9-CM codes 427.41(Ventricular fibrillation), 427.42 (ventricular flutter), and 996.61 (infection and inflammatory reaction due to internal prosthetic device, implant, and graft), have been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy.

The policy number was changed from 33215 to 33216. This revision is effective for services rendered on or after July 6, 2004. The full text revised LCD will be available on the provider education Web site *http://www.connecticutmedicare.com* on or after that date.

71010: Radiologic Examination of the Chest—Correction

We published an article in the First Quarter 2004 *Medicare B Update!* (pages 54-55) containing the list of the local medical review policies (LMRPs) for procedure codes with specific diagnosis criteria affected by the 2004 ICD-9-CM update. In the list of ICD-9-CM codes for LMRP *71010*: Radiologic Examination of the Chest, diagnosis 786.9 was published in error. The correct ICD-9-CM code is **768.9**. Connecticut Medicare apologizes for any inconvenience this may have caused.

The full text revised LMRP will be available on the provider education Web site *http://www.connecticutmedicare.com*..

LMRP/LCD (NEW)

G0104: Colorectal Cancer Screening

This Local Coverage Determination is being developed as a result of National Coverage for colorectal cancer screening. Colorectal cancer (CRC) is the second leading cause of cancer-related deaths in the United States. However, CRC is one of the most preventable cancers, as well as one of the most curable cancers when detected at an early stage. More than 33 percent of deaths from CRC could be avoided if people over 50 had regular screening tests. Risks for developing CRC increases with age. The following HCPCS codes for colorectal cancer screening are covered:

- G0107 – Colorectal cancer screening: fecal-occult blood test, 1-3 simultaneous determinations;
- G0328 – Colorectal cancer screening; fecal-occult blood test, immunoassay
- G0104 – Colorectal cancer screening; flexible sigmoidoscopy;
- G0105 – Colorectal cancer screening; colonoscopy on individual at high risk;
- G0106 – Colorectal cancer screening barium enema; alternative to G0104, screening sigmoidoscopy;
- G0120 – Colorectal cancer screening barium enema; alternative to G0105, screening colonoscopy;
- G0121 – Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

Medicare will pay for a covered fecal-occult blood test (either G0107 or G0328, but not both) at a frequency of once every 12 months after a beneficiary has attained age 50.

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay for the interrupted colonoscopy at a rate consistent with that of a flexible sigmoidoscopy as long as coverage conditions are met for the incomplete procedure. When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for this procedure as long as coverage conditions are met.

Any time the scheduled colorectal screening service turns into a diagnostic therapeutic service, the applicable diagnostic/therapeutic procedure code should be billed.

This policy is effective for services rendered on or after September 30, 2004. The full text revised LCD will be available on the provider education Web site *http://www.connecticutmedicare.com* on or after that date.

92250: Fundus Photography

Fundus photography is a procedure involving the use of a retinal camera to photograph the regions of the vitreous, retina, choroids, and optic nerve for diagnostic purposes. These photographs are also used for therapeutic assessment of recently performed retinal laser surgery and to aid in the interpretation of fluorescein angiography.

A widespread probe was performed for procedure code 92250 (Fundus photography with interpretation and report) and based on the findings, a local coverage determination (LCD) for fundus photography has been developed to identify a procedure-to-diagnosis relationship and documentation requirements with an LCD attachment that includes coding guidelines.

This revision is effective for services rendered on or after September 30, 2004. The full text revised LCD will be available on the provider education Web site *http://www.connecticutmedicare.com* on or after that date.

LMRP/LCD (REVISED)

EPO: Epoetin alfa

The local coverage determination (LCD) for epoetin alfa was last revised January 5, 2004. Since that time the policy has been revised to remove all language regarding criteria for serum erythropoietin levels.

This revision is effective for dates of service on or after July 6, 2004. The full text revised LCD will be available on the provider education Web site *http://www.connecticutmedicare.com* on or after that date.

J2916: Ferrlecit®

The local medical review policy/local coverage determination for Ferrlecit® was last updated on January 1, 2003.

A revision to the policy was made for clarification regarding the dual diagnoses. Under the "ICD-9 Codes that Support Medical Necessity" section of the policy, the words "for renal disease" were removed.

At the end of this section, the previous wording read as follows:

*The billing of Ferrlecit® for renal disease requires a dual diagnosis. ICD-9 codes 585 and one of the secondary codes for iron deficiency anemia (ICD-9 codes 280.0, 280.1, 280.8, or 280.9) must be submitted to ensure reimbursement.

The text now reads as follows:

*The billing of Ferrlecit® requires a dual diagnosis. ICD-9 codes 585 and one of the secondary codes for iron deficiency anemia (ICD-9 codes 280.0, 280.1, 280.8, or 280.9) must be submitted to ensure reimbursement.

The new LCD format was implemented with this policy revision.

These changes are effective for claims processed on or after May 4, 2004. The full text revised LCD will be available on the provider education Web site *http://www.connecticutmedicare.com* on or after that date.

J9000: Antineoplastic Drugs

The local medical review policy/local coverage determination for antineoplastic drugs was last updated on January 1, 2004. A revision to the policy was made to update the following drug codes with the addition of the ICD-9-CM codes listed below based on the Compendia-Based Drug Bulletin and/or the Antineoplastic Drugs Workgroup for diagnoses and/or indications and limitations of coverage.

CPT Codes:	Diagnosis Codes Added:
J9000 (Doxorubicin)	152.0-152.9, 153.0-153.9, 155.1, 156.0-156.9, 158.8, 162.0, 164.8, 181, 183.2, 197.6, 198.5, 259.2
J9001 (Doxorubicin, Liposomal)	158.8, 158.9, 170.0-170.9, 171.0-171.9, 197.6, 203.00-203.01
J9045 (Carboplatin)	151.0, 158.9, 197.6
J9170 (Docetaxel)	158.8, 158.9, 160.0-160.9, 170.0-170.9, 197.6
J9178 (Epirubicin)	158.8, 158.9, 197.6
J9181, J9182 (Etoposide)	158.8, 158.9, 164.8, 181, 183.2, 197.6, 198.5
J9185 (Fludarabine)	204.90-204.91
J9200 (Floxuridine)	155.1, 158.8, 158.9, 197.6
J9201 (Gemcitabine)	158.0-158.9, 164.2, 164.3, 164.8, 164.9, 181, 194.4, 197.6

J9206 (Irinotecan)	162.0
J9265 (Paclitaxel)	158.9, 160.0-160.9, 197.6
J9280, J9290, J9291 (Mitomycin)	154.2, 154.3, 160.0-160.9
J9350 (Topotecan)	158.8, 158.9, 197.6
J9390 (Vinorelbine tartrate)	158.8, 158.9, 197.6

Under the Indications and Limitations of Coverage and/or Medical Necessity, additional off label uses were added, changed, or removed for the following CPT codes: J9000, J9001, J9045, J9170, J9178, J9181 & J9182, J9185, J9200, J9201, J9206, J9263, J9310, J9350, and J9390.

The new LCD format was implemented with this policy revision, with a coding guidelines attachment.

This revision is effective for services rendered on or after September 3, 2004. The full text revised LCD will be available on the provider education Web site *http://www.connecticutmedicare.com* on or after that date.

NESP: Darbepoetin alfa(Aranesp®)(novel erythropoiesis stimulating protein [NESP])

The local medical review policy (LMRP) for Aranesp® was last revised February 2, 2004. Since that time, we have received information supporting additional criteria for extended dosing. This policy was revised to extend dosing guidelines for patients with anemia associated with chronic renal failure that does not require dialysis. The LMRP has been converted to the local coverage determination (LCD) format.

This revision is effective for services rendered on or after June 8, 2004. The full text revised LCD will be available on the provider education Web site *http://www.connecticutmedicare.com* on or after that date.

NCSVCS: The list of Medicare Noncovered Services

The local medical review policy/local coverage determination for NCSVCS was last updated on July 1, 2004. The local medical review policy/local coverage determination for noncovered services was originally developed to create a list of medical services and procedures that are never covered because a national decision exists for noncoverage, or the service/procedure was determined by the contractor to be excluded from coverage.

The following CPT codes have been added to this policy as local noncovered services:

- *97755 – Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes (New 2004 CPT Code)*
- *0016T – Destruction of localized lesion of choroids (e.g., choroidal neovascularization), transpupillary thermotherapy*
- *0060T – Electrical impedance scan of the breast, bilateral (risk assessment device for breast cancer) (New 2004 CPT Code)*

According to CMS, procedure code 97755 is provided by a "Rehabilitation Engineer". Because Medicare does not recognize this specialty, this service has been added to the list of noncovered services.

Procedure code 0016T for transpupillary thermotherapy (TTT) delivers heat to the choroids and retinal pigment epithelium through the pupil using a modified diode laser. With TTT, a low power laser is used, thus enabling its use for prolonged periods of time. TTT is designed to gently heat the choroidal lesion, thus limiting damage to the overlying retinal pigment epithelium. Because TTT is considered investigational as a treatment of choroidal neovascularization due to lack of data regarding use and impact on health outcomes, this procedure is a noncovered service.

Procedure code 0060T is bilateral electrical impedance scan (T Scan) of the breast as a risk assessment device for breast cancer. It is recommended for patients under age 40 who are asymtomatic and present to their doctors for an annual check-up, that includes a clinical breast exam (CBE). The T-Scan is an additional screening test that does not take the place of a mammography, and does not offer any absolute diagnostic distinctions. Therefore, this code has been included in the noncovered services.

CPT code 90760 for Routine Physical Exam is no longer valid. Therefore, it has been replaced with 99391-99397 for Period Comprehensive Preventive Medicine.

The new LCD format was implemented with this policy revision. This revision is effective for services furnished on or after 09/30/2004 for codes 0060T and 97755, and effective for claims processed for procedure codes 99391-99397. The revision for code 94799 is effective for services furnished on or after January 1, 2004.

Furthermore, the descriptor for procedure code G0295 has been revised based on Transmittal 173, Change Request 3286, dated May 7, 2004. Effective for services performed on or after July 1, 2004, the descriptor has been revised as follows: *"Electromagnetic therapy, to one or more areas, for wound care other than described in G0329 or for other uses."* The full text revised LCD will be available on the provider education Web site *http://www.connecticutmedicare.com* on or after that date.

ZEVALIN: Ibritumomab Tiuxetan (Zevalin™) Therapy

The local medical review policy (LMRP) for ibritumomab tiuxetan (Zevalin) therapy was last revised January 1, 2004. It has been brought to our attention that services billed with CPT codes 78804 and 79403 were receiving denials when not billed with the ICD-9 codes listed in the policy. Although these codes are included in this policy, they are not exclusive to Zevalin. Therefore, the policy has been revised to specify the appropriate CPT and diagnosis codes for use when rendering this service. The LMRP has been converted to the local coverage determination (LCD) format.

This revision is effective for claims processed on or after May 25, 2004. The full text revised LCD will be available on the provider education Web site *http://www.connecticutmedicare.com* on or after that date.

65855: Laser Trabeculoplasty

The latest revision for local medical review policy (LMRP) laser trabeculoplasty was effective May 8, 2003. This policy has been revised to remove ICD-9-CM code 365.24 (residual stage of angle-closure glaucoma) from the "ICD-9 Codes that Support Medical Necessity" section of the policy. ICD-9-CM code 365.32 (corticosteroid-induced glaucoma, residual stage) has been added to the "ICD-9 Codes that Support Medical Necessity" section of the policy. This policy has also been converted into the local coverage determination (LCD) format. This LCD has a linked LCD attachment that includes coding guidelines.

This revision is effective for services rendered on or after September 30, 2004. The full-text of this local coverage determination may be viewed on the provider education Web site *http://www.connecticutmedicare.com* when it becomes available.

67221: Ocular Photodynamic Therapy with Verteporfin

The latest revision for local medical review policy (LMRP) ocular photodynamic therapy (OPT) was effective August 20, 2002. This policy has been converted into the local coverage determination (LCD) format. This LCD has been revised per Change Request 3191, dated April 1, 2004 to expand the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD as follows: Effective April 4, 2004, Medicare will consider OPT with verteporfin medically reasonable and necessary when performed for treating: subfoveal occult with no classic choroidal neovascularization (CNV) associated with AMD and subfoveal minimally classic CNV (where the area of classic CNV occupies <50 percent of the area of the entire lesion) associated with AMD. These two indications will be considered reasonable and necessary only when: the lesions are small (4 disk areas or less in size) at the time of initial treatment or within the 3 months prior to initial treatment and the lesions have shown evidence of progression within the 3 months prior to initial treatment. OPT with verteporfin medically reasonable and necessary when performed for treating: Patients with predominantly classic subfoveal CNV associated with macular degeneration, secondary to presumed ocular histoplasmosis or pathologic myopia. In this regard, the following ICD-9-CM codes have been added to the "ICD-9 Codes that Support Medical Necessity" section of the LCD: 115.02, 115.92 and 360.21.

The full-text of this local coverage determination may be viewed on the provider education Web site *http://www.connecticut medicare.com* when it becomes available.

70544: Magnetic Resonance Angiography (MRA)

A corrected article was published in the Third Quarter 2004 *Medicare B Update!* listing the ICD-9-CM codes for MRA of the pelvis (72198). The article failed to mention additional ICD-9-CM codes had also been added to MRA of the abdomen (**74185**).

The following additional ICD-9-CM codes for MRA of the abdomen (74185) have been included in the policy:

441.03, 441.9, 444.0, 447.1, 996.81, V12.59

These changes are effective for services rendered on or after January 5, 2004. The full-text of the revised LMRP is available on our provider education Web site at *http://www.connecticutmedicare.com*.

In addition, the local medical review policy (LMRP) for Magnetic Resonance Angiography (MRA) -70544 was previously revised on June 9, 2003, and published in the Fourth Quarter 2003 *Medicare B Update!* (page 74). During that time, additional ICD-9-CM codes 198.0, 223.0, 223.1, 233.9, 263.90-236.99, 403.00-403.91, 404.00-404.93, 405.01, 405.11, 405.91, 440.1, 447.3, 580.0-580.9, 581.0-581.9, 582.0-582.9, 583.0-583.9, 588.0-588.9, 593.81, 593.9 were added to MRA of the abdomen (CPT code **74185**).

These changes are effective for services rendered on or after July 1, 2003. The full text revised LCD will be available on the provider education Web site *http://www.connecticutmedicare.com* on or after that date.

83880: B-Type Natriuretic Peptide (BNP)

The original local medical review policy (LMRP) B-Type natriuretic peptide (BNP) was effective January 5, 2004. This policy has been converted into the local coverage determination (LCD) format. This LCD has a linked LCD attachment, which indicates that the places of service allowed to perform this service have been expanded to include urgent care facilities (POS 20).

93975: Duplex Scanning

The local medical review policy (LMRP) for duplex scanning – 93975 was effective September 29, 2003. Since that time, the policy has been converted to Local Coverage Determination (LCD) format and diagnosis codes V42.0, V42.7, V42.83 and 902.29 have been added to the "ICD-9 Codes that Support Medical Necessity" section of this policy for procedure codes 93975 and 93976 and diagnosis codes 440.20 and 440.29 have been added to the "ICD-9 Codes that Support Medical Necessity" section of this policy for procedure codes 93978 and 93979. In addition, an indication was added to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy for procedure codes 93975 and 93976.

These changes are effective for services rendered on or after July 26, 2004. The full text revised LCD will be available on the provider education Web site *http://www.connecticutmedicare.com* on or after that date.

98940: Chiropractic Services

The latest revision for local medical review policy (LMRP) chiropractic services was effective April 27, 2004. Program Memorandum 12 (Change Request 3063, dated 05/28/2004) was issued to communicate revisions for chiropractic services. Revisions include changes in definitions for chronic subluxation and maintenance therapy. Also, this change request added the following requirement: The AT (acute treatment) modifier must be used when providing active/corrective treatment for acute or chronic subluxation as claims submitted without the AT modifier will be considered as maintenance therapy and denied. Therefore, revisions have been made to the following sections of the policy:

- Indications and Limitations of Coverage and/or Medical Necessity
- Documentation Requirements
- Utilization Guidelines
- Coding Guidelines

This policy has also been converted into the local coverage determination (LCD) format with an LCD attachment which includes the coding guidelines.

These revisions are effective for services rendered on or after October 1, 2004. The full text revised LCD will be available on the provider education Web site *http://www.connecticutmedicare.com* on or after that date.

COMPREHENSIVE DATA ANALYSIS

Modifier Billing Error Identified for Computed Tomography of the Abdomen – Connecticut Only

The comprehensive data analysis staff evaluated Connecticut carrier claims data for computed tomography (CT) of the abdomen. The analysis revealed the possibility of duplicate billing of modifier 26 (professional component). It appears that duplicate professional reading of the same CT scan may be taking place. It is also possible that duplicate scans are being performed but billed with an incorrect modifier.

A modifier provides the means by which the reporting physician can indicate that a service or procedure has been altered by some specific circumstance but has not changed in its definition or code. The judicious application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstances. For example, modifiers may be used to indicate to the recipient of a report that:

- a service or procedure has both a professional and technical component;
- a service or procedure was performed by more than one physician and/or in more than one location; or
- a service or procedure was provided more than once.

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, adding modifier 26 to the appropriate procedure code may identify the service. Code of Federal Regulation specifies that the professional component of a diagnostic procedure include an interpretation and written report for inclusion into the beneficiary's medical record. When a procedure needs to be repeated by the same physician subsequent to the to the original service, it should be reported by adding the modifier 76 (repeat procedure by same physician) to the appropriate procedure code. Repeat procedures by a different physician should be reported with modifier 77(repeat procedure by another physician) appended to the appropriate procedure code.

We encourage providers to examine their current billing practices and ensure only appropriate modifiers are submitted.

CONNECTICUT EDUCATIONAL RESOURCES

Evaluation & Management Hot Topics Campaign

Presented by First Coast Service Options, Inc.,
Your Connecticut Medicare Part B Carrier

Connect With Medicare "Let's Talk" Teleconference
Start Date: August 25, 2004
Duration: 1 Hour-30 minutes
Registration: **NO REGISTRATION/OPEN TO FIRST 100 CALLERS**!

Recent data analysis confirms that there is a need for continuing education on the Evaluation and Management visit codes, related modifiers and the following issues affecting claim denial and unprocessable claims:

- Correct Coding Initiative (bundling of codes), fragmented billing
- Provider Identification Number (PIN) or group number missing
- Diagnosis denial (LMRP)
- Invalid or missing modifier
- Duplicate claim submission
- Unique Provider Identification Number (UPIN) missing or invalid
- Primary diagnosis not linked correctly on claim
- Place of service codes

The provider specialty type identified as having a high volume of inquiry during this period fell into the general physician type. Other specialty types identified in the data included primary care, ophthalmology, optometrist, psychiatry, physical medicine/rehabilitation, and orthopedics.

We have scheduled this "Let's Talk" teleconference to provide a forum for providers to talk with subject matter experts and for the carrier to provide updates on processing guidelines. This forum is scheduled as follows:

Date: Wednesday, August 25, 2004
Start Time: 1:00 p.m.
Call-in Phone#:
Conference ID: Evaluation & Management
Conference Leader: Estella Ramirez

For current educational event updates, Listserv registration and educational materials, please visit our Web site at *http://www.connecticutmedicare.com*. If you have any further questions you may call the Education Team at 203-634-5430/5514.

Global Surgery Hot Topics Campaign

Presented by First Coast Service Options, Inc.,
Your Connecticut Medicare Part B Carrier

Connect With Medicare "Let's Talk" Teleconference
Start Date: August 11, 2004
Duration: 1 Hour-30 minutes
Registration: **NO REGISTRATION/OPEN TO FIRST 100 CALLERS!**

Recent data analysis confirms that there is a need for continuing education on the Global Surgery concept, related modifiers and the following issues affecting claim denial and unprocessable claims:

- Correct Coding Initiative (bundling of codes), fragmented billing
- Provider Identification Number (PIN) or group number missing
- Diagnosis denial (LMRP)
- Invalid or missing modifier
- Duplicate claim submission
- Unique Provider Identification Number (UPIN) missing or invalid
- Primary diagnosis not linked correctly on claim
- Place of service codes

The provider specialty type identified as having a high volume of inquiry during this period fell into the general physician type. Other specialty types identified in the data included primary care, ophthalmology, optometry, psychiatry, physical medicine/rehabilitation, and orthopedics.

We have scheduled this "Let's Talk" teleconference to provide a forum for providers to talk with subject matter experts and for the carrier to provide updates on processing guidelines. This forum is scheduled as follows:

Date: Wednesday, August 11, 2004
Start Time: 1:00 p.m.
Call-in Phone#: 1-800-860-2442
Conference ID: Global Surgery
Conference Leader: Donna Pisani

For current educational event updates, Listserv registration and educational materials, please visit our Web site at *http://www.connecticutmedicare.com*. If you have any further questions you may call the Education Team at 203-634-5430/5514.

CONNECTICUT MEDICARE PART B MAIL DIRECTORY

Connecticut Medicare Part B welcomes any questions that you may have regarding the Medicare Part B program. Always be sure to clearly explain your question or concern. This will help our staff to know exactly what issues to address when developing a response to your inquiry.

Please submit your questions to the appropriate department. This will ensure that your concerns are handled in a proper and timely manner. This can be achieved by including an Attention Line below the address on the envelope. Listed below is a directory of departments that includes the issues that you would address to their attention.

With the exception of Reviews and Medicare EDI, please submit all correspondence with the appropriate attention line to:

Attention: (insert dept name)
Medicare Part B CT
P.O. Box 45010
Jacksonville, FL 32232-5010

Attention: Correspondence

The Correspondence attention line is used for inquiries pertaining to general issues regarding Medicare Part B. Some examples of these issues are deductibles, assignment, and beneficiary address changes. Do not use words such as *REVIEW* or *RECHECK* when sending general correspondence.

Attention: Financial Services

Use this attention line to return duplicate payments or overpayment refunds.

Attention: Fraud and Abuse

If you encounter what you believe is suspected, potential, or possible fraud or abuse of the Medicare program, we encourage you to contact this department.

Attention: Freedom of Information (FOIA)

This department handles requests for information available under the Freedom of Information Act.

Attention: Medical Review

Questions regarding LMRPs/LCDs and correct documentation for evaluation and management services are handled by this department. Documentation for off-label chemotherapy use should also be submitted to the Medical Review Department.

Attention: MSP

Write to the Medicare Secondary Payer (MSP) department when submitting an Explanation of Benefits from a primary insurance, Exhaust letters from Auto Liability claims, and MSP calculation review requests.

Attention: Pricing/ Provider Maintenance

Address your envelope to this department to apply for a new provider number, change a business or billing address of a provider, or to make any changes in the status of a provider. This department also handles fee schedule requests and inquiries, participation requests, and UPIN requests.

Attention: Resolutions

Use the Resolutions attention line when inquiring or submitting information regarding dates of death, incorrect Medicare (HIC) numbers, incorrect beneficiary information, etc.

MAILING ADDRESS EXCEPTIONS

We have established special P.O. boxes to use when mailing your review and hearings requests, paper claims, or to contact Medicare EDI:

Reviews/Appeals

Please mail only your requests for reviews to this P.O. Box. *DO NOT* send new claims, general correspondence, or other documents to this location; doing so will cause a delay in the processing of that item.

If you believe the payment or determination is incorrect and want a claim to be reconsidered, then send it to the attention of the review department. Requests for review must be made within 120 days of the date of the Medicare Summary Notice. These requests should not include review requests on Medicare Secondary Pay calculations. Claims that are denied for return/reject need to be resubmitted and should not be sent as a review. These resubmitted claims should be sent in as new claims.

Hearings

If you believe that your review determination was incorrect and want it reviewed by a Hearing Officer, send your inquiry to the attention of the Hearing Department. A request for a hearing must be made within six months of the date of the Review Department determination and at least $100.00 must remain in controversy from this decision.

Post Office Box for Appeals/Hearings:

Medicare Part B CT Appeals/Hearings
First Coast Service Options, Inc.
P.O. Box 45041
Jacksonville, FL 32232-5041

Electronic Media Claims/EDI

The Electronic Data Interchange department handles questions and provides information on electronic claims submission (EMC).

Post Office Box for EDI:

Medicare Part B CT Medicare EDI
P.O. Box 44071
Jacksonville, FL 32231-4071

Claims

The Heath Insurance Portability and Accountability Act (HIPAA) requires electronic submission of mpst types of Medicare claims. We realize, however, that on occasion it is necessary to submit a paper claim. When this happens, submit your claims on the approved red-and-white Form CMS-1500 to:

Medicare Part B CT CLaims
P.O. Box 44234
Jacksonville, FL 32231-4234

CONNECTICUT MEDICARE PHONE NUMBERS

Provider Services
First Coast Service Options, Inc.
Medicare Part B
1-866-419-9455 ***(toll-free)***

Beneficiary Services
1-800-MEDICARE ***(toll-free)***
1-866-359-3614 *(hearing impaired)*

Electronic Data Interchange (EDI)
Enrollment
1-203-639-3160, option 1

PC-ACE® PRO-32
1-203-639-3160, option 2

Marketing and Reject Report Issues
1-203-639-3160, option 4

Format, Testing, and Remittance Issues
1-203-639-3160, option 5

Electronic Funds Transfer Information
1-203-639-3219

Hospital Services
Empire Medicare Services
Medicare Part A
1-800-442-8430

Durable Medical Equipment
HealthNow NY
DMERC Medicare Part B
1-800-842-2052

Railroad Retirees
Palmetto GBA
Medicare Part B
1-800-833-4455

Quality of Care
Peer Review Organization
1-800-553-7590

OTHER HELPFUL NUMBERS

Social Security Administration
1-800-772-1213

American Association of Retired Persons (AARP)
1-800-523-5800

To Report Lost or Stolen Medicare Cards
1-800-772-1213

Health Insurance Counseling Program
1-800-994-9422

Area Agency on Aging
1-800-994-9422

Department of Social Services/ConnMap
1-800-842-1508

ConnPace/ Assistance with Prescription Drugs
1-800-423-5026

WEB SITES

PROVIDER
Connecticut
http://www.connecticutmedicare.com
Centers for Medicare & Medicaid Services
http://www.cms.hhs.gov

BENEFICIARY
Connecticut
http://www.connecticutmedicare.com
Centers for Medicare & Medicaid Services
http://www.medicare.gov

FLORIDA MEDICAL REVIEW

This section of the *Medicare B Update!* features summaries of new and revised medical policies/coverage determinations 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 that the carrier's medical policies and review guidelines are consistent with accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), carriers no longer include full-text local medical review policies (LMRPs)/local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LMRPs/LCDs are provided instead. Providers may obtain full-text LMRPs/LCDs on our provider education Web site, *http://www.floridamedicare.com*. Final LMRPs/LCDs, draft LMRPs/LCDs available for comment, LMRP/LCD statuses, and LMRP/LCD comment/response summaries may be printed from the Part B Medical Policy section.

Effective and Notice Dates

Effective dates are provided in each policy, and are based on the date of service (unless otherwise noted in the policy). Medicare contractors are required to offer a 45-day notice period for LMRPs/LCDs; the date the LMRP/LCD is posted to the Web site is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new and revised LMRPs/LCDs are posted to the Web site, subscribe to the FCSO *eNews* mailing list. It's very easy to do; simply sign on to the provider education Web site, *http://www.floridamedicare.com;* click on the yellow "Join our electronic mailing list" bar and follow the prompts.

More Information

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

Medical Policy
First Coast Service Options, Inc.
P.O. Box 2078
Jacksonville, FL 32231-0048

1-904-791-8465

Medical Review Table of Contents

Advance Notice Statement

Advance Beneficiary Notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

Reminder to Providers to Supply Information to Medicare's Comprehensive Error Rate Testing (CERT) Program

Provider Types Affected

All Medicare providers.

Provider Action Needed

Providers are reminded that they must comply with requests from Medicare contractors for medical records needed for the CERT program.

Background

The CERT program produces national, contractor-specific, and service-specific paid claim error rates, as well as a provider compliance error rate. The paid claim error rate is a measure of the extent to which the Medicare program is paying claims correctly. The provider compliance error rate is a measure of the extent to which providers are submitting claims correctly. The program uses independent reviewers to review representative random samples of Medicare claims (including both paid claims and denied claims) to ensure that the decision was appropriate.

The CERT process begins at the Affiliated Contractor (AC) — your Medicare carrier or intermediary processing site — where claims have entered the Medicare claims processing system. The CERT contractor randomly selects and extracts claims from the claims processing system each day. The CERT contractor obtains medical records from providers (or from the AC, if the AC had previously subjected the claim to manually medical review).

The CERT contractor requests medical records from providers in a written format, including a checklist of the types of documentation required. In addition, the CERT contractor follows up on written requests with phone calls to providers. Providers must submit documentation to the CERT Operations Center via fax or by mail at the number/address specified in the *Additional Information* section below.

Although providers are required to send documentation to support claims as part of the CERT process, many providers do not comply with this requirement. Providers may believe that it is a HIPAA violation to send patient records to CERT, they may not understand the CERT process, or they may not understand the importance of sending documentation in a timely fashion. It is, however, important to respond in a timely fashion to CERT requests and to provide the CERT contractor with all applicable medical records used to support a sampled claim.

If providers do not respond to initial CERT requests for medial records, they will receive up to four letters and three phone calls from the CERT contractor. Providers who fail to submit medical documentation to the CERT contractor should expect to receive overpayment demand letters from their AC, as services for which there is no documentation are interpreted as services not rendered.

Additional Information

The fax numbers for the CERT contractor are:
804-864-3268;
804-864-9940; and
804-864-9979.

You can also mail documentation to:
AdvanceMed
CERT Operations Center
1530 E. Parham Road
Richmond, VA 23228

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

To learn more about the CERT program, you can view the manual instructions issued to your carrier/intermediary under CR 2976 by visiting:
http://www.cms.hhs.gov/manuals/pm_trans/R67PI.pdf

Recently, CMS issued additional clarifications (CR3229) to your carrier/intermediary. To view these clarifications, visit:
http://www.cms.hhs.gov/manuals/pm_trans/R77PI.pdf

To find future CERT manual instructions issued to your carrier/intermediary, visit:
http://www.cms.hhs.gov/manuals/108_pim/pim83c12.pdf

Related Change Request (CR) #: 2976
Medlearn Matters Number: MM2976
Related CR Release Date: February 27, 2004
Related CR Transmittal #: 67
Effective Date: March 12, 2004
Implementation Date: March 12, 2004

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CORRECTIONS

93501: Cardiac Catheterization

An article was published in the *Third Quarter 2004 Medicare B Update!* (page 80). However, since that time the ICD-9-CM codes were removed from the "ICD-9-CM Codes that Support Medical Necessity" section of the policy based on data analysis.

This revision is effective for service rendered on or after July 6, 2004. The full-text of this local coverage determination may be viewed on the provider education Web site *http://www.floridamedicare.com* when it becomes available.

LMRP/LCD (NEW)

32491: Lung Volume Reduction Surgery (LVRS)

LVRS or reduction pneumoplasty, also referred to as lung shaving or lung contouring, is performed on patients with severe emphysema in order to allow the remaining compressed lung to expand, thereby improving respiratory function.

The Centers for Medicare & Medicaid Services (CMS) developed a national coverage determination (NCD) for LVRS in October 2003. Effective January 1, 2004, the NCD expanded coverage for LVRS.

CMS instructed carriers to develop ICD-9-CM codes that support medical necessity for LVRS. This LCD was developed to outline the criteria specified in the NCD and to define appropriate ICD-9-CM codes for lung volume reduction surgery.

This policy is effective for services rendered on or after September 30, 2004. The full text revised LCD will be available on the provider education Web site *http://www. floridamedicare.com* on or after that date.

80076: Hepatic (Liver) Function Panel

The hepatic function panel consists of albumin; bilirubin, total; bilirubin, direct; phosphatase, alkaline; protein, total; transferase, aspartate amino (AST)(SGOT). Analysis of data revealed that CPT 80076 (hepatic panel function) is an aberrant code in Florida.

The hepatic function panel may be helpful for the assessment and management of individuals with hepatic disease or injury and for monitoring the effects of medication and toxic material on liver function. A local coverage determination (LCD) for hepatic function panel has been developed to define indications and limitations and to provide guidance regarding the type of documentation that should be maintained to support medical necessity.

This policy was presented to the Carriers Advisory Committee February 21, 2004. It will be effective for services rendered on or after September 30, 2004. The full text LCD will be available on the provider education Web site *http://www.floridamedicare.com* 45 days prior to that date.

92250: Fundus Photography

Fundus photography is a procedure involving the use of a retinal camera to photograph the regions of the vitreous, retina, choroid and optic nerve for diagnostic purposes. These photographs are also used for therapeutic assessment of recently performed retinal laser surgery and to aid in the interpretation of fluorescein angiography.

Local medical review policy (LMRP) 92015 ophthalmological diagnostic services includes the covered diagnosis codes for CPT code 92250 fundus photography. However, this LMRP is only a procedure to diagnosis billing guideline and medical necessity issues are not addressed. Therefore, a separate and distinct policy has been developed and LMRP 92015 will be revised to delete references for procedure code 92250.

A local coverage determination (LCD) for fundus photography has been developed to identify a procedure to diagnosis relationship and documentation requirements with an LCD attachment that includes coding guidelines.

This revision is effective for services rendered on or after September 30, 2004. The full-text of this local coverage determination may be viewed on the provider education Web site *http://www.floridamedicare.com* when it becomes available.

LMRP/LCD (REVISED)

A4644: Low Osmolar Contrast Media

The local coverage determination (LCD) for low osmolar contrast media (LOCM) was last revised effective April 1, 2004.

Since that time, CR 3187, Transmittal 74, issued April 23, 2004 notified carriers to correct the effective date for instructions in a previous change request (CR 3053) that was incorporated into Florida's LCD for LOCM. The LCD was revised to reinstate HCPCS codes A4644 through A4646 and to change the status of code A9525 to "not payable by Medicare." The effective date for these changes was published as dates of service on or after April 1, 2004. *This date was incorrect.* These changes are to be retroactive to January 1, 2004. Therefore, codes A4644 through A4646 are reinstated as of January 1, 2004, and code A9525 is invalid for dates of service on or after January 1, 2004.

This revision is effective for dates of service January 1, 2004. The full-text of this local coverage determination may be viewed on the provider education Web site *http://www.floridamedicare.com* when it becomes available.

EPO: Epoetin alfa

The local coverage determination (LCD) for epoetin alfa was last revised January 5, 2004. Since that time the policy has been revised to remove all language regarding criteria for serum erythropoietin levels.

This revision is effective for dates of service on or after July 6, 2004. The full text revised LCD will be available on the provider education Web site *http://www. floridamedicare.com* on or after that date.

G0108: Diabetes Outpatient Self-Management Training

The latest revision for local medical review policy (LMRP) Diabetes Outpatient Self-Management Training was effective January 1, 2004. Program Memorandum 13 (Change Request 3185, dated 05/28/2004) was issued to communicate revisions for Diabetes Outpatient Self-Management Training (DSMT). Revisions include: Changes in definition for diabetes mellitus and criteria for diagnosing diabetes mellitus, and coverage for initial and follow-up training. Revisions were made to the following sections of the policy:

- Indications and Limitations of Coverage and/or Medical Necessity
- Documentation Requirements
- Utilization Guidelines

This policy has also been converted into the local coverage determination (LCD) format with an LCD attachment that includes coding guidelines.

These revisions are effective for services performed on or after January 1, 2004. The full-text of this local coverage determination may be viewed on the provider education Web site *http://www.floridamedicare.com* when it becomes available.

J1563: Intravenous Immune Globulin

The local coverage determination (LCD) for intravenous immune globulin was last revised January 1, 2003. Since that time, a revision to the policy has been made. Diagnosis 358.0 is not to the highest level of specificity, therefore, diagnosis 358.0 (myasthenia gravis) has been changed to diagnosis range 358.00-358.01 in the "ICD-9 Codes that Support Medical Necessity" section of the LCD.

This revision is effective for services furnished on or after October 1, 2003. The full-text of this local coverage determination may be viewed on the provider education Web site*http://www.floridamedicare.com* when it becomes available.

J2916: Ferrlecit®

The local medical review policy/local coverage determination for Ferrlecit® was last updated on January 1, 2003.

A revision to the policy was made for clarification regarding the dual diagnoses. Under the "ICD-9 Codes that Support Medical Necessity" section of the policy, the words "for renal disease" were removed.

At the end of this section, the previous wording read as follows:

> *The billing of Ferrlecit® for renal disease requires a dual diagnosis. ICD-9-CM codes 585 and one of the secondary codes for iron deficiency anemia (ICD-9-CM codes 280.0, 280.1, 280.8, or 280.9) must be submitted to ensure reimbursement.

The text now reads as follows:

> *The billing of Ferrlecti® requires a dual diagnosis, ICD-9-CM code 585 and one of the secondary codes for iron deficiency anemia (ICD-P-CM codes 280.0, 280.1, 280.8, or 280.9) must be submitted to ensure reimbursement.

The new LCD format was implemented with this policy revision.

This revision is effective for claims processed on or after May 4, 2004. The full text revised LCD will be available on the provider education Web site *http://www. floridamedicare.com* on or after that date.

J9000: Antineoplastic Drugs

The local medical review policy/local coverage determination for Antineoplastic Drugs was last updated on January 1, 2004.

A revision to the policy was made to update the following drug codes with the addition of the ICD-9-CM codes listed below based on the Compendia-Based Drug Bulletin and/or the Antineoplastic Drugs Workgroup for diagnoses and/or indications and limitations of coverage.

CPT Codes:	Diagnoses Codes Added:
J9000 (Doxorubicin)	152.0-152.9, 153.0-153.9, 155.1, 156.0-156.9, 158.8, 162.0, 164.8, 181, 183.2, 197.6, 198.5 & 259.2
J9001 (Doxorubicin, Liposomal)	158.8, 158.9, 170.0-170.9, 171.0-171.9, 197.6, & 203.00-203.01
J9045 (Carboplatin)	151.0, 158.9, & 197.6
J9170 (Docetaxel)	158.8, 158.9, 160.0-160.9, 170.0-170.9, & 197.6
J9178 (Epirubicin)	158.8, 158.9, & 197.6
J9181 & J9182 (Etoposide)	158.8, 158.9, 164.8, 181, 183.2, 197.6, & 198.5
J9185 (Fludarabine)	204.90-204.91
J9200 (Floxuridine)	155.1, 158.8, 158.9, & 197.6
J9201 (Gemcitabine)	158.0-158.9, 164.2, 164.3, 164.8, 164.9, 181, 194.4, & 197.6
J9206 (Irinotecan)	162.0
J9265 (Paclitaxel)	158.9, 160.0-160.9, & 197.6
J9280, J9290, & J9291 (Mitomycin)	154.2, 154.3, & 160.0-160.9
J9350 (Topotecan)	158.8, 158.9, & 197.6
J9390 (Vinorelbine tartrate)	158.8, 158.9, & 197.6

Under the Indications and Limitations of Coverage and/or Medical Necessity, additional off label uses were added, changed, or removed for the following CPT codes:

J9000, J9001, J9045, J9170, J9178, J9181, J9182, J9185, J9200, J9201, J9206, J9263, J9310, J9350, and J9390.

The new LCD format was implemented with this policy revision, with a coding guidelines attachment. This revision is effective for services rendered on or after September 2, 2004. The full text revised LCD will be available on the provider education Web site *http://www. floridamedicare.com* on or after that date.

NESP: Darbepoetin alfa(Aranesp®)(novel erythropoiesis stimulating protein [NESP])

The local medical review policy (LMRP) for Aranesp® was last revised February 2, 2004. Since that time, we have received information supporting additional criteria for extended dosing. This policy was revised to extend dosing guidelines for patients with anemia associated with chronic renal failure that does not require dialysis. The LMRP has been converted to the local coverage determination (LCD) format.

This revision is effective for service rendered on or after June 8, 2004. The full-text of this local coverage determination may be viewed on the provider education Web site *http://www.floridamedicare.com* when it becomes available.

NCSVCS: The List of Medicare Noncovered Services

The local medical review policy/local coverage determination (LMRP/LCD) for noncovered services was originally last updated on July 1, 2004.

The LMRP/LCD for noncovered services was originally developed to create a list of medical services and procedures that are never covered because a national decision exists for noncoverage, or the service/procedure was determined by the contractor to be excluded from coverage.

The following CPT codes have been added to this policy as local noncovered services:

- *97755 – Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes*
- *0060T – Electrical impedance scan of the breast, bilateral (risk assessment device for breast cancer)*
- *94799 – Pulmonary Rehabilitation Services (Unlisted pulmonary services or procedure)*

According to CMS, a "rehabilitation engineer" provides procedure code 97755. Medicare does not recognize this specialty; therefore, this service has been added to the list of noncovered services.

Procedure code 0060T is bilateral electrical impedance scan (t scan) of the breast as a risk assessment device for breast cancer. It is recommended for patients under age 40 who are asymtomatic and present to their doctors for an annual check-up, that includes a clinical breast exam (CBE). The t-scan is an additional screening test that does not take the place of a mammography, and does not offer any absolute diagnostic distinctions. Therefore, this code has been included in the noncovered services.

The policy on pulmonary rehabilitation services has been retired. Per the *Federal Register*, December 31, 2002, (Vol. 67, no. 251) pages 79965-80184, there is no Medicare benefit for pulmonary rehabilitation. Therefore, code 94799 has been added to the list of noncovered services.

CPT code 90760 for routine physical exam is no longer valid. Therefore, it has been replaced with 99391-99397 for period comprehensive preventive medicine.

The new LCD format was implemented with this policy revision. This revision is effective for services furnished on or after September 30, 2004 for codes 0060T and 97755, and effective for claims processed for procedure codes 99391-99397. The revision for code 94799 is effective for services furnished on or after January 1, 2004.

Furthermore, the descriptor for procedure code G0295 has been revised based on Transmittal 173, Change Request 3286, dated May 7, 2004. Effective for services performed on or after July 1, 2004, the descriptor has been revised as follows: *"Electromagnetic therapy, to one or more areas, for wound care other than described in G0329 or for other uses."*

In addition, based on the Medicare National Coverage Determination Manual (Chapter 1, Section 260.5), Medicare covers intestinal and multi-visceral transplantation. Therefore procedure code 44799* (large and small bowel transplants) has been removed from the "Local Noncoverage Decisions" section of the policy.

This change is effective for services performed on or after April 1, 2001. The full text revised LCD will be available on the provider education Web site *http://www. floridamedicare.com* on or after that date.

ZEVALIN: Ibritumomab Tiuxetan (Zevalin™) Therapy

The local medical review policy (LMRP) for ibritumomab tiuxetan (Zevalin) therapy was last revised January 1, 2004. It has been brought to our attention that services billed with CPT codes 78804 and 79403 were receiving denials when not billed with the ICD-9-CM codes listed in the policy. Although these codes are included in this policy, they are not exclusive to Zevalin. Therefore, the policy has been revised to specify the appropriate CPT and diagnosis codes for use when rendering this service. The LMRP has been converted to the local coverage determination (LCD) format.

This revision is effective for claims processed on or after May 25, 2004. The full-text of this local coverage determination may be viewed on the provider education Web site *http://www.floridamedicare.com* when it becomes available.

33215: Implantation of Automatic Defibrillators

This local medical review policy was last revised effective August 11, 2003. This policy is based on National Coverage Decision (NCD Manual Section 204, 310.1) for the implantation of automatic defibrillators.

A revision to this policy has been made to remove procedure codes 33215, 33218, 33220, 33223, 33241, 33243, and 33244 since these codes apply to the repositioning, revision and repair of pacing cardioverter-defibrillators.

In addition, ICD-9-CM codes 427.41(ventricular fibrillation), 427.42 (ventricular flutter), and 996.61 (infection and inflammatory reaction due to cardiac device, implant, and graft) were added to the "ICD-9 Codes that Support Medical Necessity" section of the policy.

This revision is effective for service rendered on or after July 6, 2004. The full text revised LCD will be available on the provider education Web site *http://www. floridamedicare.com* on or after that date.

65855: Laser Trabeculoplasty

The original local medical review policy (LMRP) laser trabeculoplasty was effective September 29, 2003. This policy has been revised to add ICD-9-CM code 365.32 (Corticosteroid-induced glaucoma, residual stage) to the 'ICD-9 Codes that Support Medical Necessity' section of the policy. This policy has also been converted into the local coverage determination (LCD) format. This LCD has a linked LCD attachment that includes coding guidelines.

This revision is effective for services rendered on or after September 30, 2004. The full-text of this local coverage determination may be viewed on the provider education Web site *http://www.floridamedicare.com* when it becomes available.

67221: Ocular Photodynamic Therapy with Verteporfin

The latest revision for local medical review policy (LMRP) ocular photodynamic therapy (OPT) was effective August 20, 2002. This policy has been converted into the local coverage determination (LCD) format. This LCD has been revised per Change Request 3191, dated April 1, 2004, to expand the 'Indications and Limitations of Coverage and/or Medical Necessity' section of the LCD as follows: Effective April 1, 2004, Medicare will consider OPT with verteporfin medically reasonable and necessary when performed for treating: subfoveal occult with no classic choroidal neovascularization (CNV) associated with AMD and Subfoveal minimally classic CNV (where the area of classic CNV occupies <50 percent of the area of the entire lesion) associated with AMD. These two indications will be considered reasonable and necessary only when: the lesions are small (4 disk areas or less in size) at the time of initial treatment or within the 3 months prior to initial treatment and the lesions have shown evidence of progression within the 3 months prior to initial treatment. Evidence of progression must be documented by deterioration of visual acuity (at least 5 letters on a standard eye examination chart), lesion growth (an increase in at least 1 disk area), or the appearance of blood associated with the lesion.

The "Indications and Limitations of Coverage and/or Medical Necessity" section of this LCD has also been updated and revised to include: Effective for services rendered on or after June 7, 2004, Medicare will consider OPT with verteporfin medically reasonable and necessary when performed for treating patients with predominantly classic subfoveal CNV associated with macular degeneration, secondary to presumed ocular histoplasmosis or pathologic myopia. In this regard, the following ICD-9-CM codes have been added to the "ICD-9 Codes that Support Medical Necessity" section of the LCD: 115.02, 115.92 and 360.21.

The full-text of this local coverage determination may be viewed on the provider education Web site *http://www.floridamedicare.com* when it becomes available.

70544: Magnetic Resonance Angiography (MRA)

A corrected article was published in the Third Quarter 2004 *Medicare B Update!* listing the ICD-9-CM codes for MRA of the pelvis (72198). The article failed to mention additional ICD-9-CM codes had also been added to MRA of the abdomen (74185).

The following additional ICD-9-CM codes for MRA of the abdomen (74185) have been included in the policy: 444.0, 447.1, 996.81. V12.59

In addition, the local medical review policy (LMRP) for Magnetic Resonance Angiography (MRA) -70544 was previously revised on June 9, 2003 and published in the *Fourth Quarter 2003 Medicare B Update* (page 87). During that time, additional ICD-9-CM codes 198.0, 223.0, 223.1, 233.9, 263.90-236.99, 403.00-403.91, 404.00-404.93, 405.01, 405.11, 405.91, 440.1, 441.02, 447.3, 580.0-580.9, 581.0-581.9, 582.0-582.9, 583.0-583.9, 588.0-588.9, 593.81, 593.9 were added to MRA of the abdomen (CPT code 74185).

These changes are effective for services rendered on or after July 1, 2003.

The full text revised LCD will be available on the provider education Web site *http://www. floridamedicare.com* on or after that date.

76536: Ultrasound, Soft tissues of Head & Neck

The local medical review policy/local coverage determination for ultrasound, soft tissues of head & neck was implemented on September 29, 2003.

Due to reconsideration, a revision to the policy was made to add ICD-9-CM code V15.3– irradiation (previous exposure to therapeutic or other ionizing radiation). This diagnosis is supported under the "Indications and Limitations of Coverage" section of the policy.

This revision is effective for claims processed on or after June 1, 2004.

The full text revised LCD will be available on the provider education Web site *http://www. floridamedicare.com* on or after that date.

83880: B-Type Natriuretic Peptide (BNP)

The original local medical review policy (LMRP) B-Type natriuretic peptide (BNP) was effective January 5, 2004. This policy has been converted into the local coverage determination (LCD) format. This LCD has a linked LCD attachment, which indicates that the places of service allowed to perform this service have been expanded to include urgent care facilities (POS 20).

This revision is effective for services processed on or after June 11, 2004. The full-text of this local coverage determination may be viewed on the provider education Web site *http://www.floridamedicare.com* when it becomes available.

92015: Ophthalmological Diagnostic Services

The latest revision for local medical review policy (LMRP) ophthalmological diagnostic services was effective October

1, 2003. This LMRP includes the covered diagnosis codes for CPT code 92250 Fundus photography. However, this LMRP is only a procedure-to-diagnosis billing guideline, and medical necessity issues are not addressed. Therefore, a separate and distinct local coverage determination (LCD) has been developed for fundus photography to identify a procedure to diagnosis relationship and documentation requirements, with an LCD attachment that includes coding guidelines. This LMRP has been revised to delete references for procedure code 92250. This policy has also been converted into the LCD format.

This revision is effective for services performed on or after September 30, 2004. The full-text of this local coverage determination may be viewed on the provider education Web site *http://www.floridamedicare.com* when it becomes available.

93701: Cardiac Output Monitoring by Thoracic Electrical Bioimpedance

The local medical review policy (LMRP) for cardiac output monitoring by thoracic electrical bioimpedance – 93701 was last updated October 1, 2002. Per CMS Change Request 2689, this policy has been revised to offer more explicit guidance and clarification for coverage of thoracic electrical bioimpedance based on a complete and updated literature review. The policy was converted to local coverage determination (LCD) format and "monitoring" and "thoracic" were added to the title to reflect wording in the National Coverage Guidelines. In addition, diagnosis codes 786.05, 996.03, V42.1, V53.31, and V53.32 have been added to the "ICD-9 Codes that Support Medical Necessity" section of this policy.

These changes are effective for services rendered on or after September 3, 2004. The full text revised LCD will be available on the provider education Web site *http://www. floridamedicare.com* on or after that date.

93975: Duplex Scanning

The local medical review policy (LMRP) for duplex scanning – 93975 was last updated July 1, 2002. Since that time, the policy was converted to LCD format and diagnosis codes V42.0, V42.7, V42.83 and 902.29 have been added to the "ICD-9 Codes that Support Medical Necessity" section of this policy for procedure codes 93975 and 93976 and diagnosis codes 440.20 and 440.29 have been added to the "ICD-9 Codes that Support Medical Necessity" section of this policy for procedure codes 93978 and 93979. In addition, an indication was added to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the policy for procedure codes 93975 and 93976

These changes are effective for services rendered on or after July 26, 2004

The full text revised LCD will be available on the provider education Web site *http://www. floridamedicare.com* on or after that date.

98940: Chiropractic Services

The latest revision for local medical review policy (LMRP) chiropractic services was effective April 12, 2004. Program Memorandum 12 (Change Request 3063, dated 05/28/2004) was issued to communicate revisions for chiropractic services. Revisions include changes in definitions for chronic subluxation and maintenance therapy. Also, this change request added the following requirement: The AT (acute treatment) modifier must be used when providing active/corrective treatment for acute or chronic subluxation as claims submitted without the AT modifier will be considered as maintenance therapy and denied. Therefore, revisions have been made to the following sections of the policy:

- Indications and Limitations of Coverage and/or Medical Necessity
- Documentation Requirements
- Utilization Guidelines
- Coding Guidelines

This policy has also been converted into the local coverage determination (LCD) format with an LCD attachment, which includes the coding guidelines.

These revisions are effective for services rendered on or after October 1, 2004. The full text revised LCD will be available on the provider education Web site *http://www. floridamedicare.com* on or after that date.

COMPREHENSIVE DATA ANALYSIS

J2820: Sargramostim

The Comprehensive Data Analysis Department recently conducted an analysis of Medicare Part B claims data for CPT code J2820 – Injection, Sargramostim (GM=CSF), 50 mcg, as a result of a Florida carrier to nation ratio of 2.16.

Data revealed that Florida expended $627 per 1,000 enrollees as opposed to the nation, which expended $328 per 1,000 enrollees. Additionally Florida represents 12.15 percent of the nation in terms of dollars. $1,220,662 would not have been expended if Florida's practice patterns were similar to the nation. In June 2001 and June 2003, Florida ranked 8th and 6th respectively in the nation. Florida currently (2003.2) has a carrier to nation ratio of 1.80.

Data suggests that Florida providers may be over-utilizing this service. Many Florida providers appear to be billing for services that exceed the expected dosage range. Additionally, many physicians are billing for diagnoses that are not covered. Please insure that you are following the guidelines published in the Part B local medical review policy (LMRP) for J2820 – Sargramostim. LMRPs and local coverage determinations can be viewed at Medical Review Policies and Local Coverage Determinations can be viewed at the provider education Web site *http://www.floridamedicare.com* when it becomes available.

66821: Yag Laser

The Comprehensive Data Analysis Department recently conducted an analysis of the Medicare Part B claims data for CPT code 66821 – *Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid)*; laser surgery (eg, YAG laser) as a result of the Florida carrier being aberrant when compared to the nation.

Data revealed that Florida expended $8,963 per 1,000 enrollees as opposed to the nation, which expended $4,054 per 1,000 enrollees. Additionally, Florida represents 14.53 percent of the nation in terms of dollars. $20,271,520 would not have been expended if Florida's practice patterns were similar to the nation

The neodymium:YAG (Nd:Yag) laser is used to create posterior capsulotomies for posterior capsule opacification. Posterior capsule opacification generally occurs following cataract surgery. Desired outcomes of use of the Nd:Yag laser are an increase in visual acuity and/or improvement in glare and contrast sensitivity.

Data suggests that Florida providers may be over-utilizing this service. Many Florida providers appear to be billing this service routinely and within four months of the cataract surgery. Yag laser should not routinely be performed within four months of cataract surgery, nor should this service be performed unless the patient has symptoms that result in a reduced or inability to carry out activities of daily living. Please insure that you are following the guidelines published in the Part B local medical review policy (LMRP) for 66821 - Yag Laser Capsulotomy as well as following the established guidelines of the Social Security Act. The full-text of this LMRP/LCD may be viewed on the provider education Web site *http://www.floridamedicare.com*.

73630: Widespread Probe – X-Ray Exam of Foot, Three Views

The Comprehensive Data Analysis department recently conducted an analysis of Medicare Part B claims data for CPT code *73630 (Radiologic examination, foot; complete, minimum of three views)* as a result of the Florida carrier being aberrant when compared to the nation. Data revealed the Florida carrier allowed dollar variance of $830,510 was paid to provider specialties of Podiatry, Orthopedic Surgery, and Diagnostic Radiology; with Podiatry being predominant.

A widespread probe was recommended and performed as a result of the analysis findings. The purpose of the review was to determine if the services billed to Medicare were medically necessary, appropriately coded, and documented as having been performed. Focus was also placed on two views vs. three views, as well as possible comparison X-rays rather than medically necessary X-rays.

A widespread probe was performed on 100 claims for 20 providers for CPT code 73630 (X-ray of foot, complete, three views). These claims encompassed 132 services for 99 beneficiaries. Below is a breakdown of the review findings:

- 91 percent of the services were allowed as billed based on the submitted documentation.
- 8 percent of the services were allowed after changing the codes to 73620 (X-ray of foot, two views) because the documentation did not specify three views were performed, or 73610 (X-ray ankle, three views) based on the submitted documentation.
- 1 percent of the services were denied because the documentation did not support the service was medically necessary.
- 46 percent of the services reviewed were performed on initial visits for the beneficiaries.

Based on the results of the widespread probe for CPT code 73630, Local Coverage Determination is not being implemented at this time.

92225: Ophthalmology

The Comprehensive Data Analysis Department recently conducted an analysis of the Medicare Part B claims data for the following CPT codes: *92225 –Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial* and *92226 – Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; subsequent* as a result of a Florida carrier to nation ratio of 1.62 and 2.50 respectively.

The follow table depicts the carrier allowed dollars per 1,000 enrollees, nation allowed dollars per 1,000 enrollees, and the percent of the nation that Florida represents. $4,530,218 would not have been expended over a one-year period if Florida's practice patterns were similar to the rest of the nation.

January – June 2003			
Procedure Code	**Carrier Allowed Dollars/ 1,000 Enrollees**	**Nation Allowed Dollars/ 1,000 Enrollees**	**Percent of Nation**
92225	$513	$317	10.91%
92226	$1,401	$561	16.83%

CPT codes 92225 and 92226 are unilateral procedures. Therefore the Florida carrier would expect the utilization of modifiers 50 (both), LT (left side) or RT (right side) to indicate the service rendered. Approximately 9 percent of the services billed to the Florida carrier did not utilize a modifier. Therefore the services that were allowed were paid at the unilateral rate. The Florida carrier would like to insure that medically necessary services are billed and paid correctly. Please insure that you are following the guidelines published in the Part B local medical review policy (LMRP) for 92225 and 92226 as it applies to modifier usage. LMRPs and LCDs can be viewed at *http://wwwfloridamedicare.com*.

92225: Widespread Probe - Ophthalmoscopy

The Comprehensive Data Analysis department recently conducted an analysis of Medicare Part B claims data for CPT code *92225 (Ophthalmoscopy, extended, with retinal drawing [eg, for retinal detachment, melanoma])*, with interpretation and report; initial as a result of the Florida carrier being aberrant when compared to the rest of the nation.

Data revealed that Florida expended $513 per 1,000 enrollees as opposed to the nation, which expended $317 per 1,000 enrollees. Additionally Florida represents 10.91 percent of the nation in terms of dollars. $858,280 would not have been expended if Florida's practice patterns were similar to the rest of the nation.

A widespread probe has been recommended as a result of the analysis findings. The primary purpose of the review is to determine why different providers bill Florida beneficiaries in excess of one initial visit in a six-month period. Performing providers within a billing group often seem to share beneficiaries, each provider billing for an initial service. The secondary purpose of the widespread probe is to determine the medical necessity of all visits billed for this code. A recommendation may be made to utilize the information found in the widespread probe for the purpose of policy enhancement and further provider education.

99291: Widespread Probe – Critical Care Services

The Comprehensive Data Analysis department recently conducted an analysis of Medicare Part B claims data for CPT code *99211 (Critical care, evaluation and management of the critically ill injured patient, first 30-74 minutes)* as a result of the Florida carrier being aberrant when compared to the nation.

Data revealed that Florida expended $12,040 per 1,000 enrollees as opposed to the nation, which expended $7,522 per 1,000 enrollees. Additionally Florida represents 10.78 percent of the nation in terms of dollars. $19,733,124 would not have been expended if Florida's practice patterns were similar to the nation.

A widespread probe has been recommended as a result of the analysis findings. The purpose of the widespread probe is to determine the following:

- Does the documentation support the level of care billed
- Are providers documenting according to the guidelines published in the Current Procedural Terminology 2003 or 2004 publication
- Are the services billed medically necessary

A recommendation may be made to utilize the information found in the widespread probe for the purpose of future provider education.

EDUCATIONAL RESOURCES

THE EDUCATION AND TRAINING DEPARTMENT
OF
FIRST COAST SERVICE OPTIONS, INC.
PRESENTS

MEDICARE AT THE MOVIES!

AN EDUCATIONAL SESSION COMING TO A CITY NEAR YOU

ALL SESSIONS ARE FREE!

Each event offers four separate, 90-minutes sessions. Topics include:

- MSP for Part B Provider
- Inquiries Appeals and Overpayments
- Evaluation and Management Coding
- Preventive Services

Come and enjoy popcorn and candy while you learn about Medicare!

You may sign up for one or all for sessions

DATE	LOCATION
AUGUST 17, 2004	NAPLES
AUGUST 19, 2004	TAMPA
SEPTEMBER 21, 2004	MIAMI
SEPTEMBER 23, 2004	PALM BEACH GARDENS
October 2004	Panama City
October 2004	Pensacola

Please visit our Web site at *http://www.floridamedicare.com* for additional information and on-line registration.

For questions regarding any of our educational events, you may call (904) 791-8103

FIRST COAST SERVICE OPTIONS, INC.

PRESENTS

MEDICARE AMBULANCE TRAINING

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Topics

- Our Medical Policy Department will clarify the correct use of the GY modifier and explain the medical review process.
- We will walk step by step through the process of calculating Medicare reimbursements
- Explain changes to the calculations for the Fee Schedule portion of reimbursements effective July 1, 2004

DATE	TIME	LOCATION
AUGUST 31, 2004	1:00 PM TO 4:00 PM	GAYLORD PALMS 6000W. OSCEOLA PARKWAY KISSIMMEE, FL, 34746

Name

Street Address

City, State, ZIP Code

Telephone Number Provider number (PIN)

Email Address or Fax Number

You may register by completing this form and faxing it to (904) 791-6035, or register online at *http://www.floridamedicare.com* (in the Education section).

FIRST COAST SERVICE OPTIONS, INC.
PRESENTS

THE MEDIFEST SYMPOSIUM

First Coast Service Options, Inc. (your Florida Medicare contractor) is excited about hosting an educational symposium, which encourages open dialogue between the Medicare contractor and healthcare professionals. Providers will have the opportunity to network with representatives from their contractor, other contractors/governmental agencies, county/state medical associations and other provider organizations.

You can create a customized agenda by selecting the sessions in which you are interested. Here's your chance to learn what every provider needs to know about Medicare.

The Medifest symposium will offer topics such as:

- Diagnostic Cardiology
- Modifier Workshop
- Understanding Local Medical Review Policies/Local Coverage Decisions
- Medicare Secondary Payer
- Diagnostic Radiology
- Direct Data Entry
- Rehabilitation Services
- SNF (Consolidated Billing)
- Anesthesia/Pain Management
- Global Surgery

*Note: This is not an all-inclusive list of courses offered at the Symposium and is subject to change.

Come and spend an exciting two days with your Medicare Contractor!

Date	Location
September 1-2, 2004	Gaylord Palms Resort 6000 W. Osceola Parkway Kissimmee FL 34746

*Registration includes admission for two days, materials, continental breakfast, and afternoon snacks.

Please see the registration form on page 74.

Visit our provider education Web site at *http://www.floridamedicare.com* for more details.

FIRST COAST SERVICE OPTIONS, INC.
PRESENTS

A *FREE*
Evaluation and Management Documentation Seminar
FOR PHYSICIANS ONLY

First Coast Service Options, Inc. (your Florida Medicare Contractor) is excited about hosting our second 2004 Medifest Symposium. Our educational symposium, which encourages open dialogue between the Medicare contractor and healthcare professionals, provides something for everyone. We are extending a special invitation to those physicians who may not be able to attend our regularly scheduled day sessions. If you have ever had questions about documentation guidelines for Evaluation and Management services you can't afford to miss this session. We have made special arrangements with our Medical Policy Department to facilitate an evening session especially for you.

This free session is being scheduled in conjunction with Medifest, to be held:

Date	Location
September 1, 2004 6:30 pm to 8:00 pm	Gaylord Palms Resort 6000 W. Osceola Parkway Kissimmee FL 34746

Provider Name

Street Address

City, State, ZIP Code

Telephone Number Provider Number (PIN)

Email Address or Fax Number

You may register by faxing this completed form to (904) 791-6035, or by completing our online registration at *http://www.floridamedicare.com* in the Education section.

Please see pages 72 and 74, or visit our Web site for additional information on our Medifest Symposium.

MEDIFEST Class Schedule and Registration Form

$169.00

For complete class descriptors, please visit our provider education Web site at *http://www.floridamedicare.com*.

September 1-2, 2004
Gaylord Palms Resort
6000 W. Osceola Parkway
Kissimmee, FL 34746
Please contact hotel for directions and/or reservations 1-(407)-586-0000

Select one class per session (time slot)

DAY 1
Wednesday, September 1

9:00AM - 10:30AM SESSION 1/DAY 1
- ☐ Direct Data Exchange (DDE) (A)
- ☐ Fraud & Abuse (A/B)
- ☐ Diagnostic Cardiology(B)
- ☐ Hospital Outpatient Prospective Payment System (HOPPS) (A)
- ☐ Urology (B)
- ☐ Navigating FCSO's Web site (A/B)

10:45 AM – 12:15 PM SESSION 2/DAY 1
- ☐ Modifier 57, 78, & 79 Workshop (B)
- ☐ MSP for Part A Providers (A)
- ☐ SNF (Consolidated Billing) (A/B)
- ☐ ARNP/PA (B)
- ☐ Understanding LMRPs/LCDs (A/B)
- ☐ Preventive Services (B)

1:30PM - 4:30PM SESSION 3/DAY 1/WORKSHOPS
- ☐ ANSI 101 (HIPAA) (A/B)
- ☐ Evaluation and Management Services (B)
- ☐ Life after a Claim Denial (B)
- ☐ MSP for Part B Providers (B)
- ☐ Provider Enrollment (B)
- ☐ Rehab Services (A/B)

6:30PM - 8:00PM SESSION 4/DAY 1
- ☐ E/M Documentation Guidelines (B)*

This session is designed for physicians only. There is no charge to attend this session.

DAY 2
Thursday, September 2

9:00AM – 12:00PM SESSION 1/DAY 2/WORKSHOPS
- ☐ ANSI 101 (HIPAA) (A/B)
- ☐ Evaluation and Management Services (B)
- ☐ Life after a Claim Denial (B)
- ☐ MSP for Part B Providers (B)
- ☐ Billing Noncovered Services to the Fiscal Intermediary (A)
- ☐ Rehabilitation Services (A/B)

1:30AM - 3:00PM SESSION 2/DAY 2
- ☐ Anesthesia/Pain Management (B)
- ☐ Appeals Process for Part A Providers (A)
- ☐ Global Surgery (B)
- ☐ Medicaid (B)
- ☐ Fraud & Abuse (A/B)
- ☐ Preventive Services (B)

3:30PM - 5:00PM SESSION 3/DAY 2
- ☐ Modifier 57, 78, & 79 Workshop (B)
- ☐ Diagnostic Radiology (B)
- ☐ Navigating FCSO's Web site (A/B)
- ☐ Reason Code Resolution (A)
- ☐ Understanding LMRPs/LCDs (A/B)

For complete class descriptors, please visit our Web site at http://www.floridamedicare.com

Registrant's Name	Telephone Number
Email Address	Fax Number
Provider's Name	
Street Address	
City, State, ZIP Code	

FAXED REGISTRATION

1. Fax both registration form and class schedule(s) to **1-(904)-791-6035.**
2. A confirmation and invoice will be faxed or emailed to you.
3. Make checks payable to: **FCSO Account #700390**
4. Mail the forms (after you have faxed them) and payment to:
   Medifest Registration
   P.O. Box 45157
   Jacksonville, FL 32231
5. Bring your Medifest confirmation notice to the event.

CONFIRMATION NOTICE

Faxed registration: A confirmation notice will be faxed or emailed to you within 14 days of receiving your registration form. If you do not receive a confirmation notice (not the confirmation form generated from your fax machine, but the confirmation notice provided by Medicare Education and Training), please contact us at **1-(904)-791-8103.**

Online registration: When registering online for an education event, you will automatically receive your confirmation via email notification.

FLORIDA MEDICARE PART B MAIL DIRECTORY

CLAIMS SUBMISSIONS

Routine Paper Claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

Participating Providers
Medicare Part B Participating Providers
P. O. Box 44117
Jacksonville, FL 32231-4117

Chiropractic Claims
Medicare Part B Chiropractic Unit
P. O. Box 44067
Jacksonville, FL 32231-4067

Ambulance Claims
Medicare Part B Ambulance Dept.
P. O. Box 44099
Jacksonville, FL 32231-4099

Medicare Secondary Payer
Medicare Part B Secondary Payer Dept.
P. O. Box 44078
Jacksonville, FL 32231-4078

ESRD Claims
Medicare Part B ESRD Claims
P. O. Box 45236
Jacksonville, FL 32232-5236

COMMUNICATIONS

Review Requests
Medicare Part B Claims Review
P. O. Box 2360
Jacksonville, FL 32231-0018

Fair Hearing Requests
Medicare Part B Fair Hearings
P. O. Box 45156
Jacksonville, FL 32232-5156

Administrative Law Judge Hearing
Administrative Law Judge Hearing
P. O. Box 45001
Jacksonville, FL 32232-5001

Status/General Inquiries
Medicare Part B Correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments
Medicare Part B Financial Services
P. O. Box 44141
Jacksonville, FL 32231-4141

DURABLE MEDICAL EQUIPMENT (DME)

DME, Orthotic or Prosthetic Claims
Palmetto GBA Medicare
DMERC Operations
P. O. Box 100141
Columbia, SC 29202-3141

ELECTRONIC MEDIA CLAIMS (EMC)

EMC Claims, Agreements and Inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

MEDICARE PART B ADDITIONAL DEVELOPMENT

Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Over 40 days of initial request:
Submit the charge(s) in question, including information requested, as you would a new claim, to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

MISCELLANEOUS

Provider Participation and Group Membership Issues; Written Requests for UPINs, Profiles & Fee Schedules:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider Change of Address:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider Education:
For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:
Medicare Part B
Medicare Communication and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

For Seminar Registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Limiting Charge Issues:
For Processing Errors:
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

For Refund Verification:
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

Medicare Claims for Railroad Retirees:
MetraHealth RRB Medicare
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and Abuse
First Coast Service Options, Inc.
P. O. Box 45087
Jacksonville, FL 32232-5087

FLORIDA MEDICARE PHONE NUMBERS

BENEFICIARY

Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

PROVIDERS

Toll-Free
Customer Service:
1-866-454-9007
Interactive Voice Response (IVR):
1-877-847-4992

For Seminar Registration Only (*not* toll-free)**:**
1-904-791-8103

EMC

Format Issues & Testing:
1-904-354-5977 option 4
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1-904-791-8767 option 1
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1-904-791-8016
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
1-904-791-6895
PC-ACE Support:
1-904-355-0313
Marketing:
1-904-791-8767 option 1
New Installations:
(new electronic senders; change of address or phone number for senders):
1-904-791-8608
Help Desk:
(Confirmation/Transmission):
1-904-905-8880 option 1

OCR

Printer Specifications/Test Claims:
1-904-791-8132

DME, Orthotic or Prosthetic Claims

Palmetto GBA Medicare
1-803-735-1034

MEDICARE PART A

Toll-Free:
1-877-602-8816

WEB SITES

PROVIDER

Florida
http://www.floridamedicare.com

Centers for Medicare & Medicaid Services
http://www.cms.hhs.gov

BENEFICIARY

Florida
http://www.medicarefla.com

Centers for Medicare & Medicaid Services
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Index to Connecticut and Florida *Medicare B Update!* - Fiscal Year 2004

The following is a comprehensive index covering all articles published the FCSO *Medicare B Update!* during fiscal year 2004 through June 30, 2004 (including special electronic-only issues).

Beginning in January 2003, the *Update!* is consolidated into one issue for both states. In this index, content published for both Connecticut and Florida is listed first, followed by content intented only for Connecticut, then content intended only for Florida.

Note: Electronic issues denoted with an asterisk (*) are *not* produced in hard copy format, and are available only on FCSO's provider education Web sites, *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*.

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